HOW TO USE A 'PRINCIPLES-BASED PROCESS' TO INCREASE SOCIAL VALUE MODELS IN THE DELIVERY OF SOCIAL CARE

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REBALANCING CARE AND SUPPORT

It is Welsh Government policy to develop a stable and resilient social care sector delivering options and choice, quality and support, and good outcomes for all service users. To do this, care commissioners are being encouraged to create a more diverse provider base offering greater sustainability and social value.

But how do commissioners decide the right make-up of a diverse provider base? The answer can be found in the principles of the Social Services and Well-being (Wales) Act 2014 (the Act).

By using these principles to evaluate both existing services and plans for new services, commissioners and procurement managers will find a rationale for re-shaping their provider base: nurturing providers whose values and behaviours do the most long-term good. The 2015 Public Contracts Regulations have two reserved contracting provisions to help commissioners and procurers embed social value in service delivery (Regulation 20 and Regulation 77).

The principles will also help them nurture connections between providers and the communities around them, and to build a local ecology of support and opportunities, whether paid for or not.

Both these types of nurturing (of the market and beyond the market) will naturally lead to a rebalancing of care and support and increase the footprint of social value models of delivery.

Social Value Models of Delivery

Section 16 of the Act puts a duty on local authorities to promote "social enterprises, co-operatives, co-operative arrangements, user led services and the third sector" for the provision of care and support and preventative services. This sounds like for-profit organisations are excluded, but they too can embrace co-operative arrangements and provide user-led services. The Section 16 duty undoubtedly encourages the promotion of the not-for-profit sector, but not to the exclusion of other sectors, public or private.

The underlying intent of the duty is the same as for the whole of Part 2 of the Act: it is to increase the probability that citizens are active co-producers of well-being and that the care and support system is financially more sustainable: because it isn't just focused on narrowly defined, paid-for transactions at the end of a statutory assessment process.

Not-for-profits as providers of care should be good at co-production and good at working for public benefit, but public and private agencies can do good work too. Whatever the sector, if you are good at delivering on the principles of the Act, you are operating a social value model of delivery.

The third sector is also the home of community groups and self-help groups of all descriptions. This is where informal support can be found that prevents people needing paid-for care (or reduces their reliance on it) to achieve well-being. Care commissioners should be nurturing this sector outside of formal care contracts. The citizen-led activities that go on in communities, for the benefit of the young, old and vulnerable, are also social value models of delivery.

A Principles-based Process for Collaborative Change

The process is very straightforward. It involves four steps: evaluate, redesign, commission and deliver. The steps fit neatly into the commissioning cycle (analyse, plan, do, review) and the NHS PDSA cycle (plan, do, study, act).

The process explores how well a service (or service redesign) is operationalising six principles. These are the four well-known principles of the Act (well-being outcomes, co-production, collaboration, and prevention) plus two other principles which are implicit in the aspirations of the Act (added value and financial sustainability).

It is designed to achieve collaborative change as the process reflects the principle of co-production by encouraging commissioners to work through the process with other key stakeholders.

Existing Pattern of Services → Better Pattern of Services

Principles	Evaluate	Re-design	Commission	Deliver
Well-being Outcomes **Co-production** - Users and carers as co-producers, with voice and control **Collaboration** - between relevant organisations including community led support **Prevention** or reduction of dependency on managed care & support (demand) **Added Value** - social, environmental and economic (triple bottom line -people planet profit) Financial **Sustainability** - spending money wisely and for the long-term	Who do we need to talk with? What is the core purpose of the service? How does it score against these principles? What data do we have (eg. usage, needs, costs, quality of service, satisfaction, provider feedback etc) and what is it telling us? Are people benefiting? (To what degree is the existing model / provider delivering the required outcomes?)	Who do we need to talk with? What data can we use? What are the re-design options? How can we coproduce these? How do the options score against the principles? What are the delivery implications?	Who do we need to talk with? Is there a 'make or buy' preference? Are there any procurement implications? What can we do in-house? Do we let new contracts? Do we re-negotiate existing contracts? Do we promote Direct Payments? Can we use short-term grants to nurture community self-help activities?	This is not the end. How do we keep on talking? How do we keep on evaluating? How do we keep evolving?

Well-being Outcomes

Co-production

Collaboration

Prevention

Added Value

Financial **Sustainability**

STEP ONE

Understanding the Principles

Principles	Definitions
 **Well-being outcomes**	These are **things that really matter to people**. They are the things that make up the basics of a good life. They are all about having a life, not just having a service. The Welsh National Outcomes Framework (*) flags up eight areas of life: • physical and mental health and emotional well-being; • protection from abuse and neglect; • education, training and recreation; • domestic, family and personal relationships; • contribution made to society (community); • securing rights and entitlements; • social and economic well-being; and • suitability of living accommodation. Social care services (in partnership with others as required) should be maximizing the probability that people get what matters to them **as individuals** across **all these areas of life**. (*) More details, including plain language examples, can be found here:
 **Co-production / Voice and Control**	Co-production is all about the **involvement of users and carers** in the design and delivery of their care and support, and more importantly, their life. Their involvement makes it much more likely that they will be supported to experience what matters to them. It means users and carers having **a strong voice and real control**. It means doing things with users and carers, not doing things *to* them or *for* them. *Co-production is a mindset and a way of working in which you:* • Build on everyone's strengths • Develop networks across silos • Focus on people's lives • Work on the basis of great relationships • Enable people to be change makers. Co-production Network Wales

Collaboration (between relevant organisations, including community led support

Collaboration and partnership is all about **looking outside** a single service or department or agency and **working with others**.

