Faculty of Health and Social Care

The Centre for Ageing Studies

University of Chester

LEGACY REPORT

17. BRIGHTLIFE & COMMISSIONING

Literature Review and Content Analysis

University of Chester Evaluation Team

April 2020

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The Brightlife Commissioning Process: Literature Review & Content Analysis

1. Introduction

This report is made up of two sections; a literature review of academic articles published as regards commissioning during the lifetime of Brightlife, and a content analysis report into Brightlife's commissioning process. The aim of this report is to review Brightlife's commissioning processes with reference to current standards, so as to identify key learning to inform future commissioning strategies and decisions. This is particularly important given Brightlife's test and learn ethos, which seeks to capture emerging findings at the earliest possible opportunity to inform the subsequent design and development of Brightlife. Equally, the discussion and recommendations reported can assist with future commissioning approaches for organisations within and outwith the Brightlife Partnership beyond the lifetime of the current project.

2. Method

2.1 Literature Review

A literature review was conducted between April and August 2019 to investigate evidence of best practise of health and social care related commissioning across public, private and third sector actors, as evidenced in academic literature. As this is a literature review and not a full systematic review or meta-analysis, a basic version of the PRISMA guidelines were followed:

- Identification
- Screening
- Eligibility Assessment
- Appraisal and Synthesis

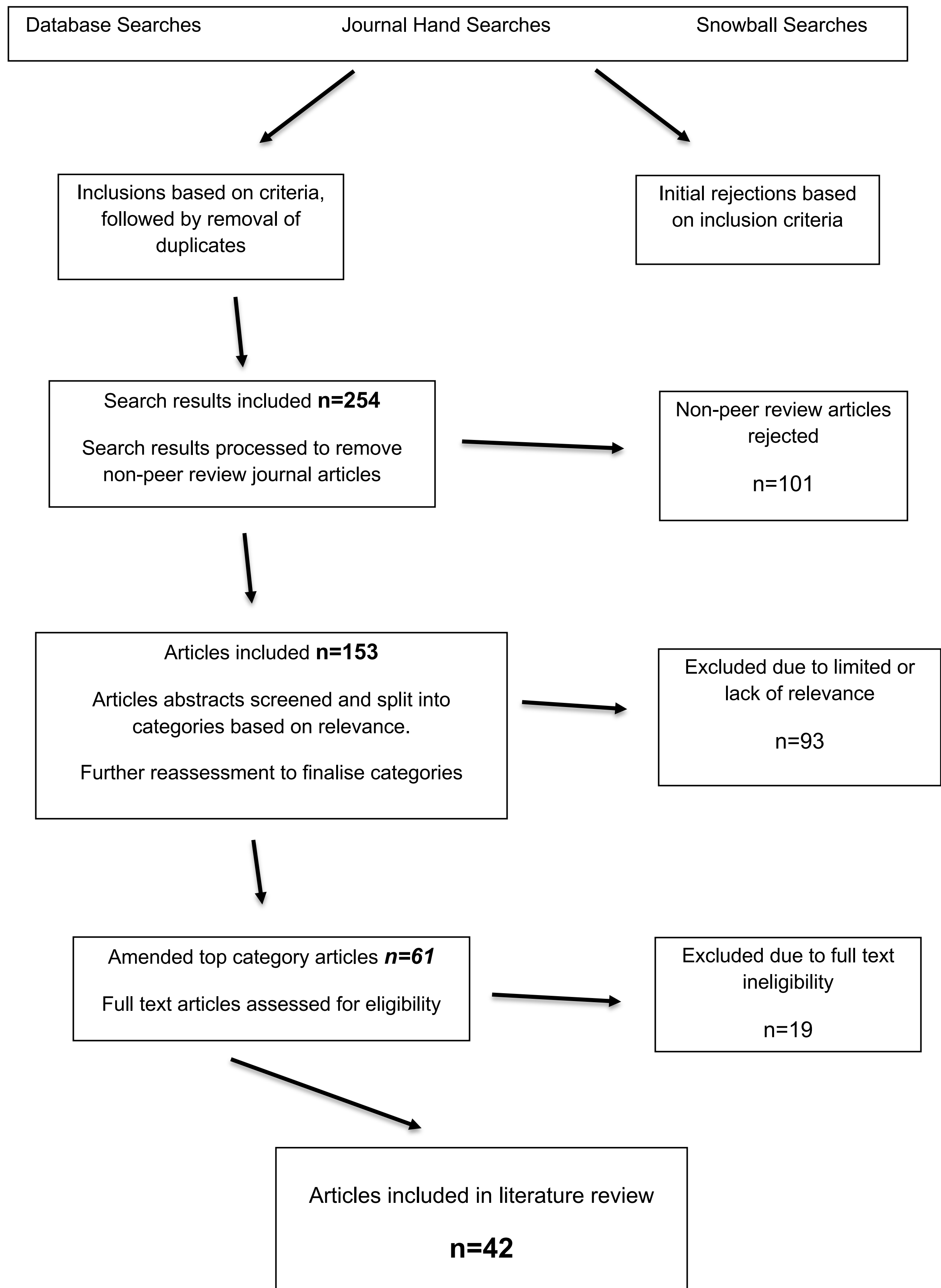
The following inclusion criteria were applied:

