Co-producing Commissioning

Commissioning done well can improve people’s well-being and improve outcomes through using available resources in the most effective way, and by creating the conditions for people to play an active role as citizens.

A resource produced by nef (new economics foundation) for NESTA
Overview

This presentation has been developed to illustrate the practical ways of embedding co-production within the commissioning of public services.

The presentation is organised as follows:

• **Scene setting** - Why co-production is relevant to commissioners.

• **Clarifying terms** - What commissioning and co-production means, and the challenges co-production presents to traditional commissioning approaches.

• **Practical ways** of applying coproduction in commissioning, which are grouped into:
  - how commissioners can directly work with people differently
  - how commissioners can influence providers to work with people differently.

• **Where you can start** to co-produce commissioning.

• **Changing roles** - How co-production changes roles and culture.
Why is commissioning co-production important?

Demographic changes, including an aging population, and increasing numbers of people with long term conditions, are driving the need for a radical change in the way services are designed and delivered. New commissioning models in health and social care need to recognise the huge, and currently untapped resources that sit within individuals and communities, and support these resources to have an active role within and beyond services to improve health and well-being outcomes and support sustainable change.

Co-production is a critical part of an effective commissioning system, as it can:

- **improve well-being** by building and supporting social networks;
- **narrow health inequalities** by promoting positive mental wellbeing and healthier lifestyles;
- rebuild traditions of ‘mutuality’;
- **prevent dependency** on public service provision, and lead to an overall reduction in demand for acute health services as community support is built around individuals in their community;
- transform services by **introducing new resources** by drawing on assets from within the community;
- **promote effective patient and public involvement**, choice and action.

All of which contribute to the long-term viability of services.

“If clinical commissioners understand the benefits and adopt a joined up co-production approach to commissioning and service delivery that sees local communities as an asset and an integral part of service provision and health improvement, clinical commissioners could lead significant system change, and have a profound impact on outcomes and cost”

NHS Alliance PPI Group, National Voices & Turning Point
Definitions

• **Commissioning**
• **Co-production**

The challenges co-production presents to traditional commissioning approaches.
Commissioning defined

Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.

DoH website

The commissioning role is one in which the authority and its partners seek to secure the best outcomes for their local community by making use of all available resources.

IDeA website

Successful commissioning means delivering the right outcomes at the right cost. Compare that with our definition of good value for money: ‘the optimal use of resources to achieve the intended outcomes’. Successful commissioning is, almost by definition, good value for money.

NAO website
Generic commissioning approach

Assess
- Assessing local needs (JSNA).
- Benchmarking local needs against national data.
- Collating and analysing views of users.
- Feeding in government targets/directives.
- Mapping existing service provision.

Plan
- Setting strategic vision.
- Deciding priorities.
- Designing services.
- Shaping structure of supply.

Review
- Managing contracts.
- Monitoring performance.
- Reviewing delivery.

Do
- Commissioning services.
- Managing implementation.
- Drafting contracts and SLAs.
- Ensuring compliance.
Challenging current practice

- **Disconnections across the commissioning process.** These fail to give a whole picture of assets, needs and change that has been supported by services.

- **Data feeding into service design is based on deficits and needs.** This leads to narrowly focused services targeting problems, as opposed to prevention.

- **Local insight and data does not drive an understanding of need.** National data, where relied upon in the absence of reliable local data sources, does not account for local needs and aspirations for services.

- **Encourages risk averse behaviour.** Anxiety about different delivery approaches, regulation anxiety, and timid legal advice on commissioning lead to a commissioning culture which is risk adverse. This reduces opportunities for innovation and new forms of partnerships to emerge.

- **Collaboration within the system is weak.** A competition based model can crowd out relationships that could be forged across services. Reducing opportunities to effectively use local resources as innovations fail to influence the system more widely.

- **Short termism.** Short term scale and cost efficiencies can reduce opportunities for developing approaches leading to longer term change.
The response

We need a commissioning system which:

- is **dynamic** and iterative;
- recognises **assets** and builds on local resources;
- applies **local insight** and data;
- builds **collaboration**;
- opens up opportunities for **innovation**, and
- takes a **longer term** view.

