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Applying a Strengths-Based Methodology to your Strategic Commissioning

Pre-reading – Introducing and Implementing Strategic Commissioning Approaches 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

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Strategic Commissioning Approach 1. Place-based wellbeing

Design and creation of a place-based wellbeing system.

Introduction to this approach

This commissioning approach fits most closely with the 'whole system design' commissioning aspect. It represents the shift from thinking about care needs first, to thinking about wellbeing first, and begins with a view that the best way to deliver outcomes for the community is to start early and 'upstream' to the individual, families, neighbours, the community and other support wherever and as much as possible. Ideally, this is well before what is called 'prevention and early intervention' and is about creating the conditions for people to be healthy, resilient, and connected in their communities. It is more than just keeping people out of care; it is about establishing the environment, so people are able to have healthy lives.

It has to be recognised that a large part of this is a demand management approach which needs to be monitored and evaluated for impact on cost and outcomes, otherwise the risk is of wider service provision while the most vulnerable continue to miss out, and services continue to struggle.

Here, the council's role is to plan and commission interventions and services that are resolutely focused on building community well-being and individual health through carefully planned public health and joined up strategies with key agencies and providers. Commissioning is therefore focused on understanding need – the needs of the whole place, not only individual services – and on ensuring that suitable approaches are set up or enabled to reduce the demand arising from that need. Indeed, it would be even better to focus first on strengths and capabilities in the place, and how they could be enabled and strengthened such that the needs do not arise.

This approach means that this work is necessarily co-produced – it is about creating the conditions for people to be in charge of or co-produce their own care and wellbeing – and is more complex and emergent because the council cannot dictate terms or set out and then implement a programme. Such an approach works best where there is a robust professional practice and commitment to prevention, political leadership is resolutely focused on the long term. Levels of deprivation and need are significant but need long-term action, and all parties from providers to community bodies work well together and are willing and able to invest for long-term benefits.

How to move towards this approach

This is a long-term approach which needs consistency of purpose, leadership, capacity, and capability. A good first step is to keep a focus on overall strengths and needs in the local place (even if they cannot be worked with immediately). Share this with partners and public as a 'convening call', be clear about where the potential lies to begin to 'get upstream' to reduce needs for care and support wherever possible, demonstrate some of this through judicious experimentation, try to create more flexibility for providers, community groups and partners to experiment and work hard on building mutually supportive relationships across the system. If local commissioning is reasonably strong in the other aspects, your commissioning development plan could consider how to focus all parties on a vision of a place that helps people to maximise their wellbeing and minimise their care needs and where needs are dealt with in a way that focuses on supporting and increasing self-efficacy.

What to do, and what not to do, when you are pursuing this approach
The goal here is to make health, wellbeing, and minimal care needs the default, easy option, so it is important not to neglect statutory requirements and crisis intervention services, and to find a way to progress incrementally, building on and reinforcing (and, if necessary, defending) moves in the right direction.

You will need to build a strong understanding of your place and its possibilities, and widely embed the concept that it is better to create the conditions where people can have their needs met by the community, meet their own needs, or not fall into need in the first place, than to provide services. Remember that it is not necessary to have control over and redesign the whole system to make a difference, if you have a good overview and can identify the most effective things you can do to support a system of wellbeing.

Specific risks and issues
The challenges with this approach, apart from its scale and optimism, are clear. Apart from all the many demands on commissioners' time and attention, large-scale issues around funding, crises, policy changes, changes of leadership and of structure will all impact success in this space. Sustainability of even small steps will be in question given current funding challenges and the push to unit-based provision.

Few councils are able to consistently work using this approach. It is also noteworthy that some examples are not easy to scale up or sustain, and do not fit into the paradigm of 'services' or comfortably into adult social care commissioning. In other strategic commissioning approaches, you will also see examples that seek to move towards place-based wellbeing, which may in some ways be more practical – to really move fully to place-based wellbeing, a lot of rethinking may be required.

Considerations for commissioning skills and structure
The need referred to above to communicate and enthuse people about the possibility of working very differently suggests that commissioners in this approach will need to be skilful communicators, and also to demonstrate examples at a small scale. It will also be important to have a grip on service delivery and costs while building a large-scale systemic picture of your whole place, influencing senior leaders, strategies, and plans, and building joined-up governance. Rather than attempting to recruit super-heroes, it is important to consider how social care commissioning can build alliances and appeal to the motivations of relevant people and organisations – acting as a catalyst and shaper, rather than taking on all the responsibility.

Examples of this approach in practice
- As part of Leicester City Council's Supported Living and Extra Care Housing Strategy, the council aims to provide up to 396 new units over ten years, including provision for supported living and other housing to delay entry into statutory care, replacement of sub-standard existing statutory care provision, and provision for care leavers aged 18-25. Two new developments contain a mix of working-age adults with care and support needs and older adults, and are connected. Tenants report that the mix has a positive impact, supports diversity, and that "some younger residents help the older ones with shopping etc, and some of the older ones support the younger ones who may not have family. This

makes for a nice community of people who can balance each other's strengths and needs."

- With over 2,000 people living with dementia in the borough, Dementia Inclusive Greenwich is an initiative to help businesses adapt their services to be more inclusive. It offers local organisations free training and practical support to make changes that can help people with Dementia – to both the built, physical environment and also the social environment. The scheme has been very successful and now requires funding and power to take it forward.
- The Small Supports Programme, delivered by NDTi, supports people with learning disabilities, mental health issues and autism and who are identified as having complex support needs because of their behaviour, forensic or offending history. The programme has a vision of people getting support that is right for them and having a choice about where they live and what they do. It supports organisations and 'partners' (including all the people who are helping the person), to plan and deliver support in a truly person-centred way. In a programme with the LGA and NHS England, they looked at how to spread this approach to more areas, identifying a number of strengths and opportunities, and a number of barriers, including a commissioning 'myth' that those who engage small providers might be sued by large providers, and a challenge that while this type of support is necessarily small, person-centred, and adaptive, this makes it hard to offer a concrete 'thing' for commissioners to grasp and understand.

One thing to read

Transforming care and Support, SCIE, https://www.scie.org.uk/transforming-care

Strategic Commissioning Approach 2. Leadership of place for whole system change

Creating a system that works.