1. Date range: date limits of publication were set from January 2014 to May 2019 for threefold reasons; to investigate the latest research in a quickly changing field, to extrapolate academic research directions regarding commissioning during the lifetime of the Brightlife Project, and to contextualise literature in the aftermath of commissioning changes following the Health and Social Care Act 2012.
2. Location limits: geographic limits were placed on research study area of articles; only articles regarding England were included, as commissioning practices and policy vary across the different nations of the UK (for narrative commentary articles considering larger scale nationwide theory shifts and background, the wider term ‘UK’ was permitted).
3. Source Type: sources were restricted to peer-reviewed journal articles, as the aim was to see how commissioning was being investigated and presented in academic literature (i.e., ‘grey’ literature, reports and professional journals were omitted).

Figure 1 shows a flow chart which summarises the appraisal process.

For a detailed description of literature review procedure, please see appendix 4.

Figure 1: Literature review appraisal flow chart (based on PRISMA)



2.2 Content Analysis

The review of Brightlife's commissioning activities was undertaken by adopting a 'content analysis' approach to objectively and systematically analyse relevant documentation, policy and guidance. Content analysis allows for a longitudinal focus to track changes over a period of time (Warde 1997, Bligh et al. 2004, cited in Bryman, 2012).

The analysis was conducted in two stages. Firstly, co-researchers reviewed all relevant commissioning information provided by Brightlife including policies, reviews and records of decisions. Secondly, discussions with the Commissioning Manager to provide further contextual information and review additional documents identified as being required by stage one.

The findings have been structured around the different approaches within Brightlife's commissioning process, but also chronologically to reflect the iterative nature of Brightlife commissioning due to test and learn.

3. Literature Review Findings

3.1 Introduction

Brightlife commission a broad range of services to address issues of social isolation and/or loneliness in older people, some of which are around social connectivity or activities and, as such, are outwith the scope of the health and social care sector. However, specific health and social care commissioning is a complex and dynamic process, with a range of relational and transactional elements operating in a resource-limited and potentially emotionally charged environment. This literature review aims to explore contemporary academic literature concerned with commissioning, and extrapolate lessons for best practice. Commissioning is a complex process, as elucidated in the following quote:

> *"The 'Art of Commissioning' entails juggling competing agendas, priorities, power relationships, demands and personal inclinations to build a persuasive, compelling case."*
>
> (Wye et al 2015b, p.1)

Literature sources reviewed in this report attempt to examine this complexity through a range of methods, including mixed methods reviews (e.g., survey, interview, focus groups, document analysis), longitudinal case studies, commentaries / narratives and systematic reviews. Being quite a 'niche' area with a short time frame (see inclusion criteria), a number of individual authors have worked on multiple papers included in review.

As Brightlife's operational period has coincided with CCG development and reporting (average academic literature analysis and publishing time meaning reports regarding changes brought about by the Health and Social Care Act 2012 emerging from late 2013 onwards), much of the literature on health and social care linked commissioning is focussed upon CCG's.

As regards the third sector and commissioning, no articles emerged from the search focussing on third sector as commissioner (highlighting the significance of projects like Brightlife), though a number explored the third sector as service provider or partner.