To achieve this requires a fundamental transformation of culture and practice.

“Commissioning is about enabling an effective dynamic with communities and individuals to understand their **needs**, their **assets** and their **aspirations**, in order to fund and guarantee effective, meaningful and efficient support”

Lambeth Living Well Collaborative
Defining co-production

“Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.

Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.”

nef, NESTA
Principles of co-production

**Assets:** transforming the perception of people from passive recipients of services and burdens on the system into one where they are *equal partners in designing and delivering services.*

**Capacity:** altering the delivery model of public services from a deficit approach to one that *recognises and grows people’s capabilities* and actively supports them to put them to use at an individual and community level.

**Mutuality:** offering people a *range of incentives to engage* which enable them to work in reciprocal relationships with professionals, and with each other, where there are mutual responsibilities and expectations of each other.
Principles of co-production

**Networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge.

**Blur roles:** removing tightly defined boundaries between professionals and recipients, and between producers and consumers of services, by reconfiguring the ways in which services are developed and delivered.

**Catalysts:** enabling public service agencies to become facilitators rather than central providers themselves.

**Coproduction in action**
http://coproductionnetwork.com/
Improved wellbeing by co-producing

5 things we all need to maintain or grow our wellbeing - how these link to co-production

• **Connect:** co-production explicitly seeks to develop new networks or sustain existing ones linking people, through common experience, shared interests or geographical proximity.

• **Be active:** Co-production becomes real when people do stuff (together), which frequently requires them to get out and about.

• **Take notice:** By building on peoples existing capabilities and treating people as assets co-production enables people to reflect on their experiences and put them to use.

• **Keep learning:** by building on peoples capabilities and encouraging people to take more control they are able to keep learning and challenging themselves.

• **Give:** Treating people as assets and embedding shared responsibility and mutuality results in developing frequent practical opportunities for people to give – their time, skills, expertise.
Redesigning Commissioning

A commissioning approach to support the principles of co-production requires more than a change to the labels on a traditional commissioning cycle.

It requires:
- a fundamental redesign of the process, and the power relationships within it.

- to address how the commissioning function will be shared.

- to establish the model of collaboration for the service.

e.g. Living Well Collaborative, Lambeth model
Is co-production always relevant?

Co-production practice has been developed mostly in the context of relationship based services, for example, in social care, housing, community services, mental health and education/young people.

- This makes the approach particularly relevant to supporting people with long term conditions, and people with complex social support needs as they tend to have a recurring relationship with health and other services.

- More acute and time limited health services, such as A&E, could still benefit from developing an asset based approach, and linking people into peer support and local networks.

Turning around a dependency on formal public service provision requires a consistent approach to supporting people to seek and develop solutions beyond public service provision.
Co-production in Commissioning

How to practically apply co-production within commissioning to:

• Strategically transform the culture and system of commissioning.
• Embed co-production into the mechanics of commissioning.
Practically applying co-production in commissioning.

Collaborative Commissioning

Co-producing Commissioning
Commissioners working with people differently

Commissioning co-production
Providers being commissioned to work with people differently

Two routes

… both are valid starting points
A co-produced approach to commissioning requires commissioners and providers to work with people differently.

**Co-producing Commissioning**

*Commissioners working with people differently*

Changing the commissioner’s approach and **opening up the commissioning process** so that **people who use services**, and the wider community, can be **involved in shaping the strategic direction and decisions** made throughout the process.

People work together through-out the entire process of planning: identifying assets and needs; shaping and implementing solutions; assessing and reviewing activities and planning for the future.

**Commissioning co-production**

*Providers being commissioned to work with people differently*

**Creating the structural conditions for co-production to flourish.** This involves changing the shape of provision through **signalling co-production as a desired approach to the provider market**, setting the approach as an expected way of working, and outlining **clear quality standards** that providers and commissioners can use to judge the depth of co-production.

