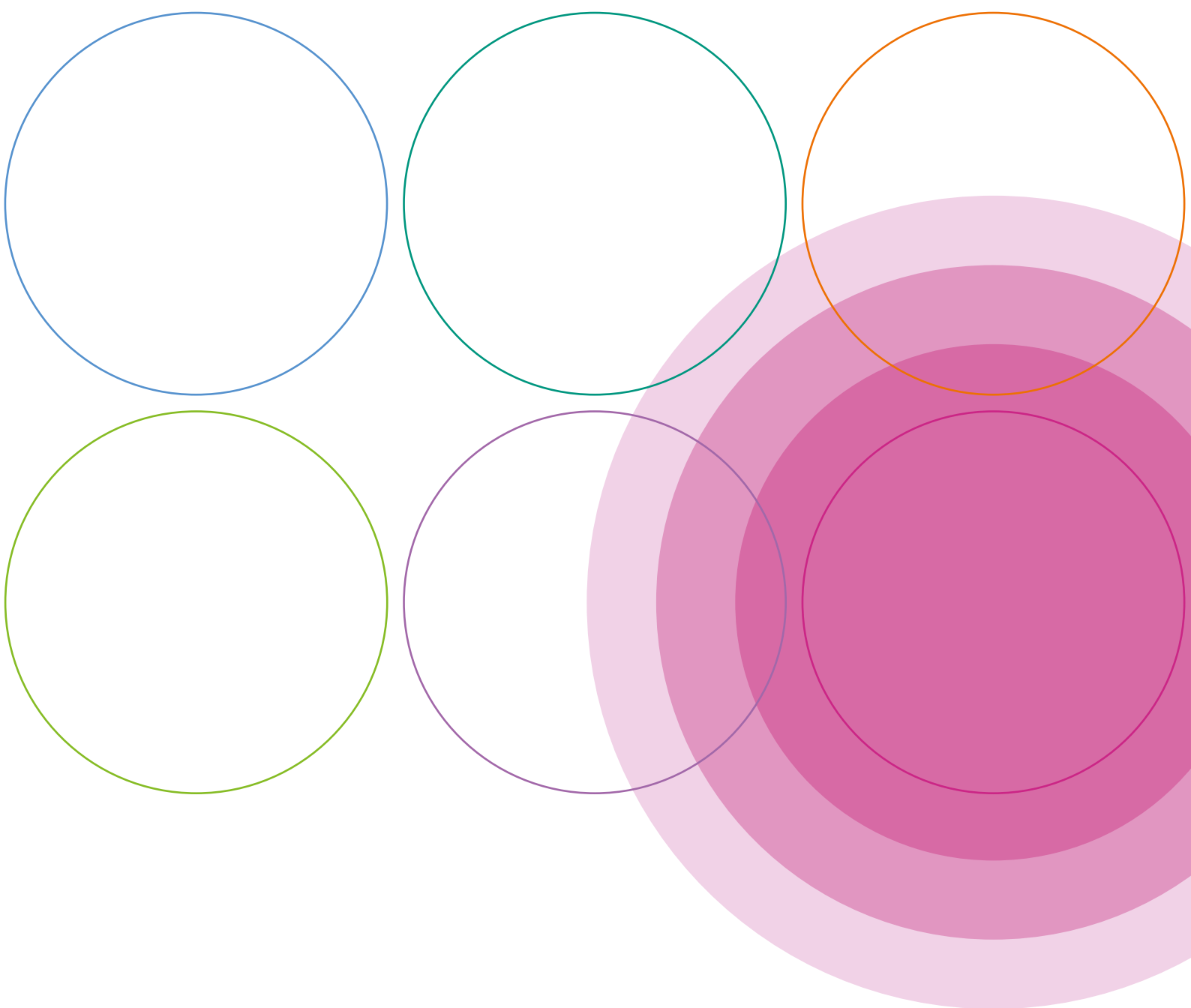


PEOPLE POWERED COMMISSIONING:

EMBEDDING INNOVATION
IN PRACTICE



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We are the innovation unit for public services. As a not-for-profit social enterprise we're committed to using the power of innovation to solve social challenges. We support leaders and organisations to achieve radically different solutions that offer better outcomes for lower costs.

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About the series

People Powered Commissioning: embedding innovation in practice is one in a series of learning products which explain why People Powered Health works, what it looks like and the key features needed to replicate success elsewhere. It draws on the experience of the six teams who took part in People Powered Health, which was led by Nesta and Innovation Unit from summer 2011 to winter 2012.

The series includes:

- **People Powered Health**, health for people, by people and with people, foreword by the King's Fund
- **The Business Case for People Powered Health**: building the business case, foreword by the NHS Confederation
- **By us, For us**: the power of co-design and co-delivery, foreword by National Voices
- **More than Medicine**: new services for People Powered Health, foreword by Macmillan
- **Networks that Work**: partnerships for integrated care services, foreword by ACEVO
- **People Helping People**: peer support that changes lives, foreword by MIND
- **People Powered Commissioning**: embedding innovation in practice, foreword by NAPC
- **Redefining Consultations**: changing relationships at the heart of health, foreword by the Royal College of GP's

We'd like to take this opportunity to acknowledge the ideas, hard work and insights of all the patients, service users carers, practitioners and commissioners who have been part of the People Powered Health programme. Special thanks go to the teams in the six localities:

Calderdale

Lambeth

Newcastle

Earl's Court

Leeds

Stockport

You can find out more about their work and about People Powered Health at www.nesta.org.uk.

Foreword

The NHS now has the opportunity for new commissioners to commission very new health services that better meet the needs of their local public. As with all new structures there will be a sharp debate about whether the new structures should develop something brand new or whether they should reproduce the past.

The NHS and the public as citizens, patients and taxpayers need the new primary care commissioners to keep their nerve and to ensure that they use the opportunity to develop services to better meet the needs of public, patients and the population. One of the main aspects of the important new services that new commissioners need to develop are those that invest in the increased capacity for people to self manage their long term condition. This acknowledges the change in the relationship between patient and care professional from one which is hierarchical to one which is more akin to partnering on a journey and one which builds on the potential of prevention of ill health.