The literature describes various ‘clashes’ central to commissioning processes, which will be explored in the following sections as a range of dichotomies; namely Continuity vs. Change, Vertical vs. Lateral Scale, Competition vs. Cooperation, Clinical vs. Managerial Outlook, and Soft vs. Hard Evidence. Each section will close with summaries regarding lessons for best practice gleaned from the academic literature.

3.2 Continuity vs. Change: The Theory of the Commissioning Cycle

The theory of the commissioning process across public services has shifted and developed over the last three decades, passing through a number of stages (i.e., competitive tendering of the 1980’s, mid 1990’s emphases on partnership working, post millennium strategic commissioning and prime contracting, recent questions of insourcing vs outsourcing, decentralisation and renationalisation of various services), though services have largely witnessed continuity at local level, despite shifts in national policy (Bovaird 2016). The current theory of commissioning as applied to health and social services can be seen in figure 2.

Figure 2 The Commissioning Cycle

From Rees, Miller & Buckingham 2016, adapted from The Institute of Public Care 2008

At the heart of the commissioning process is the conflict between authority and autonomy brought on by shifts in theory; between local and central levels, between commissioners and providers, between service developers and users.

In a 2017 study, Checkland et al interviewed commissioning staff across two "regional health care economies" (Checkland et al., 2017, p. 378), and found conflicts in terms of "decision space" (ibid, p. 380) for commissioners, posited between the vertical axis (issues of centralisation and decentralisation, i.e., nationalised top down or localised bottom up control) and the lateral axis (decision space shaped by local networks, issues and partnerships). Influence of both national / vertical and local / lateral factors will be explored in more detail in section 3.3.

Bovaird (2016) presents a narrative account of outsourcing of public services over the last 30 years, offering ten lessons for commissioners as a result. This paper emphasises the need to avoid artificial barriers being placed between commissioning and provision roles (the purchaser provider split), noting that various past projects have been held back by failures in joined up working and planning, and that it is essential that adaptability be built into contracts from their beginning (Bovaird, 2016).

Another key issue is the inconsistency between plans (theory) and practice (reality). Rees' 2014 paper explores the relationship between the public and third sectors within commissioning and identifies dissonance between the rhetoric of full cycle commissioning approaches and what is occurring in practice, determined by resource constraints, large provision scales, and payments by result; all impacting on service quality. Rees et al (2016) explore this further in a mixed methods study focussing on third sector providers commissioned within mental health services, outlining inconsistencies and instabilities, complexity and confusion experienced by third sector providers moving through the different stages of the commissioning process. Reidy et al (2016), investigating the commissioning of self-management support strategies for people with long term conditions, also address the disconnect between theory and practice, concluding that a focus on early strategic planning is essential.

Warwick-Giles et al (2016) examine the relationship between local authority led Public Health bodies and NHS based CCG's, with the former's relation to the latter embodying a number of different roles: *co-owner* (partnership with public health in an active role), *service provider* (transactional relationship based on structure, rules, trust