Introduction to this approach

This approach is paired with the 'relationships and organisation across the system' commissioning aspect and is all about achieving that capability. It begins with a view that since communities are complex and their needs are constantly changing, often in unanticipated ways, the best way to deliver good results is to understand the whole system, intervene collaboratively and disrupt compassionately. It also requires an understanding that what is often referred to as a 'system of care' may not be – and often is not – a functioning, purposeful system at all.

The council is not at the centre of the system but is one of the core, and most critical, building blocks. This approach sees the role of the council as working in partnership with all the other players in the place, and commissioning based on a shared understanding of what makes the difference to local social outcomes, particularly regarding joined-up pathways and effective referrals between different organisations. Commissioning is therefore focused upon identifying a rich mix of services, support and involvement in the local social economy to achieve pragmatic results. This approach is associated with the relationships aspect of commissioning because it depends heavily on formal and informal relationships at various levels to succeed.

The approach is likely to be called for when community need is in a state of flux, and both provision and service need are diverse and challenging. It is important that political leadership is comfortable with uncertainty and ambiguity and that there is a focus on appreciating the whole while pursuing what works, and the ability to collaborate effectively and learn through experience.

How to move towards this approach

Like whole system design, this is also an approach which requires time and broad capability. A good way to begin is by providing concrete evidence of where costs can be lowered, and outcomes improved through making the system more coherent. If different organisations can learn to work together more effectively, the case for working as a single system becomes stronger. Beyond that, good relationships are needed to ensure the recognition that interventions paid for in one part of the system, which create savings elsewhere, are important for the whole system. There are huge opportunities to engage with frontline staff, carers, providers and service users to identify opportunities for improved coherence. Clearly, integrated commissioning and funding would also be a logical step forward in this regard.

Work on shared culture, identity and vision will be valuable and necessary to progress this approach. It is also important to recognise and work with professional boundaries and the threat that a joined-up approach can pose to organisational leaders by destabilising their power bases. A strong, shared vision about how care should work in your place, with processes for learning, will, however, go a long way to support this.

What to do, and what not to do, when you are pursuing this approach
It's important to understand that this requires working across boundaries and the ability to cut through to honest conversations, confront issues productively, and to find the mechanisms which will allow a shared view – often bringing people face-to-face with the citizen experience, or demonstrating the overall savings available through a joined-up approach (along with managing the discussion about how these savings are shared). In the long-term, the drive will be towards co-commissioning with single funding pots across wider scope and organisational boundaries. This is the espoused goal of Integrated Care Systems and so it is important to engage both constructively and critically with plans and governance – it may or may not be appropriate for councils to 'put all their eggs in the one basket' of ICB governance, as it is likely that much joining-up will still be achieved outside of the formal structures. All of this means there is a need to manage the balance between national politics and nationally driven change, and local change. All kinds of providers, the community, the voluntary sector, and other services outside the scope of the ICS will also be critical.

It is important not simply to pay lip service to real joint working, ignoring the challenges of incompatible funding and performance drivers, and not to be drawn into the avoidance tactic of producing beautiful analytical shared plans which do not actually change practice on the ground.

Specific risks and issues
This approach can be derailed by poor governance, relationship challenges (between organisations and even individuals), being distracted into other urgent 'whole system' challenges, and a focus on strategy, planning and governance at the expense of practice. There is also a risk of distribution of time and focus, and losing sight of other vital elements of the commissioning role.

The main motivating factor here is that if extended governance is right, and based on real understanding and learning, it will be possible to guide and steer the whole system to be better. It is important to pursue a strategy of incremental gains and pragmatism.

There can be real challenges with a single large or dominant provider when you are on the outside seeking to influence it, or shape the market. There can be power imbalances between large and small providers, particularly if commissioners are driven by short-term funding streams. It can also be difficult to influence alliances as part of collective place governance, if the alliance is developed outside those governance structures.

Considerations for commissioning skills and structure
This approach requires strong internal relationships with politicians and senior leaders, and the ability and gravitas to influence at board level, as well as striking a balance between the procedural and the pragmatic – getting down to real change. There is likely to logical support for a long-term move to shared commissioning on a broad basis, so it is important that principles of, and approaches to, commissioning that reflect the statutory requirements and values of social care are embedded for the long-term.

This approach, like others, requires the ability to draw on all of the skills of other approaches. It is unlikely to be the exclusive approach unless it is already well advanced and may be blended with another approach.

Examples of this approach in practice
A popular and successful radical approach in this space is some form of 'alliance contracting': establishing a partnership or alliance of relevant delivery bodies with shared governance, and sharing relevant budgets across all parties with a targeted scope of interventions or outcomes (or both). This allows for various legal forms of agreement which take competition out of the picture, or limit it, and allow collaboration across a wider system to work towards shared outcomes.

- The Plymouth Alliance for Complex Needs was formed by Plymouth City Council and part of Devon CCG with a budget of £638m gross, driven by strategies for wellbeing, community, children and young people, and enhanced and specialised care. The scope covers public health, leisure services, housing services, children's services including direct schools grant, adult social care, primary care, community health services, and acute provision. The integrated commissioning team commissioned seven provider organisations under a single alliance contract, worth £7.7m and lasting up to ten years, to work together supporting adults with complex needs. The attempt is to work as one truly integrated system.
- The charitable company Community Safety Glasgow, which from 2006 to 2019 (when it merged back into the council) was a Company Limited by Guarantee, owned by Glasgow City Council and Police Scotland worked with single vulnerable people and community safety. By encapsulating responsibility – and the budget to address it – in a single entity, the model allowed a single-minded outcomes focus.
- A London borough brought together its community and voluntary sector funding into a single outcomes-based contract which it specified had to be delivered by a local alliance. The local umbrella body led a successful bid for the contract and the alliance as a whole – which needed significant support and put significant effort into developing its own governance, bid, and outcomes measurement capability – is now working in partnership with the council to deliver.

One thing to read
Place-Based systems of care: A way forward for the NHS in England. The Kings Fund (2015) https://www.kingsfund.org.uk/publications/place-based-systems-care

Strategic Commissioning Approach 3. Unlocking potential

A place where everyone can thrive.