New commissioning has a chance to challenge this mindset. We can start by emphasising that we want to commission services for patient's health care outcomes and involve the people themselves in determining what aspects of those outcomes are most important to them. What we have had in the past is a series of fragmented inputs from different services.

We can then continue to recognise that whilst patients come to us with real problems of sickness, they also have within their own lives, and the lives of their families and their communities' real assets

that can help them and the health service get on top of their condition. Commissioners need to think hard about how they invest in increasing the capacity of these assets to improve health care outcomes.

Most of the services that might increase the capacity of patients to better self manage their conditions are beyond the medical services that commissioners have traditionally seen as their area of expertise. Therefore to develop services that increase patients' capacity to self-manage, Primary care commissioners are going to have to seek help from public health, local government and from the voluntary sector. They are going to have to work with partners including the voluntary sector to help create a market in these different services in their locality.

Whilst this may have been difficult for previous NHS commissioners, GPs are embedded in their local communities and have a good understanding of what those communities have on offer. What is new is seeing these as services that need to be commissioned in the same way as any other bio-medical service

Over the next few years primary care commissioners need to learn to commission these services in such a way as to make them as normal and straight forward part of the NHS as currently they commission elective care services.

**Dr Charles Alessi is
Chairman National Association
of Primary Care (NAPC)**



People Powered Commissioning: Commissioners as innovators

Conventional approaches to achieving efficiencies through better procurement will not be sufficient to meet the needs, obstacles and opportunities that face the NHS over the next decade.

The challenges facing the NHS require radical new models and these models need to be created through an active and engaged commissioning process. At the heart of a People Powered Health approach is a focus on people, not institutions – a belief in the power of patients, service users, practitioners, clinicians and communities working together to produce better outcomes, in terms of both people's health and value for money for the taxpayer.

The People Powered Health approach requires strong leadership to drive the creative re-shaping of the system, designing innovative services and building new relationships between professionals and users, with structural support from national and local representative bodies and local authorities. Many parts of the health and social care system need to be involved in this drive but commissioners have the potential to play an increasingly critical role.

“I think it's really important that clinical commissioners are bold and brave and broader in their thinking about commissioning services that integrate health, social care, co-production and social value. It's not difficult; in fact, it's much simpler than you think.”

Frankie Lynch,
Chief Operating Officer, North West
London Commissioning Support Unit

Against a backdrop of structural reform and budget cuts, commissioners will need to rise to this challenge. Commissioners have a pivotal role as leaders within the system. They not only have direct access to the means of assessing population need but also to the budgets to commission and develop new provision. ‘Bold and brave’ commissioners are leading change by creating the opportunities for the new methods, practices, cultures and services of The People Powered Health approach to thrive.

In November 2012 the Secretary of State for Health issued the NHS Commissioning Board's mandate. One of the nineteen objectives in the mandate focusses specifically on commissioning improvements in health care for long-term conditions, by involving people more actively in their own health:

From the NHS Commissioning Board Mandate published on Nov 13 2012:

We want to empower and support the increasing number of people living with long-term conditions. One in three people are living with at least one chronic disease. By 2018 nearly 3 million people, mainly older people, will have three or more conditions all at once

The NHS Commissioning Board's **objective** is to ensure the NHS becomes dramatically better at involving patients and their carers and empowering them to manage and make decisions about their own healthcare and treatment. For all the hours that most people spend with a doctor or nurse, they spend thousands more looking after themselves or a loved one.

This is the first time that commissioners at a national and a local level have had such a clear objective to improve – in the language of the mandate to ‘dramatically’ improve – the capacity of patients to better self-manage their conditions.

The traditional structures of the NHS have produced systemic biases towards cost-effective procurement rather than the types of smart, agile commissioning for long-term outcomes that commissioners themselves have been pushing for. Changes to NHS frameworks, including the NHS Commissioning Board mandate, provide a window of opportunity for change. There is renewed support for commissioners to take bold, brave and radical steps towards not just the commissioning of new kinds of services but entirely new models of commissioning that:

- Put long-term outcomes for people, not short-term outcomes for institutions, at the centre of decision-making – a refocusing on who (rather than what) commissioning is for.
- Ensure the commissioning process reflects the lived experience of users, through processes of co-design, community research and pathway mapping.

- Re-frame the role of commissioner as one of visionary leadership of genuine partnerships and collaboratives – working in partnership with those from every part of health and social care, including patients, practitioners and providers.
- Move away from commissioning as procurement of existing services to commissioning as market-making, with a focus on commissioning different types of services, supporting alliances of providers, embracing provision from outside the mainstream and building up existing provider capacity.

There is an emerging vision of Commissioning for the People Powered Health approach that could transform health care. It concerns both what is commissioned and how. New processes and services are being tested in sites around the country, with the evidence base growing and becoming more detailed by the day. Some have been straightforward to implement. Many have taken time, energy and significant cultural shifts to be realised. All have been driven by persistent commissioning leadership.

Commissioning for the People Powered Health approach is characterised by approaches that:

- **Are outcomes based** – where outcomes attend to patients’ priorities and to indicators of social and economic value alongside traditional (bio-medical) metrics.
- **Reflect people’s real lives** – creating systems that are coherent and responsive to those engaging with them and aligned with everyday life.
- **Incentivise and support collaboration** – giving rise to new and sustainable partnerships, networks and alliances.
- **Make and shape new markets** – in which People Powered Health services can develop and flourish.
- **Lead to culture change** – under the leadership of visionary commissioners.

In each section you will find case studies from the People Powered Health programme and from other places where important changes are taking place. You will find practical advice and guidance for thinking about Commissioning for the People Powered Health approach in your context.

