APRIL 2011

Shaping the market for personalisation: Diagnostic and action planning tool

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This product was developed by Dr Sam Bennett, personalisation adviser to the Think Local, Act Personal Partnership and building on work from the Putting People First programme. April 2011.

1. About this tool

This tool was developed to help commissioners and others with a stake in shaping local markets to understand and assess their progress in delivering personalisation in adult social care. It reflects the renewed commitment to transformation through personalisation and community based support set out in the Government's new vision, *Capable Communities and Active Citizens* and the new sector wide partnership agreement, *Think Local, Act Personal*.

Shaping the market for personalisation was developed as part of the national delivery programme in 2010 and was informed by an action learning set and series of regional learning events. The tool therefore reflects both current policy and learning from implementation across the sector, including the views of more than 350 commissioners and providers from across the country.

Shaping the market for personalisation starts from the assumption that smart commissioning will play an important role in making personalisation happen and in supporting the development of stronger communities, more engaged in the design, delivery and evaluation of local services and support.

Commissioning is understood here as the process of:

> *Working together with citizens and providers to support individuals to translate their aspirations into timely and quality services, which meet their needs; enable choice and control; are cost effective; and support the whole community.*

This understanding implies a new set of responsibilities and a range of different activities for commissioners who will need to lead the way in shaping local markets while in many cases relinquishing the role of primary purchaser of care and support. Stronger, more collaborative relationships are needed where commissioners and providers work together to shape the range of support available, make best use of available resources and put the citizen at the centre.

The approach described below is organised around the familiar commissioning cycle of 'understand,' 'plan,' 'do,' and 'review.' It includes references to established commissioning activities, such as understanding needs and developing service specifications, in addition to a wider range of tasks and responsibilities associated with shaping the market. All of these tasks are critical to making a reality of a system based on personalisation and community based support. The Think Local, Act Personal Partnership hope that this tool will provide helpful impetus to continued learning and sharing and the development of innovative practice across the sector.

2. How to use it

TThe diagnostic questionnaire is divided into five main sections arranged around the familiar commissioning cycle of 'understand,' 'plan', 'do,' and 'review' with an additional section entitled 'enablers for strategic commissioning.' Each section is divided into a number of questions relating to key challenges that commissioning organisations must consider in developing their approach to shaping local markets of personalised care and support.

Each question requires that you rate your progress by choosing a statement from, '1' to '5,' that best describes your current situation regarding a particular challenge, e.g. contracting and procurement. A '1' indicates that you have not begun or are just getting started with the challenge. A '2' or a '3' indicates that you have taken some steps on your journey but still have some way to go and a '4' or '5' indicate what might be in place if you were making "significant progress." This is not an exact science! It is unlikely that any answer will fully capture your position, so try to choose the statement that is closest.

Very few commissioning organisations will be able to rate themselves as a '4' or '5' in every area because of the range of activities described and the breadth of roles and responsibilities involved. Don't let this put

you off – the process of completing the diagnostic is as much about appreciating the changes you could make as it is about identifying where you are up to on your particular journey. However you rate yourself, the next answer up should provide ideas for what you might do to make further progress, i.e. if you rate yourself at '3' in a particular area, look at what it might take to score a '4' or a '5.'

At the end of the diagnostic there is a glossary and references to other useful resources that can help you read around a subject or understand how a particular challenge is being addressed locally. These are intended to prompt and stimulate your local discussions rather than to provide you with an exhaustive reading list. At the very back is an action planning template designed to help you think through how you will evidence your progress and plan your next steps.

3. Making an impact

This tool is designed to be used independently for self-assessment and without additional support. Several councils who tested the diagnostic in early 2011 made the following observations for ensuring the greatest possible impact from using the tool:

- When used for self-assessment, it can be helpful to have people from different parts of the organisation complete the diagnostic separately and then come together to review their responses, e.g. operational managers involved in service delivery may have a different and equally valid perspective to those in designated commissioning roles;
- The diagnostic can be a useful tool for structuring senior management and/or commissioning team meetings – either completing the questionnaire during meetings or using the completed diagnostic as the basis for discussion on new strategies and next steps;
- It can help to bring people together locally to complete the diagnostic in a workshop environment with input from a wider range of different stakeholders;
- The diagnostic can be used to benchmark progress across different localities or service areas, e.g. through separate completion in learning difficulties and older people's services.

In addition, the diagnostic can be used to stimulate wider engagement beyond the commissioning organisation. Some possibilities you may want to consider are:

- Using the diagnostic collaboratively with partners in the NHS to determine progress with integration and market shaping across health and social care;
- Using the diagnostic at regional or sub-regional level with multiple commissioning organisations, to stimulate discussion and joint problem solving and to identify possible areas for collaboration;
- Using the diagnostic in tandem with Progress for providers, a diagnostic tool designed to support providers to evaluate their progress with delivering personalised services, to acquire a 360-degree perspective on market shaping across an area;
- Using the diagnostic alongside practical tools developed as part of the InLAWS project to take a rounded view of commissioning and workforce development (see http://www.skillsforcare.org.uk/inlaws/)

4. Sections summary

Below is a summary of the five sections of the Shaping the market for personalisation diagnostic, including the challenge headings for each sub-section and page references.