Introduction to this approach

This approach is paired with the 'capacity, capability, and confidence' commissioning aspect and is about having the resources, capacity, and capability available – from various sources (business, charity, mutual aid, self-efficacy) – to meet need at the point of demand or to enable people to live their lives without falling into need. It begins from a view that the best way to deliver outcomes for the community is for the community to do this for itself, and to ensure that all spend and provision is targeted to creating capacity, capability and confidence (pushing 'upstream' as much as possible, to try to prevent needs rather than deal with demand). This approach is likely to be relatively disinterested in the delivery model but focused on the direct and indirect impacts of health and care.

The council's role is to assist in the supporting of capability-building activity by deploying its assets (spend, buildings, legal advice, leadership, connections, media) to support the creation and sustaining of community groups (with varying levels of formality) and VCSE organisations, alongside other providers, to co-produce social outcomes. Commissioning is focused around understanding and influencing all the assets available to the community, and helping the community to become stronger and more capable of supporting its members; 'care by the community not merely care in the community.'.

Such an approach works well where:

- There are strong, connected communities
- Political leadership is brave, confident, and community-focused
- Levels of deprivation and need are significant but not overwhelming
- There are established public partnership bonds of trust

It requires an ability to engage with providers as partners, to consider co-commissioning approaches, and manage an effective balance of collaboration and competition, while staying within procurement and other guidelines.

How to move towards this approach

This approach requires a view of funding and support that considers the long-term and wide-ranging impacts. Therefore, strong market insight, market making, and market management capabilities are needed – a good starting point is sound knowledge of current provision, both formal and informal, and analysis of the secondary impacts of the council's actions.

There is now a strong evidence base for this kind of approach, but active engagement with all parties who can support people is critical, so developing a combination of systems analysis and engagement skills is critical. Good first steps are to explore social value – through the provisions of the Social Value Act and mainstream contractual requirements – and to prototype one or more approaches, like alliance provision (awarding to an alliance of often voluntary sector providers).

Commissioners will need to work proactively with all parts of the system to deliver change and to be able to bring in economic analysis to underline the secondary benefits as well as savings. Work to understand costs of care and market sustainability may provide an opportunity to make changes in this area.

What to do, and what not to do, when you are pursuing this approach
The main focus here is a community and place which support positive outcomes, with active and dynamic capability from an effective mixed market, all of which support self-efficacy. It is important to invest and measure returns in all parts of this, while still delivering responsive services and ensuring that they are effective and not increasing dependency. Councils need to ensure they connect to wider wellbeing agendas, including, for example, employment and physical activity.

It is important to see 'unlocking potential' as a long-term benefit, not a short-term way to save, and to be creative and collaborative in how capacity, capability, and confidence are built, including making social value core, and integrating this thinking into your Market Sustainability work. It is also important not to pay lip service to 'enablement', but to follow validated approaches like Good Help.

Specific risks and issues
This is an approach which hugely benefits from top-down support and sponsorship and place-based agreed activity. Its success also depends on the latent capacity of your markets, community and voluntary sector etc, and the history of working with them. It is likely to require long-term consistency of purpose.

A short-term savings focus in this area can lead you to unsustainably loading community, carers etc, and undermine long-term capability. You also need to ensure you are well set up to appropriately use a mix of funding mechanisms.

Considerations for commissioning skills and structure
Market engagement, community development, and a strong focus on self-efficacy are all needed – and the ability to balance a focus on unlocking potential with meeting needs in the here and now. Ideally, commissioning would be structured around pathways from need and dependency to self-efficacy, mirroring services, and be place-based or council-wide, or at least linking to an overall place-based plan.

Examples of this approach in practice

- Commissioning Home Care to rural communities: A local authority in a large rural county had experienced difficulties in securing reliable providers to deliver home care services across the county. The area covers large sparsely populated areas, comprising small towns and villages as well as isolated hamlets and farming communities.

  The existing providers were finding recruitment and retention increasingly difficult as other employment pays more, and travel costs had become a growing disincentive to home care staff. Many providers said that they could no longer cover rural areas and could only respond to requests to take on new work in the larger urban parts of the county. Hospital discharge delays were increasing partly due to the availability of home care services.

The council engaged with community groups, district and parish councils, voluntary organisations, carers groups, and NHS partners. They heard that in some parts of the county, there was the potential for greater community and neighbour support, particularly for vulnerable older people with care and support needs. However, this was unevenly spread and could not be relied upon to support newly identified needs including hospital discharge. Commissioners decided to earmark a proportion of the home care commissioning budget for a new approach. This involved establishing district home care support budgets which could be accessed by local teams – including GP surgeries – to directly 'commission' neighbours, friends and community groups to deliver care and support to vulnerable older people. At the same time the commissioning team promoted the development of micro-providers, working with the local Voluntary Service Council to offer organisational and financial support to get started.

- Enabling community development and unlocking latent potential in staff: In dealing with a fast-growing crisis and setting up the Wigan Deal, the council supported capability development in two ways that are sometimes overlooked. By the end of 2018, they had put £10m into Community Investment (at the same time as delivering over £130m of net savings). Along with reducing demand on public services and capacity building, this fund leveraged £3.9m of external funding, £5.6m of social and economic benefit, and £1.26m of recurrent savings. The asset-based approach applied to staff, too, with a focus on their strengths, their ability to focus on the strengths and capabilities of citizens and put control with citizens, a clear and inspiring development plan, and permission to spend up to £50 to resolve a citizen issue without authorisation.
- Community-led support: Somerset faced a crisis in care, with the number of people over 75 years old projected to double by 2039, and sought to move from 'assessment for service' to 'being part of joined-up community-based 'system of support', aimed at helping people to 'get on with their lives'. Co-produced, joint working with the council played an enabler role. They began to work hyper-locally in West Somerset using a "test and learn", open approach that became Community Connect, supported by Community Catalysts. The work created 575 active micro-providers and sixteen trusted trader networks, providing over 9,000 hours a week of flexible, local person-centred support to over 1,500 people, supporting community resilience, and delivering £500,000 annual savings to adult social care, and £2m total savings to the health and care system. Expanding the principles more widely across the council created a whole range of positive outcomes, reflected in customer contact metrics and better care outcomes. A contact centre aims to find community-based solutions and where possible avoid referral for a formal social work assessment. Community Connectors act as local or village-based agents with knowledge of local community assets and support a range of activities from community cafes to supporting hospital discharge, connecting people to community assets and informal services, whenever possible. A focus on personal budgets or direct payments, and services offered to self-funders, allow the council to indirectly fund non-regulated micro-businesses.