Conditions for Innovation in Commissioning

In the People Powered Health approach, we found 10 key drivers for innovation in commissioning – the ‘burning platform’. Many of these are drivers that exist across the NHS; others are rarer and more likely to give rise to radical change:

1. Financial pressures

commissioners and providers sharing a common belief that the solution to saving money lies in reducing demand for statutory services by increasing the capacity, support and capabilities of individuals, families and communities.

2. Dissatisfaction with the current commissioning model

the absence of a strong evidence base to support the impact of existing approaches – in either financial or health terms – leading to a freedom to innovate.

3. Recognition of too strong a focus on medical models of care

Commissioners understanding that long-term conditions require social, as well as medical, solutions, such as addressing poor diet, lack of exercise, social isolation, smoking and so on.

4. Growing recognition of ‘values based’ approaches

now a fundamental building block of the NHS Change Model,¹ commissioners are beginning to understand the value of services in the same way as people, families and communities do – not solely in terms of clinical outcomes.

5. Being open to different, collaborative conversations with providers and communities

especially citizens – both services users and non-service users – voluntary sector and community groups, and making these conversations a central and valued part of the commissioning process.





6. A shared vision of a positive future and a shared 'manifesto' of the steps to get there

involving a shift towards service users, practitioners and communities having shared ownership of commissioning decisions and service delivery.

7. Strong, committed leadership

from the managerial and clinical sides of the system. Individuals, not institutions, have taken on key leadership roles and invested time in slowly building trusting relationships with providers, while taking bold steps to accelerate progress.

8. Learning from others and valuing a range of forms of evidence

including smart use of financial and patient-level data as well as co-design with users and ethnography.

9. Building on early wins and small-scale prototyping

making changes real, swift and demonstrably better while taking time to embed new relationships and ways of working.

10. Flexible providers

with commissioners and providers having a sense of joint ownership of the vision and agenda. Without a shared commitment, change will be slower, less innovative and have a muted impact on service users' lives.

An outcomes-based approach: who are we commissioning for?

“The balance of resources was skewed towards clinical, crisis, acute, statutory, and skewed towards evidence-based practice. In itself this is a very good thing but it had become dogma. There was a disconnect between those doing the ‘expert’ work and the people being ‘done to’, and their carers – who were unhappy and dissatisfied with the service. Getting involved with values-based awareness to go alongside evidence-based practice was what was needed. It was about getting clinicians back in touch with why they were doing the job – to make a difference to people’s lives.”

Nick Dixon, Joint Commissioning Manager (Mental Health), Stockport Council

The current system is heavily weighted towards measuring clinical outcomes tied to inputs, clinical outputs and episodic interactions and activities. In short, it does not measure the outcomes that people care about – that is, whether their overall wellbeing (and not just their bio-medical health) is increasing. The question for commissioners has always been how to improve outcomes without increasing costs. Recently they’ve been asked to improve outcomes and to reduce costs. The People Powered Health approach can help with this:

Looking at the strongest evidence base available, the Business Case for People Powered Health predicts that the benefits to a local health economy of reducing expenditure on A&E attendances, planned and unplanned admissions, and outpatient admissions could be around £21m a year. This is 7% of the average CCG budget, or approximately £113 per patient with a long-term condition.²

Many people find it very hard to believe that significantly better outcomes in health care can be delivered with reduced resources. The People Powered Health approach starting point of people as assets and partners offers a clear route to unpicking this apparent paradox. It recognises that increased health care value can be provided by building on patients’ and communities’ capacity to look after themselves.

Key to improving outcomes are creating better definitions of outcomes to reflect real and meaningful goals and building capacity for individuals and communities to achieve these better outcomes. From a commissioning perspective, this requires managing a process of co-design of services and pathways that support patients, communities and practitioners to work together towards these outcomes.

The People Powered Health approach, this has resulted in the commissioning of new and reconfigured services that invest in the increased capacity for individuals and communities to better manage their health care, including:

- More than Medicine – for example exercise and activity groups managed through social prescribing.
- People Helping People – group, one to one, expert and coaching support from peers through crisis and onto recovery.
- Redefining Consultations – group consultations, care planning consultations and widening the range of practitioners involved.
- Networks that Work – collaboration and alliances between organisations to deliver truly integrated health care.

Wider definitions of outcomes: outcomes for patients and service users

We know that many factors combine to affect people's sense of wellbeing. Social networks, confidence, autonomy and the ability to set their own goals are critically important if people with long-term conditions are to become more active in improving their own health. But the NHS is poorly set-up to take factors like these into account and they have been systemically ignored when measuring the success of treatment, particularly for physical conditions.

Outcomes that could be measured alongside existing biomedical indicators to demonstrate improvements for people living with long-term conditions include:

- Patient confidence and control over their own health.
- Behaviour change and improvements in lifestyle.
- Healthy social networks and relationships, reduced social isolation and increased social networks of support and care.
- Patient motivation and aspirations to improve health.
- Patient perception of distance travelled.

“Recovery of the person became the driving force behind the Personalisation and Prevention Service. Recovery as a person – not recovery from a disorder. You can have a disorder and still recover as a person.”

Nick Dixon, Stockport

And there are some processes that we could look for that might indicate that people are having a positive experience of care:

- More equal and effective relationships between patients and staff as measured through patient satisfaction surveys.
- More activated patients who are more engaged in their own care captured for example using the Patient Activation Measure (PAM).³
- Increased participation in services, including volunteering, contributions to peer support and development of services.

The seemingly unbreakable link between what is measured and what is valued means that for the People Powered Health approach to flourish, a wider range of measures need to be explored and captured in evaluating the impact of provision. This is coherent with the core message of the People Powered Health approach: that long-term conditions with social as well as medical causes need social as well as medical solutions and, therefore, require appropriate measures for social indicators for health and wellbeing to demonstrate impact.



“My answer to the sceptics, whether it be professionals or service users, would be look at the local evidence base or local intelligence that we’re beginning to build up in the city of the impact of this way of working. We have enough professionals who can argue the case for the difference that co-production and self-management makes for service users and themselves. Also enough patients in the system who can articulate the added value in terms of what happens to them as an individual.”