There are at least two big benefits from doing this:

1. People have access to more opportunities and supports.
2. Access to these opportunities and supports is not constrained by the resources of just one service, department or agency.

It doesn't just mean council staff talking to health board staff. It doesn't just mean care organisations talking to other care organisations.

It might start that way, but the scope can be much wider. What about schools, churches, landlords, community groups, business firms, leisure clubs, and so on?

It helps to think in terms of a community, population, neighbourhood or 'patch', however small or big. Who else is in your patch? Can they offer opportunities and supports? Are care services connecting to any of them, or working in isolation?

Prevention or reduction of dependency

Prevention is all about helping people to reduce risks to well-being and / or maintain their well-being **before things get so difficult that they need lots of paid-for care**.

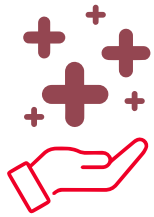
Prevention activities are good for people because most people prefer being as independent as possible.

And it's good for public services because it helps to keep down the pressure and unnecessary demand on limited finances.

It's worth asking: Does a service contribute to prevention and enablement? Or are all its skills and resources targeted at providing people with care?

Reduction of dependency is about what happens to people when they start receiving paid-for care. Sometimes a care service can do too much for people, so they lose skills, confidence and support from friends and family. Sometimes people can become stuck in a care service even though they have the potential to achieve a better life without it.

It's worth asking: Does a service actively seek to maintain or restore people's independence?

 **Added social, environmental and economic value**	All care services provide **social value** simply by providing social care. But they can do more. Do they support people to be active contributors to their communities? Do they run social events that benefit others as well as service users? Do they support and make use of local community facilities? Do they offer learning experiences for local school children or students? The list could go on. They can add **environmental value** by minimizing their carbon footprint, whether in their buildings or the travel patterns of their staff, and by participating in local environmental projects. They can also add **economic value** by paying their staff decent wages (e.g., the Real Living Wage as a minimum), offering good career paths and buying from local suppliers.
 **Sustainability**	Sustainability in this context is all about limited public finances being spent as wisely and fairly as possible, so that the whole local population experiences good levels of well-being, now and in the future. A service needs to function within the budget available, but it should also provide maximum value for money. Services which deliver on all the other principles are more likely to be delivering value, augmenting public funding with other resources, and avoiding wasted expense on preventable and reducible needs. Services, including social businesses, need to make a surplus or profit – what sets businesses apart is what they do with that surplus or profit and how much is invested back into service delivery and community benefit.

> ALL CARE SERVICES PROVIDE SOCIAL VALUE SIMPLY BY PROVIDING SOCIAL CARE. BUT THEY CAN DO MORE.

STEP TWO

Evaluate

Q1	Answer
Who do we need to talk with?	

Why this question is important?

If commissioners just talk with themselves, they may miss out on the insights of other key stakeholders:

- Current users of the service (and people who may need the service in future)
- Family carers
- Current or potential service providers and their workforce
- Multi-disciplinary team members, such as care managers and health professionals
- Current or potential collaborators.

It might be hard to bring everyone together to talk, but the more these other insights are gathered and valued, the better. There is increasing knowledge, tools and techniques including digital solutions for bringing people together, including those seldom heard, and for engaging with people on a one-to-one basis*.
This is co-production in action. It creates a richer insight into what is needed and possible. It also helps to create ownership of any changes.

* Example: Facilitating online in virtual spaces

Q2	Answer
What data do we have (e.g., usage, needs, costs, quality of service, satisfaction, feedback from providers, etc) and what is it telling us?	

Why this question is important?
Numbers can provide useful basic insights.

Is usage going up or down? Are there long waiting lists? Are population assessments flagging up the need for something new or bigger or smaller? Are people's planned outcomes being achieved? Are all required costs covered, now and for the foreseeable future? Are people satisfied with the service – are they better off as a result of the service? Have providers struggled to meet their reasonable costs?

This data is particularly relevant for thinking about Sustainability.

Q3	Answer
What is the core purpose of the service?	
Why this question is important? Sometimes the purpose of a care service is complicated by the need to serve both users and unpaid carers. It's important to ensure that the design of a service doesn't result in well-being gains for one group at the expense of another.	

Q4	How does the current service model score against the six principles?
	Answer
Well-being outcomes	
Users and carers as co-producers, with voice and control	
Collaboration between relevant agencies	
Prevention or reduction of dependency	
Added social, environmental and economic value	
Sustainability	

STEP THREE

Redesign

Q1	Answer
Who do we need to talk with?	
Has this changed from Step2?	