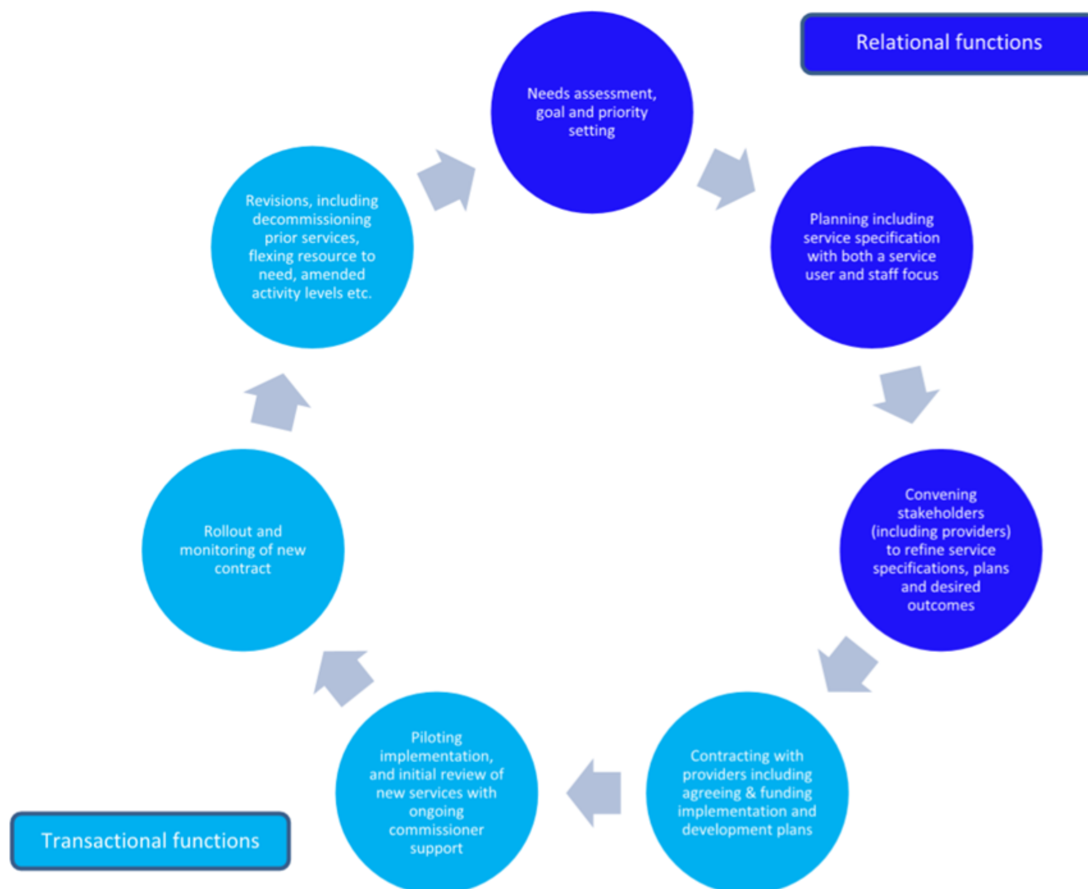
and communication), or *critical friend* (external agent offering comment/critique advisory, but not directly involved in decisions). Though these role definitions were developed for the public health/CCG relationship, they have transferability when looking at the roles of other health and social care partnership working models. Different roles have implications for integrated care / joint commissioning strategies.

The need for joint commissioning (at the permeable boundary between health and social care) is stressed by a number of authors, such as Cameron et al (2018), who explore three joint commissioning discourses: *prevention* (improving service delivery to pre-empt problems and reduce inequalities), *empowerment* (ensuring services reflect needs of service users) or *efficiency* (eliminating duplicate services). The authors note all three interact, but empowerment appears most powerful; emphasising service user involvement brings benefits including the opportunity to refocus approach (giving rise to possible innovations within specific local contexts) and legitimising controversies (sharing responsibility for potentially unpopular decisions).

Another issue of commissioning theory vs. practice identified by Rooshenas et al 2015 ethnographic study, concerns decommissioning and disinvestment, with practical and ideological barriers apparent which limit ability of commissioners to disengage from underperforming services (including a lack of clarity over how disinvestment is defined, and what it entails), raising questions regarding monitoring of commissioned contracts. The article highlights need for tools, methods, and communication improvement in disinvestment practice and project monitoring.

Monitoring shortcomings led Smith et al (2019) to develop a revised model of the commissioning cycle (see figure 3).

Figure 3 Revised Commissioning Cycle proposed by Smith et al 2019



Having identified the limitations of commissioning to implement large scale change within a joint commissioning project across multiple London boroughs, the authors noted need for commissioners to support, enable and performance manage delivery of procured services, working closely with providers to do so (Smith et al., 2019).

Key Lessons for best practice:

- Awareness of traditional and developing concepts of the commissioning cycle (theories always in flux, though practices may remain stable), with adoption of adaptable working methods
- Awareness of factors affecting commissioning 'decision space'
- Utilising different models of partnership working and joint commissioning
- Addressing conflicts between theory and practice (including decommissioning strategies)

- Essential need for active monitoring of commissioned services
- Clarity in defining roles and responsibilities of different actors within networks and/or partnerships
- Inclusion of service users in service development, (embodying the ‘empowerment’ discourse of joint commissioning)

3.3 Vertical vs. Lateral: Local and National Scale

Returning to Checkland et al.’s 2017 study exploring ‘decision space’, the authors identified the ideological placement of commissioners within both a vertical axis of national dictates vs local developments, and a horizontal or lateral axis determined by local partnerships and provider environments. Many authors identified commissioning issues across national and local scales.