Paul Morrin,

Director of Integration, NHS Leeds Community Healthcare

There is a growing movement in commissioning to include wider measures of social value in contract requirements, by writing social, economic and environmental requirements into the core of contracts. By factoring in the value of social outcomes, the cost of the status quo and the ways in which requirements differ over time and between people is made clear and allows providers to deliver broader long-term value.

A focus on different outcomes requires new structures and measures for evaluating progress – and a commitment to including a wide range of people in this process:

- **Co-designing the outcomes framework** - based on what matters to patients and communities, both at an individual and system level.
- **Co-designing the methods of evaluation** - reviewing services with the people who use them and work in them in ways that are useful to both.
- **Sharing data openly and quickly** - making evaluation real and actionable. This includes cost data, patients’ own records and data on providers.

The People Powered Health approach focuses on person and population outcomes, rather than outputs, necessitates different methods of measurement and collecting evidence than those in general use in the NHS. Value for money, progress against population targets and sound business cases are a necessity in any public service, but People Powered Health business cases by their very nature look at outcomes for service users and improved patient satisfaction with services – not just budgets. Both are necessary forms of measurement.

New structures and measures for evaluating progress



“Social value is where you try to give something more to a community and not just focus on an individual’s needs, and you look at a community as a whole area and not just as aggregate health statistics.”

Frankie Lynch,

Chief Operating Officer, North West London
Commissioning Support Unit

For services to be evaluated based truly on what matters to patients requires valuing different types of evidence beyond patient reported outcomes measures (PROMs). PROMs “provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life”.⁴ However, PROMs are currently underutilised in the NHS, being applied nationally to calculate health gains after just four types of surgical procedures (only 3.3% of all elective activity in the NHS). Challenges exist in rolling these out to long-term conditions due to a lack of tested measures, lack of a specific intervention point and difficulty in attributing change to a particular provider/intervention.⁵



“The medical model of health is about identifying and treating diseases, without thinking about the social context. The social model is about taking a much more holistic view of the individual, at the root is social circumstances.”

Chris Drinkwater, GP and
President & Public Health Lead,
NHS Alliance



Reflecting people's real lives

Commissioning is an iterative process between commissioners, citizens and providers. The power to commission services locally comes with a duty to engage people locally in the commissioning process.

People's needs change and fluctuate, and accordingly so should both what is commissioned and how. Using the commissioning process to support and engage citizens and communities can help unlock potential hidden resources and strengthen local resilience. This, however, demands that commissioners approach communities and users not just as end users of services but as partners in deciding what these should look like and how they should be commissioned.

“Evidence tells us that where we've worked before on integrating health and social care or treating long-term conditions, it hasn't been effective if the person hasn't been at the centre of it.”

Lucy Jackson,
NHS Consultant in Public Health, NHS Airedale
Bradford and Leeds

Asset mapping and needs assessment

Because the People Powered Health approach is an assets based approach, mapping assets (skills, knowledge, connections and resources) is as important at all stages as identifying needs.

Most commissioners have, through their Joint Strategic Needs assessments, become used to analysing and working with individual and community needs. Few are used to analysing and investing in individual and community assets. This requires commissioners and providers to gather detailed insight to inform their commissioning, through processes that:

- Create spaces for the community, commissioners and providers (including front line care givers) to have a new commissioning conversation and to develop networks.
- Gather insights, listen to and understand the stories of local people and families who use services and those who deliver care at the front line in order to deeply understand what matters to them, what are the assets in the community and what are the barriers to improving outcomes within the locality.
- Make it easy for people to contribute to the process in ways that recognise and value their expertise and experience.



Focus on **People Powered Health in Newcastle: pathway mapping**

Newcastle's development of new patient pathways aims to reduce its rate of non-elective admissions by 11% and to reduce the use of emergency and primary care services.

The team has developed a full map of patients' progress through available pathways including all services they might encounter – including both

what is visible to patients on the journey and the back-office provision and commissioning activity that make these happen. The maps have been used to raise questions, concerns and stimulate understanding and debate of local need and gaps in provision. They have also been used as basis for individual scenarios – plotting real individuals with particular lifestyles and characteristics to test whether new pathways would meet their needs..

Co-design and experience-based design⁶

Co-design is a process of facilitation and transformation, supporting the design and creation of better organisations. This involves both creating services and reconfiguring the system to foster communities.

Co-design in commissioning looks at the overall path of patients' care (not just the end point), and the process of designing these pathways requires collecting, using and valuing different forms of evidence at every stage of the design and delivery process:

- Evidence from the point of view of those who interact with services about how well they work.
- Evidence about the impact of other services and methods.
- Evidence about new ways of working and the value of the process, including aspects that are difficult to measure, such as culture, capabilities and wellbeing.

Crucial among these is narrative-based evidence – stories, testimonies, user journeys, service maps, video and ethnographies that show the interactions between patients and services as on-going experiences, not a set of disjointed outputs and measures from institutions. This type of evidence is often thought of as being less valuable than data sets from large cohorts of patients, but in fact

these stories provide more nuanced and powerful information about what really does, and doesn't, work. Evidence from patients that services really make a difference to their lives is difficult to argue with. The switch from treating people's diagnoses to focusing on what they want to achieve means finding ways to measure outcomes according to patients' own metrics of success.

In Stockport, using an Experience Led Commissioning⁶ process resulted in a significant shift in the commissioning questions asked, following the introduction of a more participatory, assets-based commissioning approach. Commissioners started out by asking what people in Stockport needed to help them to return to independent living following care from the mental health trust. At the first ELC event, participants wanted to change the question to, "what needs to happen so that people with mental health issues in Stockport can live life to the full?" This transformed the dynamic of the commissioning conversation and ensured that the process shed more light on what really matters to people and families living with mental health issues in Stockport.



Focus on People Powered Health in Lambeth: the Living Well Collaborative

The Lambeth Living Well Collaborative brings together a cross-section of mental health services in Lambeth to radically improve the outcomes experienced by people living with long-term mental illness.