**Insight, understanding**

**Data, monitoring**
Co-producing commissioning involves a shared role in:

• **Understanding assets and needs**
• **Shaping and delivering services**
• **Reviewing service performance**

Practical examples demonstrating varying degrees of co-production:

• **Local Participatory Commissioning**
• **Community Health Champions**
• **Community Researchers**
• **Community based participatory research**
• **Living Well Collaborative, Lambeth**
A shared commissioning role

The insight and knowledge of people using services, their families and communities shape the commissioning cycle from the outset.

Co-producing commissioning requires a shared role in:
-identifying and recognising local assets as well as needs;
- deciding what services are needed, how they are shaped and the role people will play in delivering them; and
- interpreting the results of those services.

These functions come together to provide insight about the relevance, and effectiveness of the service.

And a shared control over the services.

Scrutiny panels should include:
- a co-production assessment.
- expert by experience auditors.

“We spend time collecting data, but little time making sense of what that data means in terms of how we support positive changes to people’s lives”
An outcomes framework is a key component of the insight function.

Developed from the asset mapping and needs assessment, it should be a combination of:

- statutory and local success criteria,
- service specific and wider community outcomes (social, economic, and environmental).

The outcomes framework:

- describes the desirable change people want to see resulting from the service;
- should contain both service specific and wider community outcomes to ensure integration with other services;

Progress should be captured and reviewed against the outcomes described in the framework.
Practical example: Local participatory commissioning

Participatory Commissioning in Tower Hamlets

The requirement to retender the Tower Hamlets Health Trainers service provided the PCT and LSP an opportunity to design and implement a more participatory commissioning process. Enabling local residents, key stakeholders and service users to feedback on existing service priorities.

How were people involved.
Residents were given a presentation detailing the nature of the problem facing their local area. This included local health profiles, information about the services health trainers could provide and information about how the commissioning process worked.

The participants were then asked to address the four health trainer priority areas, and identify how a service meeting these priorities should be structured. Each group chose the two suggestions they felt were most important. A series of electronic votes were then cast, allowing the residents present to identify which, of the ideas generated, were the main priorities.

At the events individuals who were interested were asked to form a residents panel to interview potential providers using the following questions:

- How would you deliver your services based on cultural differences and expectations?
- How will you involve local people and local organisations in service delivery?
- What will you do to motivate individuals/clients to achieve and sustain their healthy lifestyle goals?
- Going forward how are you going to measure your success?

Deepening involvement

To move from participation to a more co-produced approach, two aspects of this process would need to be particularly addressed:

- Public participation in the process was on the commissioners terms, for a very specific task, rather than being part of an on-going dialogue about service delivery, and what services are needed.
- Commissioner did not involve people in identifying needs or asset mapping; this limits the amount that people are truly able to shape the agenda and contribute their own expertise.
- The assumption throughout is that the end service will be provided ‘to residents’ by ‘professionals’ and did not seek to actively engage people in what active role they would take within the service.
Local people are recruited as community health champions, and aim to identify existing local assets which promote physical and mental wellbeing. This is so commissioners and health champions know what is out there, what they should preserve, what they can build on, and what they could develop.

Sheffield Community health champions conducted asset mapping exercises to complement the Joint Strategic Needs Assessment process. This was a 12 month pilot, working in two neighbourhoods and the information was used to inform Health Watch Boards and GP consortia.

**Co-production**: local people who often have a greater knowledge of the resources within the community are able to play an active role in sharing their knowledge, and influencing how local commissioners and decision making bodies think about the resources available.

**Deepening involvement**: Although the Champions introduce new information into the process, this was to be used by other people. A key next step would be to shape and design services with people who use them building on the information about assets and needs collected from within the community.
Practical example: Community Researchers

The Earl’s Court Health and Wellbeing Centre is a new integrated community hub delivering a range of health and wellbeing services to local residents. A partnership between Turning point, Greenbrook Healthcare (a GP surgery), NHS Dentists, and the Terrence Higgins Trust.

A key part of the centre is their focus on paid and trained community researchers.

Community researchers fulfil three main roles:

- **Conduct research** in the community on local needs and the Health and Wellbeing Centre to ensure that it is meeting the requirements of the local community.
- **Promote and raise awareness** of the Health and Wellbeing Centre in the local area.
- **Recruit people** to the timebank and peer mentoring scheme to build links between the Centre and the wider community.