  This work required expertise and experience, a culture of innovation, permission, and strong leadership from both political leadership and senior officers and, at multiple levels, significant work with front line teams, relationship-building to

generate trust, and strong relationships across strategic commissioners, those leading programme development, and the VCE infrastructure organisations.

One thing to read

How-To Guides for creating an asset-based area. TLAP. 2018
https://www.thinklocalactpersonal.org.uk/Browse/Building-Community-Capacity/how-to-guides-for-creating-an-asset-based-area/

Strategic Commissioning Approach 4. Citizen-centred commissioning

Putting people in charge of care.

Introduction to this approach

This approach pairs with the 'user and outcome-centred' commissioning aspect and is about putting people in charge of their own care and making their assessment of whether they get what they needed the measure of success in the system. It begins with a view that services often get in the way of people leading their lives as they want to and make it hard for them to get the support they need. There are several perspectives on this. One is that the aim should be to shrink the state and let people get on with living their own lives or empower them through direct funding and creation of marketplaces. In this perspective, the council's role is to provide necessary information and advice for people who have social care needs to enable them to find their own sources of support. Service provision is for those unable to help themselves. This is care based on individuals and families caring for themselves. In these circumstances, the approach works best where community need is mostly minimal with only some deprivation, there is little community-led demand for significant public services, and political leadership is focused on reducing the state.

There is also the highly person-centred approach provided in the case study provided in the pre-reading materials of a council and place that scores higher in the 'user and outcome-centred' commissioning aspect, where the locus of decision-making about care lies in conversations with the citizen and their own decision-making, through a combination of accessible community, universal, and self-funded services, and access to commissioned specialist services, where appropriate. This approach works best where a coalition can be built and its success demonstrated to key stakeholders, and where learning can expand across the whole health and care system. The 'three conversations' technique is an example of this.

There is a broader approach to including citizen reports on outcomes and co-design into more traditional service provision, including, where appropriate, payment mechanisms (though there are risks inherent in 'payment by results' contracts which mean they should only be used by exception). This approach can be introduced contract by contract and become a part of ongoing practice, and link to front-line interventions. This works best where there are good relationships with providers and a good understanding of how practice works and are able to build learning and adaptation into provision.

How to move towards this approach

Perhaps more than other approaches, this requires a compelling vision for commissioning and the ability to communicate it, and requires connection with senior leaders including politicians, frontline practitioners, and providers including community support. Transformational change requires a shared vision of change from all, best driven by experiencing what is possible.

It means shifting the basis on which services are purchased and resources allocated from units of service provision for pre-defined needs to what is needed to ensure that

the outcomes desired by service users are met. The emphasis is on the results and learning, not the activity or intervention itself, and on empowering citizens to make their own choices. It can be challenging to win over senior leaders and to change the culture of assessment and design of plans.

There are several, potentially new, skills that need to be developed across the system from how to distinguish outcomes from outputs, inputs and processes, how to engage with the public and how to utilise data and analysis. Good first steps are setting up real prototyping and building in "did you get what you needed?" and further qualitative questions to all service provision feedback.

What to do, and what not to do, when you are pursuing this approach
At its heart, this is about moving commissioning into a facilitative role, to aid people in their lives. So this means co-design, a careful approach to statutory duties (neither letting them dominate, nor neglecting them), and measures driven by what people say they want and their experience and results.

It is important to note the risk of creating new 'citizen-centred' silos by building new services around specific needs, of adding to confusion and making services inaccessible by having a bewildering variety of choices, and to maintain a strengths-based approach. The main focus here is trust that individuals are their own best determinants of their care.

Specific risks and issues
Key risks include losing control of provision and being unable to learn about the system, by not building in connections back to practice and results – with obvious financial risks. At the same time, it is important to build in assurance that statutory requirements are being met. A 'big bang' approach is quite risky in this space, as it requires learning a new way to do these things, and unlearning some existing practices – small prototypes are useful. An alternative risk, though, is paying lip service to being citizen-centred, picking up the jargon without actually changing practice on the ground. There is also a risk of paying attention to the details of citizen engagement without being able to put in place the broader services that citizens need.

This approach is vulnerable to lack of understanding across partners and leaders, including politicians, which means a requirement to engage them in the practice so that they understand the approach and its benefits, as well as risks. This needs to be ongoing work, with succession planning, because changes of officer or political leadership may mean you have to make the case all over again. There is also a risk of attempting to adopt this approach 'under the radar', which can work at small scale and to demonstrate new ways of working, but is risky at a strategic level, without appropriate authorisation.

Considerations for commissioning skills and structure
This approach requires an inversion of the normal structure, so is challenging to do across a whole council, therefore the structure is likely to be focused on adult social care, though inevitably an approach led by what people are trying to achieve in engaging with your services will require strong connections with internal and external partners. That inversion is about supporting and learning from practice, which in turn

is led by the citizen. So commissioners need to be strong change managers and have the credibility to get the backing for quite radical experiments from senior leaders, and need to be very open to learning, and showing their working. They also need to be able to support front-line experiments while maintaining an overview of and approach to the whole service system.