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5. The diagnostic

Section 1: Enablers for strategic commissioning

1.	**Leadership**	
1	There is no interest in personalisation from senior management – this is not even on the agenda;	
2	There is some interest in personalisation from senior management but this has not translated into policy or strategy;	
3	We have strong leadership for personalisation located with one or two individuals in the department/directorate, this has resulted in some changes to policy or strategy but does not feel like an organisational response;	
4	We have strong leadership for personalisation across the department/directorate, this is reflected in our policies and strategies and is also on the corporate agenda;	
5	We have strong leadership for personalisation across the department/directorate and the wider organisation; this is reflected in our policies and strategies and the commitment of local partners in the statutory, third and independent sectors.	
Evidence:		

2.	**Commissioning strategy**	
1	We have not considered the impact of the personalisation agenda in terms of our commissioning strategy;	
2	We think that personalisation will have an impact on commissioning but we are not sure what this will be or what we should do about it – this has not impacted significantly on our commissioning activity and is not reflected in commissioning strategies and plans;	
3	We have begun to review commissioning strategies and plans in light of personalisation and are putting some new plans in place, we expect changes to our activity to be marginal and discreet;	
4	We have developed a new commissioning strategy and plans outlining our approach to personalisation and developing the local market, we expect significant changes to our activity over time and evidence is emerging that this is leading to greater choice and control and better outcomes for people;	
5	We have a commissioning strategy and plans outlining our approach to personalisation and developing the local market that is embedded in our activity and strongly linked-in to local area strategies, this is leading to changes at all levels of commissioning (strategic, operational and individual) and we have evidence that this is leading to greater choice and control and better outcomes for people.	
Evidence:		

3.	**Capacity and capability**	
1	We don't have designated commissioning teams or senior management leadership of commissioning;	
2	We have limited commissioning capacity, very few people in commissioning roles at senior level and limited capability for strategic development – our commissioning tends to be reactive, focusing on short term imperatives, e.g. as contracts come up for renewal;	
3	We have dedicated commissioning teams and senior leadership of commissioning but not enough capacity and/or capability to make a real impact or to fully implement personalisation within our commissioning activity;	
4	We have good commissioning capacity and capability to facilitate changes in the market and plan for the long term, we have the skills and competencies to commission for personalisation but this is confined to social care and our priorities are rarely reflected in corporate or health plans;	
5	We have good commissioning capacity and capability to facilitate changes in the market and plan for the long term; we have the skills and competencies to commission for personalisation, to build effective partnerships within the organisation and to influence wider system change across health and social care and a range of universal services.	
Evidence:		

4.	**Culture change**	
1	People with care and support needs are seen as passive consumers, there is little consideration of their abilities and resources, staff are resistant to personalisation and feel their professional status is under threat;	
2	People with care and support needs are rarely seen as active citizens and there is little consideration of their abilities and resources, staff struggle with the changes associated with personalisation and are anxious about how their roles will change;	
3	People with care and support needs are increasingly seen as active citizens and decision makers regarding their support, this is starting to change the way that staff work, but roles are not yet clear and the organisational culture has not significantly changed;	
4	People with care and support needs are seen as active citizens and key decision makers in all aspects of their support, staff are working differently and are clear in their roles and the culture of the directorate is changing to support personalisation;	
5	People with care and support needs are seen as active citizens and key decision makers in all aspects of their support, staff are working differently and are clear in their roles and the principles of personalisation are embedded across the directorate.	
Evidence:		

5.	**Coproduction**	
1	We provide information about our commissioning strategies and plans, there are few established channels for feedback and participation;	
2	We provide information about our commissioning strategies and plans, user reference groups express their views though this is mostly the "usual suspects" and has minor impact on final commissioning decisions;	
3	We provide information and consult on commissioning strategies and plans, this is usually against a pre-set list of priorities, a range of community and user groups express their views, this sometimes has an impact on final commissioning decisions;	
4	We promote reciprocity and value working in partnership with local people and community groups, there are a range of ways to participate in commissioning, including for hard to reach groups, this is an open conversation where we make commissioning decisions together;	
5	We are equal partners with local people in the design, planning and provision of local services and the development of community capacity, citizens are empowered and supported to play a leading role in commissioning throughout the cycle, we delegate responsibility for some commissioning decisions to community groups.	
Evidence:		

6.	**Safeguarding and personalisation**	
1	We have not thought about safeguarding in the context of personalisation;	
2	Safeguarding is a clear priority and we are developing a systemic response, but this is seen as running counter to our work on personalisation which is limiting our progress on both fronts;	
3	Safeguarding and personalisation are both high priorities, they are seen as compatible but we have struggled to put this into practice and staff sometimes feel themselves pulled in two different directions;	
4	Safeguarding is working well alongside personalisation, staff at all levels of the organisation understand their roles and responsibilities and are able to effectively manage the balance between safety and positive risk taking;	
5	Safeguarding is fully integrated within a local system of personalised care and support that promotes wellbeing and improves safety - our self-directed support process provides a thorough and holistic approach to risk management resulting in high quality plans that help keep people safe, strengthen individual citizenship and build people's natural support networks.	
Evidence:		