Members include GPs, mental health commissioners, carers, peer supporters, patients and service users, information managers, clinical directors and representatives from the local authority, primary and secondary NHS care, housing support and voluntary and third sector organisations. Primarily working together to establish a set of outcomes that are meaningful to people's lives and aspirations, the Collaborative recognises people's assets as well as needs, aiming to harness the knowledge of providers and service users much more systematically within commissioning practices.

What sets Lambeth's approach apart is the inclusion of participants not as experts, but as co-designers and facilitators of ideas within the workshops. This has both brought in a wider range of ideas and skills, and begun a process of culture change through those traditionally in charge of care learning from patients directly the ways in which the system is failing them. It has also raised awareness of what provision is currently available – signposting for practitioners, not just patients – and has built networks and trust between clinicians and services.

The core Collaborative group – numbering about 20 – meet fortnightly at a cafe in Clapham run by people with learning disabilities and mental health problems. The venue was picked to highlight the change in working style and dynamic that the group wanted – of leaving their 'organisational baggage' at the door and working as a team on a radical vision for mental health. Members of the wider Collaborative community are regularly invited to add new perspectives, and smaller groups are formed to tackle particular challenges.

The Collaborative follows a service design process of 'monitor, insight, co-design, co-delivery', referred to respectively as the 'ears, brain, hands and legs' of the system. Each phase encompasses different tools, approaches and aims, providing a rigour to the work and a clear set of progress measures. Central to every stage has been the use of co-design workshops – large-scale events at which representatives from every group come together to refine the vision, generate ideas, create networks and tackle problems. The events are explicitly productive, rather than discursive, and incorporate prototyping, user journey mapping and analysis of narrative-based research. Having begun with 30 people, the workshops now attract upwards of 160, with about 1,600 people attending a workshop in the first two and a half years.

“The Collaborative is about recognising that the old or traditional ways of doing things – of commissioner/provider relationships – aren't that helpful. Particularly when they are rigidly run by formal contracting and procurement frameworks, specific forms with specifications for contract value, providers are measured and valued by the widgets and outputs linked to the service specification – and our view is that that is very restrictive. It doesn't bring out the wider added value that providers bring in terms of additional resources beyond the service specification.”

Denis O'Rourke,
Assistant Director, Integrated Commissioning
in Mental Health, NHS Lambeth

Lambeth's model of commissioning follows eight principles

Commissioning should:

- 1 Assess needs, aspirations and assets.
- 2 Be of real value and meaning to all.
- 3 Have collaboration, not competition, as its default.
- 4 Use positive competition between a range of suppliers.
- 5 Actively shape markets.
- 6 Use iterative specifications that change over time to best meet needs and reflect assets.
- 7 Use mixed accountability panels to challenge and spread co-production.
- 8 Be a shared learning process that builds expertise and holds onto it.

At the same time, the Collaborative has used prototyping to create an evolving structure for pathways in mental health that can meet changing needs as they are generated through new forms of assessing and planning. The 6-week project involved a small cohort of 12 people who were long-term users of services who were isolated from support networks and were at high risk of moving back into secondary care services.

Putting together teams of professionals from Community Mental Health Teams (CMHTs), the Community Options Team, psychiatric nurses,

peer support groups and GPs, the project looked at each person's route through services and the effects of every aspect of their lives and interactions with services, including housing, personal budgets, peer support, Improving Access to Psychological Therapies (IAPT) services, employment, home treatment teams and the wider voluntary sector. The prototype was successful both in terms of better care provided to service users and the number of new ideas, problems and questions it generated. It also made a case for the need to keep trying out new ideas and the ability to do so in a productive way.



Focus on **People Powered Health in Earl's Court: community research and service co-design**

Earl's Court Health and Wellbeing Centre is a primary care centre developed with an ethos of community-led design and delivery.

Run by a consortia of Turning Point, Greenbrook Healthcare, NHS Dentists and the Terrance Higgins Trust, the centre integrates GP, dentist and sexual health services with a range of community and social value services including peer support groups, a time bank, exercise and diet classes, a job club and space for community-run groups.

The centre was established following a campaign from local people for more primary care services and community space, and the original tender was constructed in close consultation with the local community.

Turning Point were explicitly commissioned to co-design the services at the centre with those who would use them, and through its Connected Care Team it has included its users and the community at every stage – including in asset and needs mapping, commissioning in-centre providers and building up community skill and capacity to develop services from the bottom up. Key to this is the use of Community Researchers, a team of service users who provide a link between the centre, patients and the wider community by researching local need, identifying gaps in provision, gathering feedback and disseminating information. Researchers sit on the social value steering group to share their findings from the research, and are included on interview panels for the centre's staff.

“This is an on-going process of tailoring services according to changing community need. It's not something that has been thought by high-up people in the primary care trust or politicians who think ‘they might need something like that’.”

Noni Beasley,
Community Researcher, Earl's Court Health and Wellbeing Centre



Frankie Lynch,
Chief Operating Officer, North West London Commissioning Support Unit

“We spoke to many of the residents, and the community groups in the Earl's Court area and they gave us a very strong message that they also wanted a centre that would do more than look after their physical health. They wanted facilities for creative things but also to reach out to some of the wider determinants of ill health and tackle the wider issues around ill health including isolation and poverty. We decided to be more creative about how we commissioned our health services, but with a clear social value commitment to the residents of the area”.

Incentivising and supporting collaboration

People Powered Health systems require a process of commissioning that goes far beyond mere procurement, to develop, mould and commission services that reflect the genuine needs and aspirations of their populations.

Commissioning for the People Powered Health approach is not a top-down process, but a dynamic, engaging one that understands the needs and aspirations of its population and wraps services and support around individuals, including practitioners

It is much easier to design a service than design a system. But designing a radically different service often requires having to redesign the system – to provide the spaces, opportunities, capabilities and support for new services to be possible. Many of the sorts of services which make up the People Powered Health approach already exist; what does not is the opportunity for them to scale and have real impact.