Examples of this approach in practice

- Co-production to transform mental health services: A council faced high rates of psychosis, Mental Health Act admissions, acute hospital admissions, and adults in high cost residential and inpatient placements. Working with their then Clinical Commissioning Group, they tested co-production on a large scale, putting citizens at the heart of their own care. A series of storytelling and co-design sessions helped set a bold and shared vision for a system focused on prevention rather than crisis care. A resource map, brought to life by trained peer researchers telling community stories, identified that little funding was going to services designed to help people live well in their communities. Four key changes were made: a collaborative across service users, GPs, providers and commissioners to drive the change, an empowered network of providers, support agencies, statutory organisations and others with a focus on 'living well', a jointly-funded organisation that manages funds for those who need personalised care and personal budgets, and a hub to provide easy, integrated access to services. The result was a 32 per cent reduction in referrals to secondary care, with 500 people now supported by the network, many of whom would not have previously had any support at all. The waiting time for support in secondary care reduced from one month to one week. Professionals recognised the integral value of working with people with lived experience of mental health problems, and the initiative saved 20 per cent against an original budget of £12m.
- Empowering users and their families to take control: A council needed to change the way that day services for people with learning disabilities were organised. The existing centres were increasingly seen as inappropriate, particularly for younger people. Families and carers were dissatisfied, but feared that the council would close the centres, depriving them of essential day-time respite. A campaign group – "Save our Centres" – was being talked about by a number of families and there was some political nervousness. The council decided to explore the potential for handing over the day centres to families and carers, who would form themselves into a user-led Community Interest Company. The commissioning team pulled together a council-wide working group to develop the business case, including estates, legal, and finance. They also sought a delivery partner to work alongside the family/carer group whilst they developed their skills and capability to manage the business. The centres were leased to the CIC, staff were offered a secondment to work with the new organisation, and a budget for service development was established. The CIC were then able to offer commissioned places via the community learning disability team and directly to service users and families.
- Drug and alcohol service cost reduction and service improvement: A council identified the need to make savings while re-tendering for a drug and alcohol service and moving it to a new lower-cost building which presented opportunities for variation in service delivery. A commercial board was set up to govern the

project, with procurement and commissioning staff, and approved a procurement route using a widened definition of 'most economically advantageous tender' (PCR 67 (4)): 'The cost element may also take the form of a fixed price or cost on the basis of which economic operators will compete on quality criteria only.' The specification was presented as a flow chart, tracing the value chain from resources to activities to delivery arrangements, outputs, near outcomes, and overall outcomes, and focusing on outputs such as 'improved opportunities for non-opiate users to use the service' and 'opportunities for substance using parents with resident children to access treatment', and near-outcomes including 'high levels of successful completions of treatment'. The responses were evaluated primarily based on providers setting out their resources, activities, and delivery arrangements, effectively comparing the council's logic model for what would achieve the outcomes with those of the potential supplier. The council was therefore able to identify a supplier with the most credible delivery model to meet the outcome specification, within a fixed budget which delivered the required savings.

One thing to read

Do Asset-Based Areas Commission? Public Service Transformation Academy. 2017
https://www.publicservicetransformation.org/2017/10/asset-based-areas-commission/

Strategic Commissioning Approach 5. Values-based/disruptive commissioning

Changing the status quo

Introduction to this approach

This approach incorporates two very similar approaches and relates to the 'information, insight, and innovation' commissioning aspect and challenges the status quo, based on citizen perspectives and equity or innovation and creativity. Values-based commissioning is based on prior beliefs about what is the right thing to do, whereas disruptive commissioning believes in the value of innovation and learning and that better solutions will emerge. Disruption here should be seen not as commissioners disrupting the market (though that is possible), but more about a belief that it is OK for things not to always remain the same and creating a climate where it is possible for innovation to happen on an ongoing basis.

Disruptive commissioning is named after 'disruptive innovation' – the introduction of new techniques, knowledge, products and services which emerge to change existing patterns and support the development of new models, markets and practices. Often this approach takes lessons from the world of technology where disruptive technology drives productivity, and can improve quality and reduce costs, from data and analytics to the 'internet of things' and market platforms.

A disruptive commissioner is likely to seek opportunities (even small scale) to completely revolutionise practice and therefore, as well as seeking lessons from other markets and geographies, needs to be closely connected to practice, particularly when the disruption emerges from citizens (including self-funders), working with people who are willing to provide the support they need. They may also introduce approaches like citizen commissioners and citizen juries, and opportunities for supply-side innovation from negotiated bidding processes to hack days and innovation clauses in contracts.

A disruptive approach will work well where commissioners have the freedom to act, where the council can take account of the need for strategic agility and recognise the costs of failure to adapt (and may have experience of this from the past). It will also thrive where there is good capacity-building and development for commissioners and all those who need to engage in innovation, and where the support for innovation can be sustained in the medium to long-term.

Values-based commissioning reflects a more qualitative approach based on service user and carer experience and perspectives. This is closer to citizen-centred commissioning – shaping services that are about, and for, that person and their needs, not just commissioning services as an end in itself. Its scope is wider, thinking about how health and care provision can support the 'levelling up' of individuals and groups whose needs are not fully met by the current system. Values-based commissioning explicitly tries to achieve ethical outcomes and is likely to emphasise co-production and co-commissioning. This is likely to be emotionally appealing to many people involved in delivery, if it gets leadership backing. It is likely to represent something of a culture shift and therefore requires engagement and involvement from all those involved.

How to move towards this approach
Undertaking a strategic options appraisal and looking at room for manoeuvre in commissioning is a good first step to develop such an approach. For both values-based and disruptive methods, maximising commissioner capacity and capability and room for manoeuvre is critical, as is building credibility – through results. To be disruptive, it is also critical to begin to learn from practice and from other systems where innovation can result, and it can be demonstrated how improved outcomes have been achieved.

What to do, and what not to do, when you are pursuing this approach
It is important to work in an open and sharing way, inviting engagement and criticism of the picture you are creating, connecting to multiple sources of data, and understanding that all information is structured and interpreted, and so subject to different interpretations. Councils need to make their insight and drive for reform available and useful to everyone across the system. Commissioners need to be coalition-builders for change, taking people along, so that they have insights from understanding the system better and differently, and can see the benefits of change. Small-scale demonstrations of what is possible in real services are invaluable in this approach.

Try not to fall into the trap of trying to create perfect knowledge of a complex system. It will be essential to maintain testing and proving it in the real world. Do not try to 'boil the ocean' by building everything into the model, and do not try to take all the responsibility or credit. The main focus here is the insight that will allow new and optimal solutions to be delivered.

Specific risks and issues
A clear risk here is plans for innovation that are either blocked because they are too radical and do not get buy-in, or are forced through without enough evidence of feasibility and end in disaster. It is important to balance small-scale demonstrations of disruptive working with coalition-building for shared values, and being open to challenge and critique. A balanced risk appetite is important.