**Co-production:** there is a continuous feedback loop between members of the community and health staff within the centre.

Services are influenced by the insight and expertise of local people, and local people are supported to play an active role in this process.

The extent, and the mechanisms, through which community researchers influence services is the key distinguishing feature between activities which involve and engage, and those services which are co-produced.
A research approach which integrates education and social action to improve health and reduce health inequalities. It is a partnership approach to co-producing local health insight and knowledge, involving; local communities, local authorities, health boards and agencies, academic partners, and GPs. The focus is on collaborative research, capacity building, relationship building, mutuality and shared decision making.

Seattle Partners for Healthy Communities A partnership of community activists, community agency representatives, public health professionals and practitioners, health care providers and academics. Their mission is to improve health in Seattle’s urban communities by conducting community based participatory research. The research is both investigative and evaluative; it identifies needs and opportunities, and assesses current initiatives.

- The research conducted is action and project oriented.
- New initiatives are set up where there are unmet needs.
- As an approach the roles blur the distinction between professionals and community activists.
The Living Well Collaborative is currently developing a co-produced commissioning system to enable people with severe mental illness and complex life problems to recover and stay well, and to participate fully and on an equal footing in family, community life and in the wider society.

Creating a preventative infrastructure frees up capacity for secondary services to see the people they need to see right at the time when they need to be seen.

**Vision**
A collaboration of people who are using the services, providers and statutory bodies.

Collaboration is the default position in process and practice including over: the control of resources, decision-making, monitoring and understanding change.

**Functions in the system**
The system embeds a co-production approach in the key functions of the system:
- Monitor – the ears of the system
- Co-design – the hands of the system
- Co-delivery – the legs of the system
- Insight – the brain of the system
- Scrutiny and accountability
Commissioning co-production

Commissioning co-production involves:
Opening up the space in the mechanics of the commissioning process to embed an outcomes based approach to commissioning, and co-production.

Examples in this section include:
• Provider development: Capacity Building, Framework Agreements, Alliance contracting
• Legal structures: Joint ventures, Consortia
• Procurement documentation: Service specifications, PQQs
Creating the structural conditions for co-production

to flourish

For many Commissioners, driven by issues such as:
• Substantial budget reductions, and
• Service failure
creating the structural conditions for co-production is their starting place.

Opening up the space
to develop market capacity
for co-production

Putting a requirement for co-production in a service specification or ITT alone will not create a provider base able to co-produce their services.

Commissioners need to proactively shape the market and support new and emerging provision by signalling that:
• an outcomes focused based approach is required, and services need to match logically their intended activities to supported explicitly stated outcomes, and
• co-production is the expected way of working.

Commissioners must then consistently use a range of procurement tools at their disposal to open the space up for co-production.
Provider Development: Capacity building

Commissioners need to proactively work with their provider base in their local areas to develop capacity for co-production over a period of time, as part of their market shaping activities.

This can be achieved both within and outside of a commissioning relationship.

Providers are unlikely to immediately start co-producing their support. Commissioners should aim to inspire their providers though:

- Introductory sessions on co-production.
- Identifying good/promising practice that can be shared more widely.
- Encouraging providers to go on study visits outside of their areas.
- Inviting in experts by experience, peer support and user-led groups to inspire and challenge providers.
- Maintaining a consist ‘quality’ focus on co-production

“We over-estimated the level of innovation in our market. People were quick to take on the language, of co-production to re-package their activities, but not to follow through on the culture change.” A Commissioner.
Provider development: Framework Agreements

Commissioners should use Framework Agreements, particularly for complex services where a local provider base exists.

Criteria for PQQ for the framework should include testing for willingness to apply a co-produced approach.

Local prevention framework for youth services  
Surrey County Council used a framework agreement as a mechanism to support and develop a borough based local commissioning process. This mechanism attracted a response from mainly locally based providers, which may have been due to a combination of the nature of the services, and the requirement to use a co-produced approach which would require greater knowledge of the community. Pre-screening providers through a PQQ process to join the framework opened up the space for 11 local commissioning panels to be involved in shaping services, and provided for young people to be involved in the procurement decision.