7.	Integration with Health	
1	Joint commissioning is not well developed and there is little overlap between our plans and those of commissioners in partner agencies – health have their own priorities;	
2	We have clear governance arrangements in place to support joint commissioning but this has not translated into successful practice – there is minimal joint investment and little integration across relevant services;	
3	We have clear governance arrangements to support joint commissioning and management and systems are in place, outcomes are mixed dependent on partnership arrangements and this needs to be strengthened;	
4	All relevant social care commissioning strategies are joint with health, they clearly identify shared priorities including personalisation, prevention and service integration, underpin joint investment in these areas and are understood and supported by staff at all levels;	
5	All relevant social care commissioning strategies are joint with health, they clearly identify shared priorities including personalisation, prevention and service integration, underpin joint investment in these areas and are understood and supported by staff at all levels. We are working together with health colleagues to ensure the success of personal health budgets and develop the role of GP commissioning in delivering personalisation.	
Evidence:		

8.	Wider system integration	
1	There is generally poor understanding and commitment to personalisation in other parts of the system outside of social care;	
2	There is generally poor understanding and commitment to personalisation in other parts of the system, but there are some exceptions where headway is being made;	
3	There is mixed understanding and commitment to personalisation in other parts of the system but momentum is building in some targeted services, e.g. through the introduction of personal budgets for disabled children and for children in transition or council and job centre plus involvement in the "right to control" programme;	
4	There is good understanding and commitment to personalisation in other parts of the system, e.g. through the introduction of personal budgets for disabled children and for children in transition and council and job centre plus involvement in the "right to control" programme, this is reflected in the strategy of the Health and Wellbeing Board;	
5	There is good understanding and commitment to personalisation in all parts of the system, including targeted and universal services, e.g. in planning, education, employment, community safety, arts and leisure, transport and across the voluntary and community sector etc. This is reflected in the strategy of the Health and Wellbeing Board.	
Evidence:		

Section 2: Understand

9.	**Understanding need**	
1	We have undertaken a Joint Strategic Needs Assessment (JSNA), but this doesn't link well with our corporate strategies or commissioning plans;	
2	We have undertaken a JSNA and are considering how best to use this alongside other data (e.g. ONS/NASCIS) to profile the needs and characteristics of local populations;	
3	We are using our JSNA alongside other data (e.g. ONS/NASCIS) to profile the needs and characteristics of local populations, this is linked to some commissioning plans;	
4	We have used the JSNA to establish a local data set for everyday use by agencies across health, social care and housing to better target resources and interventions, this has engaged the public throughout, this is linked to commissioning plans;	
5	We have used the JSNA to establish a local data set for everyday use by agencies across health, social care and housing to better target resources and interventions, this has engaged the public throughout, this is linked to commissioning plans and corporate strategies.	
Evidence:		

10.	**Understanding experience**	
1	We don't commonly use qualitative and experiential information for commissioning purposes, we do not have ways of systematically recording and analysing people's views about support or the perspectives of paid staff;	
2	We collect some qualitative information about people's experience of support and the perspectives of paid staff, but this tends to provide service specific snapshots for quality assurance purposes rather than for commissioning;	
3	We collect a range of qualitative information about people's experience of support and the perspectives of paid staff, including user satisfaction surveys, compliments and complaints and feedback from user forums, staff forums and reference groups though we struggle to use this routinely and systematically in commissioning;	
4	We collect a range of qualitative information about people's experience of support and the perspectives of paid staff using multiple feedback mechanisms, we are also developing ways of routinely collecting person-centred information and using this systematically for commissioning (e.g. using *working together for change*);	
5	We use a wide range of qualitative information about people's experience of support and the perspectives of paid staff for commissioning; including through person-centred information collected routinely from support planning and reviews (e.g. using *working together for change*) and staff supervisions and appraisals, this is shared across the organisation and externally and underpins all our commissioning and market development activity.	
Evidence:		

11. **Understanding demand**	
1 We do not have ways to systematically and strategically understand the level and type of demand now and in the future and what this means for commissioning;	
2 We recognise the need to better understand the level and type of demand and the things people want now and in the future, but do not know where to start or how to achieve this;	
3 We have information on the likely level of demand in the future and are developing commissioning plans to meet this, we are consulting with people about what they want now and in the future and are using this information to quality assure certain decisions and strategies;	
4 We have information on likely level of demand in the future, we understand what is driving demand and are developing commissioning plans to meet and reduce it, we have asked people about what they want now and in the future and are collating information about the purchasing behaviour of personal budget holders and self-funders;	
5 We have information on likely level of demand in the future, we understand what is driving demand and are developing commissioning plans to meet and reduce it, we understand what people want now and in the future and are making this information available to the market, and using it to underpin all our commissioning and market development activity.	
Evidence:	

12. **Understanding supply**	
1 We have little market intelligence beyond the information we collect from monitoring and reviewing existing services and contracts;	
2 We have a reasonable understanding of the structure of the local market – the numbers and types of suppliers and the range of current services available at what price;	
3 We have a good understanding of the current structure of the market, including its drivers and capacity for growth and innovation, we understand common barriers to market entry and are working to reduce these through our commissioning activity;	
4 We understand the current structure of the market and have a clear vision of how the market needs to change to respond to changing need, demand and expectations, we share this information routinely with providers in a market position statement;	
5 We understand the current structure of the market (both state and self-funded) and where it needs to be in the future, we are working in partnership with providers and know what it will take to deliver the changes people want to see, this information is shared with the market and explicitly linked to investment and disinvestment decisions.	
Evidence:	