Considerations for commissioning skills and structure
Commissioners in this model clearly need a sense of drive, an ability to engage, and to have or have close access to great data analysis and research and engagement skills. They also need to be able to build a case for change, balance risk, and support small-scale demonstrations of new ways of working. Commissioning might be organised into – or working across – broader themes to which social care and other services contribute, and is likely to be part of a wider policy and strategy conversation.

Examples of this approach in practice
- Ethnicity and mental health – a new beginning: Analysis has shown a lack of parity between black and minority ethnic (BME) people and the white majority in access, experience, or outcomes of mental health care. This disparity has been demonstrated for over half a century, and yet little has changed in that time. Attempts to change established practices have largely created a sense of helplessness and pessimism, particularly in the absence of a national plan or strategy or other clear leadership focus. The Ethnicity and Mental Health

Improvement Project (EMHIP) in Wandsworth, London, attempts to address this situation. It is a collaborative project involving the local mental health service, South West London and St George's Mental Health NHS Trust (SWLSTG), and a BME community mental health organisation, Wandsworth Community Empowerment Network (WCEN).

After a decade of work, it became clear that a fundamental reconfiguration of the mental health system was required. EMHIP started from an evidence base, bringing together experiences of service users and individuals from BME communities, examples of good practice across the country, evidence in relation to equitable and effective mental health care, and research findings and recommendations from inquiries and reports. WCEN developed an approach to situate the majority of mental health care in the community, through engaging community leaders and those sought out by people with mental health problems in BME communities, and who are well-placed to identify and support, with high-quality, professionally-accredited, mental health support training. Patient work over many years has begun to provide insight and understanding with a solid and professionally-developed evidence base which shows the effectiveness of this kind of intervention, which is the ultimate goal of the research.

- Shifting domiciliary care to local providers: In one borough, domiciliary care was commissioned through a framework on a zoned/locality basis, but this was found not to be effective. It led to thirteen providers, mostly based out of the borough, with only eight active and half of these had very small numbers placed with them, long travel times for carers, and reporting of data/outcomes was poor. The council let a contract to a single, borough-wide provider who sub-contracted other providers. This had led to improved monthly monitoring and a detailed analytical understanding of need and activity, and the provider is invested in the borough, both in terms of strengthened relationships and infrastructure which has paid dividends. The council currently has no service users waiting for homecare and most homecare workers reside in the borough.
- Neighbourhood approach to homecare and supported living: A council had a large number of homecare providers, and struggled with capacity, quality and price variation. Providers were struggling with recruitment and travel time/cost, and residents were unhappy with changing staff and a prescriptive approach to the delivery of support.

  The council developed a new framework, focused on robust testing of shared ethical values, commitment to collaboration, place, local investment and growth and centred around 'I' statements, co-produced with customers and carers. Homecare was reorganised on a neighbourhood basis, with a lead provider for each neighbourhood and collaborative relationships with adjacent providers to manage peaks in demand. The neighbourhood model enabled the introduction of walking routes, bringing new people into the homecare workforce, reducing carbon emissions and travel time and cost. This supported the utilisation of a consolidated hourly rate, underpinned by a co-designed pricing model.

  This local model meant that homecare workers knew and understood the neighbourhood and could better connect people to community assets and develop relationships with local partners such as primary care. 86% of the home care workforce now live in the place where they are delivering care, 45% of visits are delivered via walking or cycling routes and nearly half of the workforce are

aged 30 and under. The success of the neighbourhood model has seen the same approach taken to the commissioning of supported living, strengthening customers' connection to their local community while increasing provider resilience and reducing costs.

One thing to read
Human learning systems – Plymouth case study,
https://www.humanlearning.systems/case-studies/#plymouth-alliance429

Strategic Commissioning Approach 6. Strategic procurement of services against needs

Services that meet demand.

Introduction to this approach

This approach is paired with the 'managing the policy and compliance landscape' commissioning aspect, and is about providing services that meet demand. It begins with a view that the best way to deliver efficient public services is through excellent procurement practices. The council's role is to understand need, develop requirements, and to go out to tender for a carefully and strategically selected set of service.

Commissioning is focused upon carefully designed specifications and effective post-procurement contract management that is both tough and fair, holding providers to account for achieving that which they have said they will do for service users, learning lessons and negotiating appropriate changes within the scope of the contract and the procurement, as and when required.

This approach works best where there is an excellent team of procurement professionals, commissioners specialise in needs assessment and appropriate engagement with practitioners, providers, and people with lived experience, and political leadership is trusting of professionally-led commissioning. The approach is one of compliance and efficient delivery, and gaps in services are met through contract extensions, signposting services, and/or new contracts to ensure the care system is relatively coherent.

There is a focus on service user satisfaction, predicated on getting the research right before specification design, and the necessity of fitting citizen needs into pre-defined service categories is recognised as one of the implications of appropriate scale and standardisation. However, there is a premium on good contract management and properly-managed change and adaptation of service delivery in-contract.

The big opportunities for innovation and outcomes focus occur with big contract renewal, where aggregation or disaggregation and reinvention of the requirements are regularly considered, with good input from market knowledge, needs analysis (including unmet needs), feedback from people with lived experience, including those who draw on services, and benchmarking.

How to move towards this approach

This approach has historically been what many people have understood commissioning to be. It requires a sound process, which can be properly adapted for different types of requirements, and effective management of commissioner time and portfolios to ensure that all phases get due attention, and very close working relationships with procurement. Formal training on market management would be a strong first step, as would studying key contracts from elsewhere.

What to do, and what not to do, when you are pursuing this approach

Commissioners should make sure that they are actively creating the world in which they work, rather than being a victim of all the constraints they are under. Part of this will be to ensure an understanding of the goals of the place and the limits being work

within, as part of a collaborative effort with service users, leaders, wider colleagues, partners, and suppliers.

Be aware of the risk of focusing on what is not possible and limiting yourself to 'only' doing what is mandated. The ultimate goal here is a clear sense of purpose within known limitations, and to effectively present that to suppliers, to ensure clarity.

Specific risks and issues

Commissioners should set the right, well-informed risk appetite, and need to avoid being completely risk averse. It will be important to ensure that the understanding of 'needs' and 'services' is not prescriptively narrow but takes into account co-design with citizens, to ensure impacts both up- and down-stream of services.