“Before, commissioning tended to be hierarchical and professionally led. Now, we have co-produced decisions – there’s no one person who’s the boss. We work by consensus. And this only works because a lot of time and effort went into laying a foundation of trust and understanding.”

Dr Adrian McLachlan,
GP and Chair of Lambeth Living Well Collaborative Board



Collaborative commissioning

“Co-producing commissioning is about a mature relationship with providers and stakeholders, and commissioners agreeing the vision, where we want to get to – and a dialogue about how we’re going to use the resources we’ve got to get there.”

Nick Dixon, Joint Commissioning Manager Mental Health, Stockport

Lambeth and Stockport have forged collaborative commissioning vehicles – alliances of providers and communities of people working together to assess local need and assets, co-design the services required, produce tenders and, in some cases, co-deliver the services themselves.

This approach requires transparency about budgets and working closely with the health and social care sectors, primary and secondary care, mental health services, the voluntary sector and local authority.

“Who is it to say that, as a commissioner, I know how it ought to be done? It becomes even more apparent when difficult decisions are made to do with funding. What can we do without? We’ve got some hard choices to make. It seemed obvious to me that we sit round a table and we have a mature conversation about that, and try to get people to think about the bigger picture. That’s what we’re trying out. On a good day I think yeah.... And then I think ‘crikey’. It’s inevitably going to be two steps forward and one back, but the bigger picture is we’re moving forward.”

Nick Dixon, Stockport



Commissioning and the voluntary sector

The voluntary sector is a key ally, advisor and resource in achieving the aims of the People Powered Health approach. The voluntary sector has a very good understanding of the asset base of any community and therefore with small amounts of investment can unlock large amounts of health care value by investing in that asset base.

It is not unusual, however, for health and social care commissioners to have had little experience in contracting with voluntary sector providers. ACEVO recommends the following approaches when working with the voluntary sector at each stage of the commissioning process:

Assessing needs and designing services

- Use voluntary sector contacts to understand local needs and challenges and together plan solutions. This means consulting with the sector from the earliest stage.
- Make use of umbrella bodies and local infrastructure organisations as key points of contact that can help navigate the sector and engage with local organisations that work with under-represented or disadvantaged groups.
- Seek to create meaningful relationships, with the aim of upholding the independence of the voluntary sector. This might entail representation in patient reference groups, on CCG or health and wellbeing boards, or creating a specific voluntary sector reference group. Be as open and transparent as possible.

Sourcing providers

- Make small changes to tendering and contract processes to make it possible for voluntary sector organisations to bid for contracts. This might entail breaking up larger contracts to encourage smaller organisations to bid or thinking about whether it is appropriate to use procurement or grants.
- Consider investing in the provider base to enable providers to scale up to deliver services or supporting them to come together to deliver services.
- Many voluntary sector providers are small organisations with limited financial reserves. Flexible but consistent payment options such as paying a proportion of money up-front to cover initial costs enables smaller providers to sustainably deliver services.

Delivering to users and evaluating success

- Remain flexible in approaches to service delivery by holding providers to account on the outcomes they achieve rather than prescribing the methods. One of the strengths of voluntary sector providers is the ability to adapt approaches to meet the needs of service users most effectively.
- Measurement methods should be agreed before funding agreements or contracts have been put in place. Consult with providers on what would be most appropriate and useful.
- Think about the role that the voluntary sector could play in evaluation. This might mean commissioning an organisation to conduct an independent evaluation, or making the most of their expertise, evidence base and closeness to service users to feed in to evaluation processes. This should include a critical assessment of where it would be appropriate to decommission services and/ or reallocate resources to achieve the same, or better, outcomes more effectively.

Adapted from 'A Clinical Commissioner's Guide to the Voluntary Sector', ACEVO, September 2012 <http://www.acevo.org.uk/document.doc?id=2206>

Market making and shaping: commissioning people powered services

Services that increase the capacity of individuals and communities to better manage their health exist in various forms, however they are rarely organised into a straightforward, easily accessible market. As such, market development becomes a core commissioning task in a People Powered Health system.



Commissioners shouldn't be designing services directly, but should instead create the conditions in which services can be designed by those who know what's needed. So for those seeking to drive a People Powered Health approach to commissioning and service design, maintaining dialogue, nurturing and developing current and potential providers is key. A People Powered Health system acts as a platform – or many platforms – that can support, foster and enable co-designed services and communities to flourish; and afford opportunities to grow a different practice and knowledge base.

All of this needs investment in time and organisation by commissioners, but the goal is better services delivering better outcomes for less. Developing open market relationships that encourages new providers including voluntary sector organisations to come into the market for improving self-management is a vital part of commissioning.

“The old ways of drawing out the spec and putting it to the market won't cut it. We need to ensure that patient, users, communities are at the heart of service design and delivery – and part of our role is to facilitate that. So I would say, provider development is just part of the role. It's not to say that we are the experts or that we know all the answers, but what we do know is when something is not working.”

Denis O'Rourke,
Assistant Director, Integrated
Commissioning in Mental Health, NHS
Lambeth

Beyond procurement

When commissioning and service redesign work is aligned with the principles of the People Powered Health approach, it makes sense to adopt a collaborative, approach to procurement and contracting, which is both values and outcomes based.

There are, of course, legal and regulatory rules around procurement that commissioners must follow, but these are often less constraining than is assumed. The key principles that must be rigidly applied are parity, fairness and transparency, along with robust evidence that the approach being adopted is in the best interest of the public and those who use services. After that, regular and constructive provider dialogue is possible.

In the commissioning process, there will come a time when relationships are separated in order to observe due process and comply with legal requirements. But before and after that happens, open and honest dialogue between commissioners and providers is essential.

Consortia and alliances

Consortia often fail to win contracts because members of the consortia are assessed individually rather than the consortia being assessed as a whole. This is a barrier to new organisations, or smaller civil society organisations seeking to participate: third sector providers can often be small and lack the capacity to bid for major contracts.