13.	**Relationships with providers**	
1	We have adversarial relationships with providers – there is an "us" and "them" culture between commissioners and providers and very little trust;	
2	We have good relationships with some providers but there is little understanding or openness, though there are some exceptions, we have no means of reaching potential future providers;	
3	We are working hard to build collaborative relationships with contracted providers as we know this will lead to better outcomes but it feels like an uphill struggle – we have regular provider forums but it is difficult to square price negotiations and efficiency targets with genuine partnership;	
4	We have some strong collaborative relationships with contracted providers and are realising the benefits – we have an open dialogue around commissioning intentions and make support available for current and potential future providers to understand and adapt to the demands of personalisation;	
5	We are delivering personalisation in active partnership with providers; we are working closely with our most progressive providers to do things differently and share this learning, we have created a collaborative environment where we work through challenges together to achieve better outcomes and maintain market stability.	
Evidence:		

Section 3: Plan

14.	**Residential care**	
1	We have comparatively high spend on residential care and no plans to alter this, many people who might wish to remain in their own homes or live independently in the community are not enabled to do so;	
2	We have comparatively high spend on residential care, we understand the reasons for this and want this to change and have so far focused on negotiating lower fees;	
3	We have comparatively high spend on residential care, we understand the reasons for this and have developed robust plans to change it through a combination of negotiating lower fees and reprovision;	
4	We have comparatively moderate spend on residential care and this is decreasing further as we support more people to live independently in the community, widen usage of reablement and develop alternative housing options; what we do commission is of good quality and as personalised as possible;	
5	We have a comparatively low spend on residential care and this is decreasing further as we support more people to live independently in the community, widen usage of reablement and develop alternative housing options; what we do commission is of good quality and as personalised as possible, this strategy is reflected in council-wide plans, including the corporate planning strategy.	
Evidence:		

15.	**Prevention and early intervention**	
1	We have not invested in prevention and early intervention, we have increased our eligibility threshold to 'critical' in an attempt to control costs;	
2	We are developing a strategy for prevention and early intervention including a local business case for investment in reablement and assistive technology;	
3	We have a prevention and early intervention strategy in place, have invested in reablement for hospital discharges and make some use of assistive technology but we are not seeing the benefits we expected and we do not understand the impact of this across the system;	
4	We have a joint prevention and early intervention strategy in place with health, have invested jointly in intermediate care, 'entry model' reablement for everyone presenting with care and support needs and falls prevention, we are make increasing use of assistive technology and are starting to understand benefits derived across the system;	
5	We have a joint prevention and early intervention strategy in place with health which is a corporate priority, we have invested jointly in intermediate care, reablement, falls prevention and assistive technology and are successfully using predictive modelling to identify and better target interventions (e.g. PARR, EARLI), the benefits are traceable across the system and are releasing savings (e.g. reduced requirement for ongoing support, usage of acute care and hospital admissions).	
Evidence:		

16. **Wellbeing**	
1 We make minimal investment in low level support, we provide some information and signposting about health and wellbeing through our website;	
2 We have information about health and wellbeing services on our website and make some grant funding available to the voluntary sector for this, we are developing business cases for investment in low level services;	
3 We provide a range of accessible information and advice through the voluntary sector, we have some low level services supporting older people to remain at home though the benefits of these are unclear;	
4 We have a range of accessible information and advice available through the voluntary sector and at various focal points in the community (libraries, leisure centres, GP surgeries etc), we have low level services supporting older people to remain at home and part of the community and we are evaluating the benefits;	
5 We have a comprehensive range of accessible information and advice available through the voluntary sector and at various focal points in the community, we are investing in a range of low-level support for self-funders and those who do not meet our eligibility thresholds, including navigation services, first contact services and case coordination (see POPPS) and we are evaluating the benefits of these.	
Evidence:	

17. **Support planning and brokerage**	
1 We have not thought about the range of options people may want for support planning and brokerage, all support plans are delivered by social work teams;	
2 We want to develop a diverse range of support planning and brokerage options for people directing their support but do not know how to do this or where to start;	
3 We are developing plans to improve the range of support planning and brokerage options available, most support plans are delivered by social work teams, we are working to increase user led capacity to deliver this support;	
4 We have a range of support planning and brokerage options available, including paid staff, the voluntary and community sector, independent providers and peer support, user led organisations are delivering some support plans but not consistently across client groups, we are starting to measure the impact of these choices;	
5 We have a diverse, mixed economy of support planning and brokerage options available, including paid staff, the voluntary and community sector, independent providers and peer support, user led organisations are delivering an growing number of support plans which is improving direct payments uptake, use of community based provision and unpaid support.	
Evidence:	