There should always be enough capacity for big contract renewal. Whilst building opportunities to co-design and test and learn into the system, caution will be required to avoid being sucked into 'analysis paralysis', and always trying to get the perfect specification.

Considerations for commissioning skills and structure

Commissioners need strong technical skills and abilities in engagement with service users and others, and will ensure active contract management and ongoing learning. Commissioning is likely to be quite closely coupled to service providers, and therefore adult social care focused. Good data on results and satisfaction will be required for analysis. Commissioners also need to be subject matter and policy experts, or work very closely with those who are, and have strong market-shaping and market engagement skills.

Commissioners in this model need to be good research and engagement managers, and excellent at project management and time management. It is important that they support each other as a team to avoid overload and the risk of becoming blinkered and focused only on their allocated focus areas.

Examples of this approach in practice

- Two councils in very different parts of the country developed a *de facto* social license putting constraints around the market for home care – requiring a Living Wage, services to be based in the borough, and creating small lots. This created a structure which met their compliance requirements and achieved their social and outcome goals.
- A county worked to implement a county-wide commissioning strategy and policy, driven by integrated needs analysis and clear policy-setting from the integrated health and care board, the children's joint strategic needs analysis, the police and crime strategy and the local economic partnership. Working closely with district councils and other partners, their adult social care commissioning was therefore a clear part of overall county goals, enabled by strategy, and with clear connections to families, employment, crime, etc.
- A borough entered into shared commissioning arrangements across contractual partners to support implementation of a place-based plan. This meant lifting significant amounts of adult social care funding out of their own organisation structure, and spreading it across the new joint organisation, where much was operationally managed by partner organisations. This allowed a focus on the

place-based plan and more flexible procurement while still meeting compliance requirements.

One thing to read

NSW Government Commissioning and Contestability Practice Guide. NSW Government. 2016 https://arp.nsw.gov.au/tpp16-05-nsw-government-commissioning-and-contestability-policy/

Strategic Commissioning Approach 7. Market management

Creating conditions for best value and outcomes within financial constraints.

Introduction to this approach

This approach links with the 'commissioning process' aspect of commissioning, and is about using commissioning tools to drive best value outcomes given financial constraints. It begins from the perspective that the best way to deliver good results for the community is through plurality and a good mix of providers, vying with each other robustly but collaboratively – and that this shows up both in:

- Market making, where the council's role is to understand, map and develop the range of commercial and VCSE providers so that local needs are met; and
- Carefully structured procurement and management process (often tightly specified and let to a single provider, sometimes more broad-based and let on multiple lots or to a single consortium or alliance) to choose the most economic, efficient and effective provider.

In both, commissioning is focused on understanding community need in the big picture and in requirements, and ensuring that there is enough capability, capacity, knowledge and appetite to provide that best value is assured. Despite fair cost of care requirements (and ambivalence about workforce costs), this still means achieving an optimum price, and despite increasingly collaborative arrangements, this still means maintaining the credible threat of alternative providers, based on the ability to measure whether delivery units are achieving the results they committed to, and ultimately the removal of the delivery unit and/or their management if not (sometimes referred to as 'contestability').

Commissioning is focused upon encouraging providers through effective partnership, sharing strategic insights and future plans. In this way providers can mould themselves to the future needs of the community. User feedback is regarded as a key ingredient in assessing the performance of the providers into the future. Such an approach underpins all successful commissioning and is perhaps simplest and best where there is a focus on cost reduction and market resilience. Needs are relatively well understood and specified, and there is no strong ideological push to either insourcing or outsourcing; there can be a relatively neutral view of sourcing opportunities.

This approach, at best, balances the need for good value with long-term resilience and the need for competition, with the ability to put long-term contracts in place to generate real continuity and security of provision.

How to move towards this approach

A strong understanding of needs (including from citizens and frontline practice), of contractual routes for delivery, procurement and contract management, and learning approaches are all needed for this approach. Councils must consider how to integrate this into the necessary 'plate spinning' most active social care commissioners have to undertake, managing various different pieces of work at different stages simultaneously while trying to support coherence between them.

What to do, and what not to do, when you are pursuing this approach
Councils need to make sure that 'commissioning' is not seen as just a narrow function within social care, but that all relevant technical experts (procurement, legal, finance etc), and partners and citizens – as well as providers and potential providers – see themselves as an active part of the process.

It is important that commissioners do not get so stuck in the process that they are simply recommissioning without seeing the bigger picture. Allocation of time and resources must be managed so that 'commissioning', that is, strategic procurement, does not take all of the focus, and contract management, learning, insight, and partnership working are all invested in.

The ultimate goal of this approach is really well-specified services drawing from an engaged, active, innovative supply side.

Specific risks and issues
There is a significant risk of getting caught in narrowing down the definition of commissioning to competitive procurement, so ensure that co-design and shared learning and collaboration play their role.

There is also a risk of commissioning services in isolation, so consider using colleagues' expertise to support partnership-led commissioning, and focus on market and context shaping and the knock-on implications of commissioning decisions.

Considerations for commissioning skills and structure
To be most effective, the commissioning function is likely to work across internal and external boundaries, engaging in a lot of partnership working and co-commissioning. Commissioners therefore need to combine technical excellence with an openness to see themselves as enablers, not owners. This could include commissioners working as a whole-council function or even wider, but certainly as a bridge-builder as well as a technical expert. At the same time, they need to be able to draw clear boundaries and not be seduced into trying to 'fix everything' through commissioning.

Commissioners in this model need to demonstrate expertise, experience, and ability and eagerness to learn. They need to draw their credibility from clearly understanding what good technical process and expertise can guarantee, and from being able to estimate and engage with the uncertainty beyond that.

Examples of this approach in practice
- A council commissioned a 'rich picture' infographic of their adult social care commissioning services, intending to use this as a mechanism to engage the public and partners. They found that having to map out all of their commissioned services and pathways was actually a powerful learning exercise for commissioners too, revealing some overlap and confusion. It identified the potential to spread good ideas more widely.
- Despite reduced demand post-COVID, a council found itself faced with providers threatening withdrawal of services and even bailiffs if not paid. This led to a realisation that caseload was disorganised, officers did not see their role in the bigger picture, and systems were not supporting practice. Critical information was in the heads of individuals and time was being spent firefighting, creating a vicious cycle. Rather than blame and restructuring, they engaged in an exercise

to pull together an overview of their work, share the bigger picture in terms of strategic goals and purpose, and implement simple IT systems to pull together data so everyone could see the whole story at a caseload level.