Q2	Answer
What data can we draw on (e.g., usage, needs, costs, quality of service, satisfaction etc.) and what is it telling us?	
Has this changed from Step2?	

Q3	Answer
What is the core purpose of the service?	
Has this changed from Step2?	

> IT'S IMPORTANT TO ENSURE THAT THE DESIGN OF A SERVICE DOESN'T RESULT IN WELL-BEING GAINS FOR ONE GROUP AT THE EXPENSE OF ANOTHER.

Q4	What is the current design?	What might be a better re-design option?
Location/s		
	Think about things like family and community connections, travel distances for everyone involved, and how to strengthen the potential for collaboration and added value.	
Assets		
	Think about who is (and who could be) providing opportunities and support for people. Does the current service design just focus on its own staffing? If yes, how might a re-design bring in more assets? Could they collaborate with others? Could they work with community assets?	
Roles and relationships		
	Think about the roles within the service. Are they geared towards achieving the benefits of all the principles? Do any need redefining? Also think about current and potential relationships. How does the service relate to users and their families? How does it relate to care management and other specialists? How does it relate to other agencies and the wider community?	
Access and activity processes		
	Think about how people access the service. Is there a positive prevention stage in which the service is engaged, or is it just geared toward accepting clients? Think about the activities that the service supports. Are they flexible enough to offer what matters to individuals? Do they reduce dependency? Do they mobilise assets outside the service?	
Funding		
	Think about whether the way the service is funded contributes to a lack of flexibility to meet individual well-being outcomes. Think about whether funding could be more user-led. Think about whether funds are used for maximum value in line with the six principles. Think about whether it is funded as a silo or as part of a local pattern of services with shared goals and shareable assets.	

Questions	Answers
2. Enabling Community	
How could we nurture communities with grants or other funds in processes that meet their needs but retain sufficient public accountability?	
How can we engage with communities so that we know what is needed and make good decisions about supporting them?	
How can we learn from what's working / not working and share the learning for countywide benefit?	

Q5	Answer
Do we need further redesign, or can we move on to the planning and commissioning stage?	

HOW CAN WE ENGAGE WITH COMMUNITIES SO THAT WE KNOW WHAT IS NEEDED AND MAKE GOOD DECISIONS ABOUT SUPPORTING THEM?

STEP FOUR

Redesign

Questions	Answers
1. Paid for Services	
Who do we need to talk with?	
What can we do in-house (if applicable)?	
How could we optimize the system for individualized funding? (E.g., Direct Payments, Individual Service Funds, etc.)	
How could we optimize delivery and outcomes via contracts? a) What new contracts might usefully be let? (Where are the main service gaps we want to fill?) b) What current contracts might usefully be re viewed? (using a whole-county, whole-service, principles-based approach)	
How could we build clear expectations about principle-based delivery and added value into the contracting system? (e.g., co-production, collaboration, dependency reduction, decent wages, etc).	
How will we bring providers together - to get them on board as contributors to a collaborative system?	

STEP FIVE

Service delivery

Delivery is the most important stage. If delivery doesn't happen, every other stage in this process may be a waste of public funds!

But how new services are put in place is largely beyond the scope of this process.
Just remember, it is not the end. You should continue to ask these questions:

- How do we keep on talking?
- How do we keep on evaluating?
- How do we maintain the momentum of collaborative change?

A final reminder on the importance of the principles-based process to increase social value models in the delivery of social care

There are three big challenges facing social care and the achievement of widespread well-being:

1. Quality – the challenge of providing services that do the most good and the least harm.
2. Quantity – the challenge of having enough capacity to cope with current and future demands.
3. Finances – the challenge of achieving quality and quantity with a finite pot of public funds.

If we address these three challenges, we will be creating what a Welsh Minister once described as "sustainable social services". The principles of the Social Services and Well-being Act are all geared towards this objective.

Focusing on **well-being outcomes** is mainly about quality – and particularly quality of life - doing what matters to people rather than just delivering a narrow menu of inputs. But it helps with quantity and finances too. When we talk to people, we can discover that what matters to them requires less quantity and less cost.

The principle of **co-production** is there to make sure we DO talk to people and find out what matters. It also requires us to think about people in terms of their strengths and assets, rather than just their needs. Can they help themselves? Can they be reconnected to a social network? Can they help others? Positive answers to these questions can lead to quality, well-being outcomes, but they can also lead to reduced dependency on paid for support.

Prevention and reduced dependency is, again, not only good for people, but reduces current and future pressures on services and tight budgets.

And finally, **collaboration** can lead to all sorts of benefits for people – more resources, more opportunities, more ideas and solutions – and at the same time it increases capacity in the system with little or no extra cost.

So, the principles are like building blocks for a high quality, high capacity, affordable social care system. They are the roadmap for transforming services, achieving social value, and rebalancing the market for long-term sustainability.

We hope you will find this principles-based process a useful guide for bringing people together and going on a transformative journey together.

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