In 2010 Stockport council supported the voluntary sector in setting up Synergy, consortium of charities and third sector providers for the local area. Synergy is made up of voluntary and community groups including Mind, All Together Positive, For Local Advice and Guidance (FLAG) and Anchorpoint. The consortium has been heavily involved in the redesign of pathways and provision of services in Stockport; all work closely with Pennine Care Foundation Trust to support and supplement traditional mental health services.

The Prevention and Personalisation Service in Stockport is run by Mind and All Together Positive, and offers people with mental health problems support to achieve their goals which may include linking them up to volunteering opportunities, helping them with their employment issues or supporting their financial needs. The multidisciplinary nature of this service works best when provided by a multidisciplinary team who are connected to the local third sector economy.

The consortia is supported and managed by one of its members, Anchorpoint. It facilitates and supports the activities of other members – anything from managing buildings to helping with CRB checks to fundraising.

Find out more



For more information on alliance contracting

<http://halliances.org.uk/>

<http://www.nuffieldtrust.org.uk/talks/videos/iain-mccormick-alliance-contracting-health-sector>

Networks that Work (PPH publication)

Building provider capacity

“Some of the answer is about looking at what groups are already in existence and maximising your assets in your local area e.g. connecting in to existing activities, local assets, community groups. How do you graft on to and develop what is there?”

Chris Drinkwater,

GP and President & Public Health Lead, NHS Alliance

Some providers are necessarily more innovative than others; part of the role of commissioners is to grow those who are willing to innovate while challenging existing practice to enable and support their process of change.

Lambeth’s work towards building a collaborative commissioning framework led it to a realisation that it needed to actively grow, foster and invest in the capabilities needed to work in this way. It is developing a Co-Production Academy, a collection of platforms through which the system adapts and grows to shape the skills and capabilities needed to create shared insight and to co-design and deliver services. Its aims include:

- Supporting a continuing process of culture change and mobilisation.
- The development of new suppliers and new ways of working with them.
- Ensuring that the commissioning model learns from and sustains community expertise.

The vision of the Academy is to develop cross-agency platforms that are owned and delivered with carers, peers and service users. Replacing the traditional approach of top-down training, a platform-based approach focuses on facilitating the

development and growth of new ways of working – through exchange of time and expertise, experience of working in different ways and with new groups of people, and exposure to the different methods and capabilities of co-design and co-delivery. The aim is for key platforms to be developed collaboratively, with platforms only scaling according to how valued and useful they really are to those who use them.

Another example comes from Newcastle West Clinical Commissioning Group, where GPs have worked to embed and to spread the concept of social prescribing. GPs have received care planning training to sensitise them to social prescribing as a supplement or an alternative to medical interventions. GPs then refer people living with long-term conditions who meet the scheme’s criteria to a one of a team of link workers who sit within three voluntary sector provider organisations. They in turn work with people and together co-design a ‘social prescription’ that is bespoke to the person and helps them to build the resilience, personal capacity and the social networks they need to improve their lives and clinical outcomes. This could include exercise and dietary advice, art classes or a vast range of other interventions and support services offered by local voluntary sector providers.



Focus on People Powered Health in Lambeth: market shaping

The Lambeth Living Well Collaborative aims to incentivise greater collaboration, integration and knowledge sharing between providers, rather than operating under the default of competition that characterised the existing system. It seeks to incentivise cooperation between providers by developing a long-term alliance contract on the basis of outcomes, within an integrated supply chain across the whole system of primary care, social care, secondary care and the voluntary sector.

With 25 voluntary sector providers, over 50 GP practices and more than a hundred voluntary and private sector providers contracted to work with the local authority, creating an integrated system is far from straightforward. To ensure flexibility and innovation, the contracts will be strong on the long-term outcomes that the Collaborative is seeking to achieve, and looser on the outputs.

It has been important for commissioners to create a relationship where providers not only share data on case-loads, performance and other data with one other but also feel able to challenge commissioners on the existing design of services, and come up with new alternative models of provision, without the risk of losing competitive advantage or a withdrawal of funds. Lambeth engaged with potential providers to build their capacity to provide services under this new model. This meant facilitating a new conversation with existing providers about what future provision – with the user at the centre – could look like, and engaging those providers who were willing to take part in this conversation.

Since then, Lambeth has continuously expanded this conversation to include new providers who are interested in working under the new model. The requirements for new providers put the principles of the Collaborative at the heart, focusing more on their ability to engage with the values of collaboration than on traditional legal and financial requirements. The commissioner's role in the Collaborative has also been to challenge existing providers on their current practice, and to facilitate processes that can re-orientate them towards a more user-centred model.

The first new service offers – including peer support, a community options team (COT) and use of the IAPT service – were implemented in March 2011. In the medium term, the priority remains the necessity of safely providing more with much less available resource. Long-term, Lambeth aims to completely change the culture of mental health services to reflect a new, more productive, workforce culture. This has led to the development of a Co-Production Academy – a platform of tools and support which aims to build providers', users' and commissioners' skills in commissioning and providing co-produced services through prototyping.

“Often when you pick up ‘toolkits’ on commissioning, they will say “provider and market development”, but traditionally what that means is putting out to the market and seeing what comes in. What we are doing is working collaboratively with the market on developing it.”

Denis O'Rourke,
Assistant Director, Integrated
Commissioning in Mental Health,
NHS Lambeth

Decommissioning

The NHS tends to frame decommissioning as failure; something negative and to be avoided, rather than seeing decommissioning as a natural response to a constantly changing environment and a positive sign that we now better understand how to improve outcomes for people who use our services.

Although potentially a creative process, decommissioning is more often prompted by short-term crisis – a sudden change in financial circumstance or in response to failure of poor performance – than driven by a search for ways to deliver more effective public outcomes. Nesta's 'The Art of Exit' report argues that truly transformational public innovation requires creative decommissioning: actively challenging incumbent service models and mindsets to invest properly in new approaches. Commissioners should apply the same principles of involvement and participation to decommissioning as they do to commissioning work, maintaining trust and limiting 'entrenchment' by making providers part of the solution.

