As the AGS and Audit Commission states, commissioning is a complex and challenging activity. North Lanarkshire Council has developed a positive reputation for its approach to commissioning social care in partnership with the private and third sector; partner agencies such as NHS Lanarkshire; and people who require support and their carers. I am pleased that our approach was first cited as best practice exemplar in a report by the (then) Social Work Inspection Agency (February 2009) and more recently in 2 case studies contained within the AGS and Audit Commission Report.

Commissioning is a strategic activity that seeks to ensure there is sufficient support available to meet assessed need in a defined geographical area, usually a local authority boundary. Assessing need is not as scientific an activity as we might wish it to be but our view is that, in an authority the size of North Lanarkshire, it is a reasonable aspiration that everyone's needs should, wherever practicable, be met within the Council's boundaries. Whilst there will always be a small number of exceptions to this guiding principle, its application better enables people with support needs to remain connected to their own networks and communities.

An effective commissioning strategy must seek to minimise the number of people living in institutional care settings by ensuring support is available to help people to be safe, healthy and included in their own homes and communities. Our own interpretation is that this entails individualising the planning, designing, funding and delivery of support, recognising that a person's needs are unique to them; that people should not have to 'fit' into existing services (as in historical patterns of services); that good physical health and mental wellbeing are likely to reduce peoples’ reliance on services; and that a formal service may not always be the best way to meet a person's needs.

This is highly challenging to achieve and in North Lanarkshire we would not begin to pretend that we always get it right – we don’t. Successful commissioning has to focus on intensive alternatives to institutional care settings and a range of preventive approaches that help prevent an escalation of need becoming a crisis. The efficacy of such an approach can be assessed by comparing the balance of care for children and young people; younger adults with disabilities; and older adults in care homes i.e. the proportion of a population living at home.

As the AGS and Audit Commission study helpfully highlights, local authorities and their partners are under increasing pressure to balance increased need arising from factors such as demographic change and improved healthcare on the one hand; and reduced resources through declining budgets on the other. In such circumstances there is a perhaps understandable temptation to increase thresholds at which need will be met and exclude those who may previously have received some form of assistance.
In our view this is inappropriate because it increases the likelihood of unintended negative (and invariably more expensive) outcomes e.g. the older person who needs some time to restore confidence and maximise capacity following a hospital admission may, if this is not provided, become more likely to see their abilities diminish and therefore more likely to present as requiring formal care at an unnecessarily early stage of their life.

Importantly, preventive approaches do not have to be formal services or cost a lot of money. We can cite numerous examples of working with taxi drivers; leisure centres; Motherwell football club; arts organisations; theatre groups; supermarkets etc to lift people out of formal services or help keep them out. Most people do not have an aspiration to enter services when their needs can be met in other, more inclusive ways. As in our own lives, there are many ways to meet a need and a strong commissioning strategy has to embrace a wide range of possibilities.

We believe that a commissioning strategy should also be explicit about the circumstances in which a service is likely to be purchased from a third party organisation and the circumstances in which it is likely to be provided directly by a local authority or other statutory agency. These considerations and judgements will vary according to local context but are likely to be influenced by factors such as the level of specialist expertise required; legislative obligations; the external market; best value; and best practice.

There is an active tension between the need to commission highly personalised support for people, many of whom are amongst the most vulnerable in our communities, and Councils' requirements to conform to EU regulations that were generally designed to procure items such as furniture rather than care and support.

Lengthy guidance attempting to navigate this complex environment was previously produced by the Scottish Government’s Joint Improvement Team with CoSLA and there are approaches that can, at least partially, mitigate the potentially adverse consequences of treating social care in the same way as general procurement. Access to expert legal and procurement advice in this context is therefore necessary.

The development of Self-Directed Support - a concept first devised in North Lanarkshire, and currently the subject of planned legislation, offers a direction far removed from procurement processes that are not fit for purpose. The commissioning task is to create an environment where there are sufficient high quality services for those who wish to purchase support directly or who wish their support to be provided in this way but arranged by the local authority.

The identification of an indicative individual budget early in the process is key, as this allows people to make active choices about the extent to which they wish to exercise choice and control over the resources identified to meet eligible need. Early knowledge of the likely resource available is essential as it enables the person and/or their representative to conduct meaningful planning. Our experience to date is that people will often use the allocated resource in imaginative ways to meet mutually identified outcomes. To achieve this, local authorities must put in place equitable and transparent systems for allocating resources to need.
This approach fundamentally changes the nature of the relationship between the local authority; the person and their carer(s); and potential providers. It effectively creates ‘mini commissioners’ who purchase their own support, unconfined by constraints such as EU regulations or a limited range of providers commissioned by a local authority. With it come challenges (associated with issues such as protecting vulnerable people; workforce regulation and oversight of quality) but also major opportunities to achieve genuinely transformational change in people’s lives.

It is probably accurate to state that commissioning is an evolving art. In some areas of activity - such as homes for older people- care is often not actively commissioned in the same way as described above but rather left to market development where a price is determined by a national contract and individual selection governed by Directions on Choice. Our approach in North Lanarkshire is to share information about future trends and commissioning intentions to inform and influence capacity planning. In other areas of activity- such as highly condition-specific support – contested views may occasionally develop e.g. between families who have confidence in a designated specialist provider and a local authority that may considers the outcomes could be achieved in other appropriate but much more economic ways. A commissioning strategy requires local authorities and their partners to address such issues from their respective local perspective.

A strong commissioning strategy cannot be produced by one agency alone or without effective participation from organisations that represent people who need support and carers. Joint commissioning is necessary and appropriate though it is important to recognise that the act and meaning of commissioning differs in the NHS and local government. Most, though not all, NHS treatment is directly provided by a range of directly provided primary and acute services; or through self-employed contractors such as GP’s and dentists. Commissioning social care tends to take place within a different context and wider range of potential options. For this reason experience of commissioning expertise of the type required for social care is likely to be less well developed within the NHS.

This will be an important factor for partnerships to consider as they respond to the Scottish Government’s impending consultation on integration of health and social care, as effective commissioning is a critical lever in driving improved outcomes within an environment of reduced resources.

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