Challenges have included being able to make involvement in the local panels attractive for young people, particularly the group of young people targeted by some of the services. Incentive payments have been trialed with little result. A key message from this is that procurement mechanisms themselves cannot deliver engagement with people using services. As systems change, people need to be supported into their different roles over a period of time.
Legal Structures: Alliance Contracting

Legal structures can be used to create the space for collaborative working between providers.

Alliance contracting, is an agreement mechanism developed in the construction industry where the delivery of a project requires cross business co-operation. An alliance contract is described as reducing the adversarial nature of contracts.

Parties will in an early stage of the project seek to align their (commercial) interests and avoid win-lose scenarios. They will accept a collective responsibility for risk, performance and outcome (gain-sharing / pain-sharing) and avoid a blame culture.

It describes a shared intention that links the parties, including:
- A statement of shared aims and objectives, values and principles
- Shared collective responsibility for specified outcomes
- Encourages openness and co-operation between the parties.
- Membership can be expanded subject to the terms of the agreement.

The Living Well Collaborative, Lambeth are developing an Alliance contract as an agreement to link providers and commissioners in a common intention to work collaboratively.
Legal Structures

Creating legal agreements that can support collaborative working between providers.

**Joint ventures**  
A contractual business undertaking between two or more parties, based on a single business transaction. Organisations choose to enter joint ventures in order to share strengths, minimize risks, and increase competitive advantages in the marketplace. Joint ventures can be distinct business units (a new business entity may be created for the joint venture) or collaborations between organisations.

The Institute of Psychiatry at King’s College London and South London and Maudsley NHS Foundation Trust, in association with Rethink is an example of a joint venture between public and third sector bodies.

In Derby care for diabetes patients is being provided through a joint venture between a consortia of GPs and the Local PCT.

**Consortia**
Smaller providers can be technically excluded from delivering public service procurement due to the size, or nature of their organisation. Allowing for consortia bids within the procurement documentation, including standard terms and conditions, can widen the potential provider base to include more locally based third sector providers.

Commissioners need a good understanding of their provider market.

Do you need to be an active provider to open up the space for co-production?

Do you need to open the space for new collaborations to emerge?
Commissioners need to work closely with procurement teams to ensure the procurement documents reflect:
- the vision for a co-produced service, and
- the outcomes expected are explicitly stated.

Procurement documentation is a stage in commissioning when the openness of a co-produced approach can get ‘closed down’ by detail, and concerns about decision-making objectivity.

Co-production needs to be described as part of the subject matter of the service, alongside the outcomes framework for the service – if it is to be used as a selection criteria for providers.

Outcomes frameworks which include service and wider community outcomes can encourage Integrated activity through the procurement process by specifying this broader outcomes framework within the service specification.

Do not lose the vision in the paper work.
Co-production needs to be reflected in:
The subject matter of the service - through the service specifications, and reference to key policy documents, and ITT.

Decision making process – PQQ, and as quality criteria as part of the weighting criteria.
Co-production

The term co-production refers to a way of working whereby decision-makers and citizens, or service providers and users, work together to create a decision or a service which works for them all. The approach is value-driven and built on the principle that those who are affected by a service are best placed to help design it. Service providers offering Short Breaks will be active participants in the development of child and family centred co-production practice in Newcastle upon Tyne. Poor performance in this key activity will constitute a contractual breach.

A diversity of needs and offers – collaboration and cooperation

Pilot studies indicate that service users who are enabled to define the things that matter most to them and to specify the outcomes they require from helping services, tend to identify a diversity of roles and activities that usually indicate the need to engage with two or more agencies. A key characteristic of all parties to this contract is an enthusiasm for cooperation and collaboration with peer organisations and to value the particular gifts and talents of others in organisations and the community.

Contract for the provision of Short Breaks (Family Support & Enablement) Service for Children with Disabilities, Transitional Service Contract 2011-14 Newcastle City Council
We would encourage providers to adopt the model of ‘co-production’ whereby services are planned and delivered in mutually beneficial ways that acknowledge and reward local ‘lay’ experience while continuing to value professional expertise. Service users should be regarded as assets and work alongside professionals as partners in the delivery of services.