Bovaird et al (2014) review of strategic commissioning over time (and successive governments with different motivations and theories) note centralised government pressures working to promote externalisation of commissioning contracts, echoed in Bovaird’s 2016 study, where external contracting is seen by centralised authorities as more cost effective than in-house provisions. Reidy et al 2016 note the tensions which can exist between local aspirations and national ones, in addition to discrepancies between policy and practice as considered earlier. They identify that national targets, outcome measures and payments have an impact on local implementation of innovative practices (Reidy et al., 2016). Though national directives are noted by some as being too prescriptive vis a vis targets, another article (Allen et al 2017) recognises inadequate guidance from above causing confusion in standardising commissioning procedures.

In terms of innovative practice, multiple authors note it is at local level that novel approaches can find space to develop. It is noted that services must remain locally appropriate, locally determined and democratically accountable (Bovaird 2016). Addicott’s 2016 review of the challenges for commissioning and contracting integrated services recognises local level developments being most innovative, but warns localised models and methods may face long-term sustainability issues, and be too local-specific, offering limited replicability into new geographic areas.

There are also studies which look at scale from the aspect of providers within the commissioning relationship. In a 2018 study of an integrated wellness service in North East England, Cheetham et al outline how the service was able to use local knowledge to construct new provider networks and relationships. Providers are characterised in the literature by whether they are offering economies of scale (specialised, large, often centrally managed provision) or economies of scope (adaptive and multitasking providers, usually operating on local levels in response to local needs) – with some authors noting there appears more evidence for the successes of the latter (Bovaird 2016).

Garnett et al (2018) explore the positive possibilities of lateral networks in their article on social enterprises in public health roles, but also identify that lateral networks can become overly complex and fragmentary, risking coherency and equitability of service planning, and negating ability of commissioners to plan strategically. Other articles also recognise such risks (Coleman et al 2014), where lateral relationships and motivations can be out of sync, because the areas covered by different groups are not coterminous (i.e., operating within different geographical or ideological boundaries). The risks to commissioning autonomy raised by both prescriptiveness of monitoring and control across the vertical axis, and confusions linked to proliferation of overlapping networks across the lateral axis, has led some authors to propose the need for some kind of 'meso-level' / regional oversight, providing connections and understanding both national and local issues (Checkland et al 2017).

Key lessons for best practice:

- Greatest innovations occurring on local scale (bottom up rather than top down), with opportunities for lateral working relationships
- Potential for regional level oversight to juggle needs of national and local interest groups
- Awareness of risks to sustainability, replicability and cohesive strategies from being too local-specific, and from misalignment and over-proliferation of lateral groups

3.4 Competition vs. Cooperation: Institutional and Organisational Issues

There are a number of institutional and organisational issues which impact on success of commissioning practices. These link to adoption of market strategies regarding competition whilst continuing to encourage cooperation strategies, and the nature of hierarchical structures within organisations impacting on working practices.

As identified by Checkland et al (2016) in a longitudinal study into CCG's (in addition to other articles, such as Allen et al 2017), the imperative placed upon commissioners is to simultaneously embrace competition and collaboration, which has assisted in developing a complex commissioning system (Checkland et al., 2016). This high level of complexity is born of the permissive and piecemeal environment in which CCG's were formed (Checkland et al, 2015).

In a debate around marketisation and privatisation, Krachler and Greer (2015) outline some consequences of moves to increase marketisation, with competition conversely reduced due to granting of long-term contracts with long established providers for the sake of stability, instead of external tendering. This in turn leads to the risk of protectionism for underperforming organisations and structures (Bovaird 2016). The article by Croft et al (2016) examines managerial dominance of commissioning organisational structures, and also identifies the risk of protectionism, this time from the potential to such behaviour within organisational hierarchies still working to out-dated methodologies (pre CCG partnerships enduring), due to a lack of clarity regarding new procedures and responsibilities. A number of authors in the academic literature identify the post CCG commissioning system as not only more complex (as noted above in Checkland et al 2015), but also more fragmentary, with dispersed decision making creating blurred boundaries of accountability, and continued flux breeding uncertainty (from Gadsby et al in a 2017 study into post CCG changes to health improvement commissioning). Again, there is a disconnect between the theory and reality, in this case the theory of competition and collaboration being opposed to each other. When looking at attitudes to competition and cooperation in health service commissioning, Osipovič et al (2016) identify a level of hybridity spanning across the supposed contradictory approaches; showing a preference for cooperative approaches, but also viewing competition as a useful tool. Other authors supported this notion, giving examples of commissioners using collaborative practices in

commissioning key services, while using competitive practices for more peripheral services (Allen et al 2017).