“A concerted effort is required to communicate the rationale for decommissioning, from politicians, managers, service users and even staff. ... Often, breaking internal cultures and working practices is the most challenging part of this process, and needs leaders to embody new behaviours.”

Nesta, 'The Art of Exit'⁷

Creative decommissioning is an opportunity to innovate and actively challenge incumbent service models and mind-sets; support development of and investment in new service delivery approaches. It is an entrepreneurial, creative activity that anticipates future demand and actively develops the providers and markets. It is an iterative, non-linear cycle that can be applied in different contexts and at different levels.

Experience shows that when it comes to decommissioning, preparation pays off. Existing models of public services are protected by powerful, mutually reinforcing alliances of producers, consumers and politicians. Creative decommissioning breaks up those alliances and builds new ones to support alternative patterns of provision across sectors and traditional role barriers – between local commissioners and leaders; services users and providers; and politicians and providers.

“Decommissioning doesn't always mean closing something. It is about drawing a line under what is currently provided and taking the time to go back a few steps and review why you are doing it in the first place. It is important to have reviews going on all of the time, often incrementally pushing the boundaries of what is possible.”

Commissioner, Royal Borough of Kensington and Chelsea⁸

Culture change and leadership: the role of visionary commissioners

The People Powered Health approach forges partnerships of equals, with every individual bringing assets, experience, skills capabilities of equal importance. But this does not obviate the need for strong leadership.

Commissioners are crucial in holding the vision, shaping markets and forming coalitions of partners. They are needed to create and safeguard the conditions in which co-designed and co-delivered services deliver radically improved and different outcomes at lower cost.

The experience of teams taking part in the PPH practical programme has demonstrated that leading culture change and workforce development are pivotal roles for commissioners. Getting these two factors right can make the rest of the process fast, productive and successful; getting them wrong can create entrenched barriers to change.

“Ultimately it is about culture change. It’s about changing behaviours more than it’s about changing practice. We reckon there is a minimum of a 1000 staff, from a practice nurse to a psychiatrist to a practice nurse, who we need to support in changing their instinctive behaviour. That’s a huge challenge.”

Denis O’Rourke,
Assistant Director, Integrated
Commissioning in Mental Health,
NHS Lambeth



Workforce development

Workforce development is an important driver and an often overlooked and under developed aspect of commissioning for change.

Being part of a multi-disciplinary, collaborative team made up of service users, carers, practitioners and providers from every sector can challenge the perspectives and attitudes of all those involved.

Current clinician training is heavily based on instilling expert knowledge and standards rather than communication and collaborative working skills required for the People Powered Health approach, but this is beginning to change. The Royal College of GPs is already developing communication and care planning skills as part of the GP curriculum; projects such as NHS Diabetes' Year of Care have been developing tools and frameworks for improving consultations; and external organisations have undertaken research around practitioner training, such as the Health Foundation's Co-creating Health programme.⁹

“You need to give coproduced projects time to embed, because of the very nature of how they evolve. Building relationships, sustaining relationships and working together. For example, Colin organised a tea party instead of having a meeting for FLAG and PPS to find out about one another. You can say ‘there’s a team over here and a team over there’ but you don’t get that understanding about what skills and knowledge everyone can bring to the table without getting to know them.”

Beverley Hart
Manager, Stockport FLAG

The role of collaborative leaders

There is much concern and debate about the ‘ideal’ capabilities of commissioners, but the real issues lie not with the skills of individuals, but with the capabilities of commissioning organisations and teams.

Commissioning requires a diverse range of skills and capabilities that could never be fulfilled by one individual: analytical skills, service design, research, customer insight, evaluation, procurement, contracting, subject knowledge and, crucially, strategic leadership. For this reason alone the catch-all label of ‘commissioner’ is unhelpful.

In general, it is not procurement and contracting where there are weaknesses in capability, but in the dialogue between commissioners, citizens and providers to determine what is working, what needs to change, and what is needed.

The important concept is leadership, not leaders. Commissioning for the People Powered Health approach is not about one person with the exact set of capabilities and skills to change the system; it is about leaders becoming facilitators of a change in context, growing the capabilities of a wide and inclusive group of alliances, partnerships and communities, holding true to a new vision for how services could be, while distributing ownership of it as widely as possible.

Changing culture

Redesigning services often relies on the engagement work being done on the front line and then trying to deliver back a directive; this can fail because the service managers haven't been exposed to the research and ideation processes.

Likewise, design work that only includes service managers fails because it hasn't engaged either the commissioning level or the practitioners and service users who will be working with services on the ground.

The success of collaborative commissioning, partnerships and service co-design stand or fall on the strength of the relationships within them, and whether the community meets purposefully and regularly in order to build up trust and confidence. Events that include a wide cross section of stakeholders, such as the Lambeth Living Well Collaborative's regular co-design workshops, ensure that a group's core vision is protected, disseminated and enhanced across as wide a range of people as possible. Also, the responsibility of engagement and idea generation is distributed and shared.

Smaller scale activities also contribute to the development of relationships. The Collaborative's breakfast meetings for example, allow commissioners and senior leaders to discuss and problem-solve as a joined-up group. Peer supporters, community options teams, users and their advocates are also round the table, resulting in direct access and conversations to those with decision-making power. Stockport, too, has launched a regular Co-Design Forum to bring together service user and carer representatives, providers, commissioners and front-line workers.

“Historically, there has been a sense of ‘them and us’ and divisions across the system – people using versus providing; primary versus secondary care; social care versus the statutory and voluntary sectors. Dramatic change and service redesign are needed, and we need to get the foundations of culture change and relationships built up first. It's important that all parts of the system are represented.”

Adrian McLachlan,
Chair of Lambeth Clinical Commissioning
Collaborative Board



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