- One London borough is implementing a Dynamic Purchasing Vehicle, following some success in rough sleeping transformation and a realisation that supported living procurement was being limited by existing governance and process. A clear vision was presented to Cabinet along with progress on regularising existing contracts and other steps to get things better structured and organised internally. After a nine-month process of making the case and proceeding through decision-making, a Dynamic Purchasing Vehicle is now going out to tender which will allow much more flexible call-off of services. The process will start with supported living, then single vulnerable adult services, and move on, with learning embedded, to residential care, extra care, and shared lives, meaning that the onerous approval process does not have to be repeated, and a new fit-for-purpose commissioning process with more room for flexibility and learning can be developed.
- A city council adult social care commissioning function was faced with the challenge of working in partnership across other council services and implementing the Care Act provisions which required flexible and effective commissioning. Over the course of a year, a Chartered Institute of Procurement and Supply (CIPS)-qualified commissioning lead supported a complete reorganisation with a strong commercial focus and significant upskilling. The service now has responsibility for service design, market shaping and ensuring effective supplier relationships. It also establishes the most appropriate routes to market, defining tendering procedures under the Light Touch Regime and tender evaluation methodologies. The council's contract management function also includes management of major corporate contracts, and covers around one third of the council's total spending. Approaches have included an award-winning, partnership-based advocacy service tender, Light Touch procurement (piloted with drug and alcohol treatment), implementation of a Dynamic Purchasing System, a new approach to voluntary sector procurement involving the creation of a single borough-wide consortium, with associates, using an outcome-based contract designed to support prevention, and brokering the sale of a vacant residential home to a new provider in order to maintain local capacity which was then block contracted to the local authority.

One thing to read

Market Shaping Toolkit – supporting local authority and SME care provider innovation and collaboration. Institute of Public Care, DH, ADASS, LGA, The Care Provider Alliance. 2015 https://ipc.brookes.ac.uk/publications/market-shaping-toolkit-supporting-local-authority-and-sme-care-provider-innovation-and-collaboration

Strategic Commissioning Approach 8. Delivery model design

Effective delivery models enabling effective practice.

Introduction to this approach

This approach is paired with the 'models and tactics' commissioning aspect, and is about designing effective delivery models to support effective practice. It begins with a view that there are real savings and improvements to be made at the level of delivery model design. At its extremes, it can support an ideological view of how care should be delivered, but in general it considers that how the work is organised, governed, and delivered, is critical. This sees commissioners moving into, or working closely with those in, the service design space, undertaking customer journey mapping, empathy work, 'citizen safaris', 'mystery shopping' and so on, to understand the experience of care and to look for improvement opportunities at the process or organisational level.

Such an approach works best where there is enough access to services to work closely with those drawing on them, and enough control or flexibility to be able to direct their adaptation. This requires good working relationships between commissioners, managers, and practitioners.

How to move towards this approach

Building engagement with services and the skills to analyse structure and processes are critical for this approach, as is relating the 'architecture' of individual services to the bigger picture. An outward-facing view is also important to pick up examples of innovative models and technology – and lessons learned – from elsewhere. It is important that time and focus be allocated to delivery model design and therefore building examples of success and demonstrating the business case is critical.

What to do, and what not to do, when you are pursuing this approach

It is important to connect social care practice with strategic commissioning, and to be open to innovative use of technology and new business models to deliver, thinking carefully about how these are implemented. Consider yourself as co-designing with staff and service users, and seek to connect small experiments with larger, well thought through changes.

Do not get so focused on practice and structure that you lose sight of the gaps between different delivery models, and do not get so excited by innovative ideas that you end up implementing them for their own sakes.

Quality delivery, connecting with citizens as the main source of innovation, is at the heart of this approach.

Specific risks and issues

To be effective in this approach requires the freedom and credibility to engage at both social care practice and executive decision-making level. Be aware of risks of interfering with people's power bases or disrupting expectations and ideology.

Take the cost of change and the capability, learning, and engagement of the workforce seriously, and spend time thinking about the real practicality of new ideas.

Ensure you are scanning the landscape beyond your own council and learning lessons from elsewhere.

Considerations for commissioning skills and structure
To be strong in this approach, you will need sufficient expertise, experience, and credibility amongst commissioners to engage effectively with the social care workforce and their managers, and for commissioning to be seen as a partner to delivery. You will also need good data, feedback loops, and shared learning across delivery and commissioning.

A commissioning structure which follows the existing service structures is likely, and commissioning is likely to be more focused on adult social care. For that reason, you will need good mechanisms focused on working with and identifying gaps between services, and monitoring and understanding the whole journey of service users.

You also need commissioners who are full of bright ideas and constantly scanning the horizon, but practical. They need the credibility with senior managers and politicians that they can be trusted and deliver results, and need to build strong relationships with parts of the council like legal and procurement, and similarly manage partner relationships well.

Examples of this approach in practice
- Review of discharge to assess which identified that people were not being contacted following their discharge (along with other practice issues), and put in place alternative mechanisms to contact them as well as addressing other issues.
- One borough introduced technology-enabled care at home to reduce the requirement for residential care. This was introduced through service design study of homecare interactions and research into citizen needs, combined with an understanding of the potential of technology, and a business case for investment to reduce overall costs.
- A commissioner carried out interviews with service users in their own homes – seeing them in context and understanding their lives as a whole helped to significantly inform her work, and fed directly into small but significant changes to requirements when homecare was re-commissioned.
- A council was paying extremely high prices for mental health supported accommodation from specialist providers, and despite significant engagement, was not able to shape the offer from those providers. They therefore took the service in-house, starting on a small scale, using housing stock and both in-house and contracted provision for care. They have cautiously scaled up the service and are still learning the lessons from practice to feed into the overall model.

One thing to read
A radical new vision for social care – how to reimagine and redesign support systems for this century. Hilary Cottam. The Health Foundation 2021
https://www.health.org.uk/publications/reports/a-radical-new-vision-for-social-care