18.	**User-led organisations**	
1	We do not have any user-led organisations locally and have no plans to foster them;	
2	We do not have any user-led organisations locally, we want to change this but don't know where to start or how to make this happen;	
3	We have a user led organisation locally but many people are insufficiently represented, we are putting plans in place to further stimulate and support this part of the market;	
4	We have supported the development of a local user-led consortia representing all client groups, members are helping people direct their support and manage personal budgets, we have a clear strategy to develop further capacity in this part of the market;	
5	We have a wide and growing range of user-led organisations engaged in service delivery, peer support, helping people to direct their own support and providing information and advice, our strategies and systems empower user led organisations to shape and drive the changes they want to see on behalf of their constituents.	
Evidence:		

19.	**Plurality**	
1	We have no strategy regarding preferred supplier mix, we have a high proportion of in-house provision and no plans to change this and small and micro providers are often excluded by our commissioning processes;	
2	We only work with large organisations who can offer the high volumes we commission for, we have a relatively high proportion of in house provision though we are looking to change this and our local voluntary, community and user led sector is underdeveloped and/or underused;	
3	We work with a range of providers from the independent and voluntary and community sectors, we are reviewing the supplier landscape (including in-house provision) and developing a vision of the preferred mix of providers we want to see in the market based on our understanding of need, demand and what people say they want;	
4	We work with a range of providers from the independent, voluntary and community and user led sectors, including mutuals, cooperatives and social enterprise, we have a vision of the preferred mix of suppliers based on our understanding of need, demand and what people say they want and are working to break down barriers for small and micro providers to enter the market;	
5	We work with a range of providers from the independent, voluntary and community and user led sectors, including mutuals, cooperatives and social enterprise, we actively seek out and support small and micro providers to enter the market, specialist advice for start ups and micro-enterprises is available and people are choosing a diverse range of provision.	
Evidence:		

20.	**Universal services**	
1	We focus only on commissioning targeted interventions for those eligible for state funded care and support;	
2	We are aware that the transformation agenda requires a greater emphasis on universal services and commissioning for the whole community but we don't know what this means for us or where to start;	
3	We have begun to think about the importance of universal services and their accessibility to all people with support needs in addition to or in place of targeted services, this is not wide ranging or systematic;	
4	We have identified ways to influence other commissioners and commissioning organisations so that universal services are becoming more accessible to people with support needs regardless of whether they are state or self-funded, our strategies are underpinned by a commitment to the social model of disability;	
5	We exert direct and indirect influence across the organisation and externally so that universal services, including transport and commercial services, are becoming more accessible to people with support needs, we are seeing a change in the overall balance of our commissioning activity away from targeted towards universal services.	
Evidence:		

Section 4: Do

21.	Unit costs and pricing	
1	We are unaware of the need for and have no unit costs for in-house or commissioned services, these are costed by building or block and funded through aggregate contracts and are unavailable to individual purchasers;	
2	We are aware that we need to understand what it costs to provide support to individuals but we don't know where to start or how to make this happen;	
3	We have unit costs (including the cost of running the service) for in-house services and are starting to expect the same from providers, pricing information is available for most services;	
4	We have unit costs for all services and providers have information about costs for each individual they support, we make pricing information available to personal budget holders and self-funders;	
5	We have unit costs for all services and providers have information about costs for each individual they support, everyone with support needs has access to clear pricing information about services and can make informed judgements on their preferred balance between cost and quality, we do not enforce universal prices for services so that these can be flexible in response to individual requirements.	
Evidence:		

22.	Tendering	
1	We tender for services by volume with a heavy emphasis on price, often through reverse e-auctions;	
2	We tender for services against rigid specifications that are often poorly aligned with our strategies and leave little scope for innovation, we take some account of quality as well as price, our processes tend to squeeze out smaller and micro providers;	
3	We tender for services using proportionate processes, engaging with providers from an early stage and inviting innovation and collaboration, we take account of quality and social returns to some extent, we have some mechanisms for involving people with support needs;	
4	We are moving towards an outcomes based approach to specifying and tendering for services that is aligned with our strategy to increase choice and control for people, we engage providers from an early stage, including small and micro providers, invite innovation and collaboration, take account of quality and social returns and have established mechanisms for involving people with support needs;	
5	We have fully switched to outcomes based approach to specifying and tendering for services and are looking at other approaches such as competitive dialogue, we engage providers from an early stage, invite innovation and collaboration, take good account of quality and social clauses and empower people with support needs to play a full and active role throughout.	
Evidence:		

23.	**Contracts**	
1	We are committed to a number of large, long-term block contracts with limited scope for variance, these are for generic, time and task based services which do not support choice and control;	
2	We are negotiating on the terms of some existing contracts and hope to use upcoming renewals as an opportunity to extend greater choice and control, but we don't where to start or how to do this;	
3	We are developing a strategy to move towards outcomes based contracts for some services, commissioned services are not currently as flexible and responsive as either personal budget holders or providers would like;	
4	We are following a strategy to move to outcomes focused contracts, we are working with providers (including small and micro providers) to support them through the transition at a measured pace, to further personalise people's support arrangements and make necessary changes to our contracts that support greater flexibility;	
5	We have a range of outcomes focused contracts covering most services that work for providers of all sizes, these are leading to greater choice and control for people and greater flexibility for providers, we incentivise and reward responsive behaviour from providers and share risk equitably between us.	
Evidence:		