Co-production requires professionals and service managers to move out of traditional roles as ‘experts’ and ‘providers’ into partnership models that work with ‘clients’ and ‘communities’. This enables them to find a solution together to the complexity of their problem and sometimes requires that the ‘problem’ be redefined. Real and lasting change are possible with approaches that build or strengthen social networks and in turn motivate people to learn about and exercise their powers and their responsibilities as citizens. Networks of friends and families should also be considered positive co-contributors to success in this approach.

### Recognising people as assets
Individuals as equal partners in the design and delivery of services

- People’s strengths are recognised from the outset. The question is asked “what kind of life do you want to lead” rather than “what needs do you have”.
- Participants co-produce the outcomes they want alongside the support needed to achieve them.
- Participants share in the development of possible choices and work to design their own solutions.
- Support plans will be asset based and positively constructed.

### Building on people’s existing capabilities
Providing opportunities to recognise and grow people’s capabilities and actively support them to put these to use

- The ethos of support is to collaboratively recognise individual potential.
- It is recognised that capacity for change varies and that different support is needed at different times.
- Participants will have skills and experience they can share with others.

### Mutuality and reciprocity
Incentives to engage where there are mutual responsibilities and expectations

- The overall approach of the service will be to ensure that participants are equal partners in their individual outcome planning.
- Participants will be clear about the benefits of the project and the level of personal responsibility they have.
- Self directed support is integral, and over time, the number of participants accessing personal budgets to pursue their goals will increase.
### Peer support networks
Engaging peer and personal networks alongside professionals
- This project has the potential to develop significant peer support. There will be particular benefits where peer support might supplement project worker support.
- The project will also want to build in mutual support for participants. This might take the form of carers support groups for example.
- The project will ensure that participants have opportunities to engage with other sources of support outside the carer’s project.

### Breaking down barriers
Blurring the distinction between professionals and recipients
- The development of the support plan will be co-produced. This, of itself puts relationships on a more equal footing.
- Project employees are likely to have experienced mental health issues themselves, or who are, or have been carers.
- Some practical steps can be taken together. Appointments might require a joint approach.
- The project will involve people who use it in planning and design.

### Facilitating rather than delivering
Becoming catalysts and facilitators of change
- The project is in place to “get things done” but only in partnership with the participant.
- The relationship will be about assets, choices, and possibilities. Solutions will be jointly agreed.
- The outcome star is based on change theory and is personal to the participant.
Procurement documentation

Pre-qualification Questionnaire  Assessing the suitability of potential providers in terms of their technical knowledge and experience, capability, capacity, organisational and financial standing to meet the requirements.

Local Prevention Framework, Services for Young People, Surrey County Council, 2011

In addition to questions on generic subjects such as professional and business standing, financial accounts, insurance and other areas considered by Council as requirements of a sound potential provider of services the pre-qualification criteria required bidders demonstrate their capacity to adapt to changing local needs, how they would incorporate co-production into their service, and their willingness to apply an outcomes-based approach to monitoring.

Capacity and responsiveness
• Please demonstrate how you have adapted your provision to changing local needs

Co-production
• Please demonstrate how you have incorporated (or how you will incorporate) young people’s skills, interests and capabilities into the a) development b) delivery c) evaluation of the service.
• Please demonstrate how your organisation builds relationships with young people, their families and local communities; establishing mutual roles and responsibilities within the delivery of services.

Partnership working
• Please demonstrate your organisation’s experience of partnership working and network building, in order to support the development and delivery of your service.

Outcomes-based monitoring
• Please provide confirmation that you have experience of and/or are willing to develop an outcomes based monitoring system as part of this service.
<table>
<thead>
<tr>
<th>Primary outcomes: which the service is expected to impact upon</th>
<th>Indicators the Council will use to measure progress towards the Primary outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people have safe places to meet</td>
<td>Increase in opening hours specific to young people within voluntary youth provision by 31 March 2015</td>
</tr>
<tr>
<td>Young people are cared for with a family setting</td>
<td>Reduction in the number of teenagers entering the care system by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>Reduction in the number of young people classified as in need attributed to family circumstances by 31 March 2015</td>
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<tr>
<td></td>
<td>Increase in the number of young people who have the skills and confidence to live independently in the community by 31 March 2015</td>
</tr>
<tr>
<td>Young people are mentally and emotionally healthy</td>
<td>Reduction in the number of young people experiencing bullying by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>Young person reports improvements in self-awareness, tenacity, confidence.</td>
</tr>
<tr>
<td></td>
<td>Young person reports improvements in satisfaction with life as a whole</td>
</tr>
<tr>
<td></td>
<td>Stated as feeling positive about themselves</td>
</tr>
<tr>
<td>Increased participation in education, training and employment</td>
<td>100% of young people identified to be within a group at risk of NEET in Key Stage 4 are EET in Key Stage 5 by 31 March 2015</td>
</tr>
</tbody>
</table>
### Specifying Outcomes

**Supported Outcomes:** Outcomes that the service is expected to be able to contribute towards (in addition to the Primary Outcomes)

**Indicators the Council will use to measure progress towards the secondary outcome**

<table>
<thead>
<tr>
<th>Supported Outcomes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people receive the support they need to lead a crime free life</td>
<td>Reduction in the number of young people entering the criminal justice system for the first time by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>Reduction in the number of young people receiving a custodial sentence by 31 March 2015</td>
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<td></td>
<td>Reduction in the number of young people reoffending by 31 March 2015</td>
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<td></td>
<td>Reduction in the number of young people who are victims of crime by 31 March 2015</td>
</tr>
<tr>
<td>Young people are sexually healthy</td>
<td>Increase in the number of young people making informed decisions about their sexual activity by 31 March 2015</td>
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<tr>
<td></td>
<td>Reduction in teenage conception rate by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>Decrease in prevalence of sexually transmitted diseases by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>100% young people have access to contraception by 31 March 2015</td>
</tr>
<tr>
<td>Young people live healthy lifestyles</td>
<td>Reduction in obesity rates at year X by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>Increase in the number of young people eating five pieces of fruit &amp; veg a day by 2015</td>
</tr>
<tr>
<td></td>
<td>Increase in young people participating in sport and physical activity 3 times a week by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>Young person reports improvements in personal energy levels, health in general, level of physical activity</td>
</tr>
<tr>
<td>Young people participate in decision-making</td>
<td>Increase in the number of young people who participate in decisions about their community, their school and their care by 31 March 2015</td>
</tr>
<tr>
<td></td>
<td>100% SCC commissioning decisions affecting young people include young people in the commissioning process by 31 March 2015</td>
</tr>
</tbody>
</table>

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An outcomes framework for Youth Services, Surrey County Council

Specify wider outcomes in the service specification, ITT as a logical framework, and weighting criteria.

This allows providers to think about how their service can be integrated with other providers.
Starting points and changing roles

• *In a commission cycle – where can you start co-producing commissioning?*
• *Payment incentives and co-production*
• *Changing roles*
  - Commissioners
  - Providers
  - People using services
Starting points

Is it critical to understand what level of co-production you are starting from to ensure any process is understood, open, iterative and embeds the values of co-production.

Undertaking a co-production assessment of services.

• Is there evidence of co-production already happening within the commissioning cycle?

• What is enabling it to happen?

• How could it be supported to scale out?

If your commissioning cycle currently looks like this – where can you start?
Starting points – where can you begin?

**Opening up the commissioning process.** People who use services and the wider community are actively involved in shaping the strategic direction and decisions made throughout the process.

This entry point into applying co-production in commissioning requires a commitment at a strategic level to transform services.

It also offers the greatest opportunity for delivering on the potential of co-production to support positive health and well-being, dismantle funding silos, and support a placed-based approach to commissioning.

**Creating the structural conditions for co-production to flourish.** Changing the shape of provision through signalling co-production as a desired approach to the provider market.