24.	**Navigating the market**	
1	We provide targeted information about services but do not have other ways for people to navigate the market;	
2	We provide targeted information about services and recognise that people directing their support will need other ways of navigating the market, but we don't know where to start or how to make this happen;	
3	We provide information on all services, including universal services, we are developing a local information hub and directory of support options to help people better navigate the market;	
4	We provide information on all services, including universal services, we are developing a range of ways for people to navigate the market, including e-portals and local information hubs, people are influencing the market directly through their purchasing decisions which we share routinely with all providers;	
5	We provide information on all services, including universal services and community resources, we have a range of ways for people to navigate the market that are accessible to everybody, people influence the market through their purchasing decisions, online vendor reviews, and information we share with providers about their aspirations for the future.	
Evidence:		

25.	**Individual purchasing**	
1	We have not considered the range of options people will need for managing their personal budget and purchasing support;	
2	We realise people will need a wider range of options for managing their personal budget and purchasing support, we have a poor record with direct payments and are developing further options, we have not considered the impact on commissioning;	
3	We have several options for people to manage their personal budgets and purchase support including direct payments and council managed budgets, we are monitoring the impact on commissioned services;	
4	We have a range of options for people to manage their personal budgets and purchase support including a streamlined direct payments service, council managed budgets and individual service funds (ISFs), we have developed easy to use, standardised templates for individual contracts and we are working with commissioned services to understand the impact on usage and outcomes;	
5	We have a range of options for people to manage their personal budgets and purchase support including a streamlined direct payments service, council managed budgets and ISFs, we have developed easy to use, standardised templates for individual contracts and we have evidence of the impact individualised purchasing is having on service usage and outcomes that is informing our commissioning.	
Evidence:		

26.	**Service development**	
1	We have not looked at how existing services or new models of support can be more flexible and responsive to individual requirements;	
2	We know that services need to be more flexible and responsive to individual requirements but do not know where to start or how to make this happen;	
3	We are working with providers to raise awareness of the need to change and adapt, some providers are actively reviewing how they can deliver support in more personalised ways, but this is limited and most services are delivering more of the same;	
4	We are actively supporting providers to make changes by raising awareness, offering joint staff training and development opportunities, engaging with business planning and sharing evidence of what has been tried and what works, this is changing the way support works for people;	
5	We have worked with providers and people with support needs to develop a vision and understanding of what makes a fully personalised service, we are actively supporting providers to make changes so that services are better coordinated, more flexible and person-centred, this is leading to different models of support that are delivering demonstrably better outcomes for people.	
Evidence:		

27. **Quality assurance**	
1 We rely solely on regulatory information and criteria regarding capacity and health and safety when assuring quality and assessing risk;	
2 We are aware of the need to review our approach to quality assurance in light of the move towards personalisation, we want to support choice and control within an appropriate risk enablement framework but don't know where to start or how to do this in practice;	
3 We have started to adapt our approach to quality assurance to better support choice and control and enable a wider range of providers to enter the market, we are working towards a proportionate approach to risk enablement but this is not consistent and work still needs to be done in this area;	
4 We assure quality through approved lists, kitemarking schemes and continuous review, this works for small, micro and unregulated providers as well as larger providers, we take a proportionate approach to risk which helps keep people safe, supports choice and control and involves minimal bureaucracy (e.g. very limited use of panels);	
5 We take a system wide view of quality assurance and empower local people to set the framework, this works for small, micro and unregulated providers as well as larger providers, we take a positive and person-centred approach to risk and we have evidence that this is keeping people safe, leading to greater choice and control and improving market diversity.	
Evidence:	

28. **Building community capacity**	
1 We focus on commissioning services for very specific support tasks that keep people healthy and safe;	
2 We are aware that we have a role in building community capacity but we don't know where to start or how to make this happen;	
3 We have begun to think about commissioning to build community capacity, we are mapping community resources and developing an understanding of local networks and their effectiveness;	
4 We have a good understanding of community resources, local networks and the extent to which community organisations include people with support needs as participants and contributors, we are actively building community capacity in partnership with local people and the voluntary and community sector, we use small grants and have a portfolio of project in this area supported by an innovation fund;	
5 We have a good understanding of community resources, local networks and the extent to which community organisations include people with support needs as participants and contributors, we are actively building community capacity in partnership with local people and the voluntary and community sector, this is a high priority and is reflected in local strategies and partnerships, this is improving people's lives and leading to quantifiable benefits across the system.	
Evidence:	

Section 5: Review

29.	Contract management	
1	We don't collect information about the performance of services consistently or routinely, except for service reviews to confirm that the volume of service delivered is in line with the contract;	
2	We collect information about the performance of contracted services using quantitative and some qualitative measures (e.g. complaints), this is patchy and of limited use to inform commissioning plans;	
3	We are developing ways to collect information about the performance and impact of contracted services against agreed outcomes using a variety of quantitative and qualitative measures, we have actively involved providers in determining our approach;	
4	We collect information about the performance and impact of contracted services against agreed outcomes using a variety of measures, this is systematic across services and routinely includes customer feedback, this information is used for commissioning;	
5	We collect information about the performance and impact of contracted services against agreed outcomes using a variety of measures, this is systematic across services, routinely includes customer feedback and involves opportunities for people to rate providers for themselves and share their views, this is used to inform commissioning and supports people to make informed purchasing decisions.	
Evidence:		