This entry point into applying co-production in commissioning favours a pilot based approach, where a service is selected, and model procurement materials are tested and refined during the process.

Without strategic support and buy-in, co-production remains isolated incidents of good practice with little opportunity for scaling out.
Payment incentives

Innovations which are yet to be tested as to whether they can drive and support co-production, and lead to improved outcomes:

• Payment by results (PbR), incentivising provider actions through a payment / non-payment mechanism.

Applying co-production principles

The test for these mechanisms in their application is to understand how they reinforce a co-produced approach.

This would require:

• PbR to be focused on the desired outcomes of service users, rather than activity based.
• Incentivisation of integrated services.
• The decision on whether the outcome had been achieved to be a shared one between people using services and commissioners.

And practically would require:

• Improved systems for outcome measurement and tracking individual journeys
• And clarity on attribution and collaboration.

Payment models less complex when:
- there are established clinical guidelines
- Understood service patterns
- Predictable disease progression

King’s Fund. 2011
Changing roles, changing culture

Applying co-production within commissioning requires a re-assessment of the share of power, risk, and ownership within the relationship between commissioners, providers and people using the service.

As co-production:
• challenges assumptions of users as the passive consumers rather than the active producers of care.

• supports collective rather than primarily one-to-one service relationships.

• recognises that support provision is an iterative and negotiated process, not a simple delivery chain.
Changing roles and culture - commissioners

Sharing power A substantial cultural shift for commissioners is the requirement within a co-produced approach to share power between statutory bodies, people using services and communities.

Moving from risk averse to risk aware

Don’t over specify leaving the detail open within the service specification so that providers can work with people using the service to develop and iterate support.

Dynamic service specifications which focus on outcomes Commissioners need to understand the change they are supporting, and develop this understanding alongside people using services and providers. Developing insight from monitoring information is a key risk management mechanism.

Strong and open relationships with providers effectively commissioning co-production involves developing confidence in how the provider understands and develops co-production in their day to day service provision. This will involve regular meetings, ideally with on site visits.
Facilitating the space for co-production to flourish

Intellectual leadership for co-production to thrive providers and people need commissioners to actively develop co-production within their day to day activities. Commissioners need to have a strong vision of what can be achieved through co-production, and set this as the ‘way we do things around here’.

Talk to people who use the service Commissioners will need to have regular exposure to people who use the services they commission. Having frequent spaces for open discussion with people will be necessary to develop this relationship, and will help commissioners build up their insight into commissioned services. Visits will develop confidence in how well co-production is being developed on the ground.

Proactively supporting through the commissioning process the development of the provider market and providing consistent messages to them about co-production. A key challenge here has been the differing expectations of in-house and externally provided services.
Changing roles and culture - providers

• **Adaptive** providers need to be able to adapt the support they provide in response to the skills and interests of the people they support. This requires a working culture which is flexible and responsive, and policies and processes that do not constrain or over-specify what the services look like.

• **Thinking differently about resources** providers will need to identify what non-monetary resources (i.e. buildings, universal services) and networks (churches, groups, peer support) are available locally, and actively work with these resources to complement and strengthen the support they provide to users.

• **Co-design** to ensure that services are developed alongside people using them, providers will need to discuss and plan what is needed with users from an early stage.

• **Reciprocity** providers will need to work with people to identify the ways they want to contribute to the service, whether that is through supporting or buddying other service users, helping to run activities, or the various ways their will identify for themselves.

• **Co-review and Co-assess** providers will need to work with commissioners, people using the services and the wider community to understand the impact of their service. This will requires shifting thinking of monitoring requirements as a burden, and using them as a base to generate insight.
Changing roles and culture - people using services

• Active agents of their own health and well-being

• Thinking about how they might support others

• Recognising the value of their own experience

• Supported to be more actively involved and give and take
Co-producing outcomes

A preventative and collaborative approach to commissioning means going beyond the traditional health service boundaries and connecting into assets within the community.

A catalogue of co-production case studies has been developed to support the People Powered Health locality sites.

It brings together a range of case studies, resources and information on co-production in health settings as well as in other sectors, in the UK and internationally documenting the change supported through a co-produced approach.