30.	Understanding the results	
1	We measure the inputs and outputs of commissioning and service delivery but have no systems in place to understand outcomes for people;	
2	We measure the inputs and outputs of commissioning and service delivery and we are considering how best to understand outcomes for people;	
3	We are developing ways to understand outcomes for people – these include quality of life questionnaires and our formal review processes;	
4	We have ways to understand outcomes for people – these include quality of life questionnaires, our formal review processes and we are also using the national POET tool to understand how personal budgets are working for people;	
5	We have ways to understand outcomes for people – these include quality of life questionnaires, our formal review processes, the national POET tool and independent evaluation led by a local user led organisation.	
Evidence:		

6. Glossary

JSNA
The Joint Strategic Needs Assessment is a statutory requirement for upper tier councils, in partnership with colleagues in Health to undertake a process to understand the health and wellbeing needs of their local population. The JSNA identifies current and future health and wellbeing needs in light of existing services and is intended to inform future service planning. It provides invaluable information for commissioners within a nationally agreed dataset and is designed to underpin commissioning strategies and plans. DH guidance describes the JSNA as a fundamental step in leading to 'stronger partnerships between communities, local government, and the NHS, providing a firm foundation for commissioning that improves health and social care provision and reduces inequalities.'[3]

NASCIS
NASCIS is the National Adult Social Care Intelligence Service, developed by the NHS Information Centre as a national information resource for social care services across England. NASCIS is a collection of data, tools and resources designed to meet the varied needs of commissioners, service planners, managers, researchers and policy makers. It is delivered through an online portal which is available at: www.nascis.ic.nhs.uk

Right to Control
The Right to Control is a new legal right for disabled people that extends more choice and control over the support they need to go about their daily lives. As part of an Office for Disability Issues Trailblazer Programme, disabled adults, councils and Jobcentre Plus in seven test areas across the country are working together to combine the support people receive from six different sources to see how this can work. The programme runs until December 2012 and will be evaluated by the ODI to inform a decision about wider rollout. Further information on the Right and the Trailblazer Programme can be found at: www.odi.dwp.gov.uk

PARR
PARR (Patients at Risk of Re-hospitalisation) is a tool developed by the Kings Fund and commissioned by the Department of Health designed to improve the management of high-risk patients, particularly those with long-term conditions. PARR is a software tool that uses routine inpatient data to predict the risk of emergency re-admission to hospital. It supports service planners to identify people in high-risk groups before their condition worsens and provides the opportunity to target care more effectively to reduce emergency admission rates. The latest version, PARR ++ was released in November 2007. Further information can be found at:
www.kingsfund.org.uk/current_projects/predicting_and_reducing_readmission_to_hospital

EARLI
The Emergency Admission Likelihood Index (EARLI) is a
tool for predicting the likelihood of hospital admissions of older people that uses a simple questionnaire completed by older people themselves or by family members. It was developed through research conducted at Castlefields Health Centre in Runcorn in the North West across an area served by 17 GP practices. EARLI can be used as a simple triage/screening tool to help identify older people most at risk so that support can be targeted to reduce demand on hospital services. It can also be used to identify at risk populations for testing different preventative interventions. Further information can be found at: www.library.nhs.uk/commissioning/ViewResource.aspx?resID=291631

POPPS
The Partnerships with Older People Projects (POPPS) were launched by the Department of Health in 2005 to develop and evaluate approaches aimed at promoting older people's health, wellbeing and independence and preventing or delaying the need for higher intensity support. Pilots across 29 council areas shifted resources towards earlier, targeted interventions for older people in the community and in their own homes. Service models tested included rapid response services, falls prevention schemes, telephone advice services and befriending initiatives. An evaluation of the programme was published in 2010, which found that a wide range of projects resulted in improved quality of life for participants,

[3] Guidance on Joint Strategic Needs Assessments, DH 2007

better local working arrangements and considerable savings. Further information can be found at: www.dhcarenetworks.org.uk/Prevention/POPPs/

ISF

An Individual Service Fund is where all or part of someone's personal budget is held with a provider or their choice under the terms of a contract between the provider and the council. Councils and providers are developing this approach so that people using commissioned services can exercise greater choice and control. ISFs have been developed in domiciliary care but are perhaps most advanced in shared services, in particular supported living services. While there is no generic ISF model, key features include:

- Money is restricted for use on the person's support and accounted for accordingly;
- No specific tasks are pre-determined so the PB holder is empowered to work with the provider to determine how any support is provided;
- Flexibility to roll money or support over into future weeks or bank it for specific purposes.

Market Position Statement

A number of councils are developing market position statements (MPSs) as a way of signalling intentions to the market and building more constructive relations with suppliers. MPSs bring together information in one place from the JSNA, from local commissioning strategies and from market and customer surveys. They are short, analytical and evidence based documents about the local market and for the local market that describe how the commissioning authority expects the market to develop in the future. They can be the basis for a constructive and creative ongoing dialogue between councils and providers.

POET

The Think Local, Act Personal Consortium is working with In Control and the University of Lancaster to check how personal budgets are working for people using a national questionnaire called the Personal Outcomes Evaluation Tool (POET). The questionnaire is for anyone living in England who gets a personal budget from the local council to meet their social care needs, including people with a direct payment. There is also a version for people who provide care or support for a relative, friend or neighbour who gets a personal budget. Councils can use the questionnaire to find out how personal budgets are working in their local area. The results of the questionnaire can help councils understand in real time what difference personal budgets are making and what changes and improvements they can make. It is web-based (as well as available in hard copy), free and easy to use, has no systems implications and produces live and immediate reporting. Further information can be found at:
www.puttingpeoplefirst.org.uk/Browse/SDSandpersonalbudgets/questionnaire/

InLAWS

Integrated local area workforce strategies - InLAWS - is a Skills for Care and ADASS project established in 2009 with support from the Department of Health (DH) and other delivery partners. The project aims to develop effective ways to support Directors (DASS) and their teams with their workforce commissioning role across the local area, and to understand changing priorities in adult social care including the government's agenda on the 'Big Society' and neighbourhood working. It is providing a common methodology and practical tools designed to help DASS and their teams develop a skilled, capable and competent workforce. For more information see http://www.skillsforcare.org.uk/inlaws/

7. Useful resources

Commissioning strategy:

Personalisation through person-centred planning: advice for commissioners, DH 2010

Personalisation briefing: implications for commissioners, SCIE 2009

Commissioning for personalisation: a framework for local authority commissioners, DH 2008

Smart commissioning, In Control, 2008

Coproduction:

Practical approaches to coproduction: building effective partnerships with people using services, their carers and families, DH 2010

Working together for change: using person-centred information for commissioning, DH 2009

Co-production: an emerging evidence base for social care transformation, SCIE 2009

Co-production: a manifesto for growing the core economy, The New Economics Foundation, 2008

Personalisation and safeguarding:

Practical approaches to safeguarding and personalisation, DH 2010

Enabling risk, ensuring safety: self-directed support and personal budgets, SCIE 2010

Independence, choice and risk: a guide to best practice in supported decision making, DH 2007

Understanding experience:

Outcome-focused reviews: a practical guide, DH 2009

Working together for change: using person-centred information for commissioning, DH 2009

Understanding demand and supply:

Developing market intelligence, National Market Development Forum (NMDF) 2010

At your service: navigating the future market in health and social care, Demos 2009

Provider relations:

Building constructive market relations, NMDF 2010

Prevention and early intervention:

Guide to making a strategic shift to prevention and early intervention, DH 2008

Support planning and brokerage:

Support planning and brokerage with older people and people with mental health difficulties, DH 2010

Peer support and the personalisation of adult social care, National Centre for Independent Living, 2009

Good practice in support planning and brokerage, DH 2008

Commissioning for support planning and brokerage: a resource tool, DH 2008

User led organisations:

Sharing the learning: user-led organisations action and learning sites 2008-2010, DH 2010

A commissioner's guide to developing and supporting user-led organisations, SCIE 2010

Planning together: peer support and self-directed support, DH 2010

Putting People First: Working together with user-led organisations, HM Government 2009

Personalisation briefing: implications for user-led organisations, SCIE 2009

Plurality:

Supporting micro market development: a practical guide, DH 2009

Personalisation briefing: implications for voluntary sector providers, SCIE 2009

Service development:

Progress for providers: checking your progress in delivering personalised services, 2010

All together NOW – collectively figuring out how to develop alternatives to just paid support, Owen Cooper and Sally Warren 2010

Gain without pain: how the voluntary sector can help deliver the social care agenda for people with disabilities, Voluntary Organisations Disability Group, 2010

Quality assurance:

An approach to quality and safety for micro social care and support services, DH 2010

Building community capacity:

Building community capacity website: www.puttingpeoplefirst.org.uk/BCC/

Understanding the results:

Changing lives together: using person-centred outcomes to measure results in social care, DH 2010

POET questionnaire: www.puttingpeoplefirst.org.uk/Browse/SDSandpersonalbudgets/questionnaire

Theme	Challenge	Response A	B	C	D	E	Summary of evidence	Action	Date of next assessment
Enablers for strategic commissioning	*1. Leadership*								
	2. Commissioning strategy								
	3. Capacity and capability								
	4. Culture change								
	5. Coproduction								
	6. Safeguarding								
	7. Integration with Health								
	8. Wider system integration								
Understand	*9. Understanding need*								
	10. Understanding experience								
	11. Understanding demand								
	12. Understanding supply								
	13. Relationships with providers								
Plan	*14. Residential care*								
	15. Prevention & early intervention								
	16. Wellbeing								
	17. Support plan. & brokerage								
	18. ULOs								
	19. Plurality								
	20. Universal services								
Do	*21. Unit costs and pricing*								
	22. Tendering								
	23. Contracts								
	24. Navigating the market								
	25. Individual purchasing								
	26. Service development								
	27. Quality assurance								
	28.Building comm. capacity								
Review	*29. Contract management*								
	30. Understanding the results								