Conflict can exist between / across different organisations along the lateral axis of local partnerships and networks, due to the different knowledge, ideologies and management strategies inherent in their unique contexts; e.g., as Sanders et al (2017) point out, local authorities are more likely to adopt a transactional business ethic, whilst third sector organisations may have limited operational capacity due to financial restraints (Morris et al 2015). These lateral conflicts can also lead to fears regarding outsourcing, and loss of established relationships to new competitors, which can again lead to potential longer term contracts between groups with established relationships, and a resultant limitation of competition and / or innovation (from Petsoulas et al 2015 article considering lessons from the past for primary care commissioners). Blurred lines of responsibility and accountability can exist between different organisational partners due to lack of clarity in roles (Checkland et al 2016), which will have a knock-on effect for providers and service users due to system interdependency (Sanders et al 2017). When role clarity is lacking, issues arise in service integration as well; different organisations contexts and knowledge base can be strikingly dissimilar, which can have capricious effects on the extent of productive co-operative working.

Key lessons for best practice:

- Understanding positives and negatives of both competitive and collaborative working, and ability to work with both structures
- Awareness of complexity of the health and social care sector, and why it has developed in this way
- Keeping staff well informed of new procedures and strategies
- Procedures in place to monitor provider performance, with disinvestment procedures in place if decommissioning becomes necessary
- Embracing long standing relationships, but not to the detriment of new organisations or innovative practices
- Creating clear lines of responsibility and accountability, whether shared or separated

3.5 Clinical vs. Managerial: Governance Structures, Professional Identities and Personal Relationships

Issues can arise in commissioning due to the governance structure of commissioning bodies, the recognition of professional identities (or lack thereof) for commissioners, partners and service providers, and the personal relationships established among different stakeholders.

The balance of membership on boards or committees of commissioners can affect efficiency and impartiality, for example, in CCG's, GP's are likely to outnumber lay members, and may overpower dissenting voices or outvote differing opinions (Coleman et al., 2014). Similar lack of balance may also affect other, non-CCG commissioning bodies. Governance management hierarchies can also lead to limiting lay / public involvement (Croft et al 2016). Membership of commissioning bodies can give rise to conflicts of interest; Moran et al (2017a) explore this in terms of GP members of CCG's commissioning products or services from their own associated practices – the authors note attempts were made to address this in the case study, but that conflicts were still inevitable given the nature of CCG systems. Hammond et al (2018) article examining localist strategies in health note that commissioning organisations tend to have a high turnover rate of staff, with a shifting 'cast' of people leading to high levels of instability and delegation. This turnover is also noted in the article from Moran et al (2017b); they note the high turnover rate of GP's on CCG's, and the necessity for adopting active succession planning.

Workforce identity issues also exist as commissioning is still a relatively young practice, without an established place in public consciousness. These professional identity issues can be seen in both the identities of organisations (outlined in Coleman et al 2014) and individuals (e.g., commissioners and partners). For example, Cheetham et al 2018 found that service users questioned the identity of those involved in coordinating commissioned services (e.g., social prescribers / link workers), with lack of clarity of where the new roles fit in healthcare systems, and lack of specific role definition giving rise to lack of trust, concerns over privacy and reluctance to share personal information.

Commissioning is a highly relational practice, with success dependent on personal practices, skills and stakeholder relationships (Rees et al 2016, Warwick-Giles et al

2017). It is perhaps paradoxical that a system so dependent on the establishment of personal relationships and the development of context-specific knowledge should also be beset by high rates of staff turnover and short-term contractual project working practices.

Key lessons for best practice:

- Balanced membership of commissioning boards, with service user representation
- Awareness of potential conflicts of interest, along with development of strategies to try to limit extent of conflicts
- Strategic succession planning to counteract staff turnover rates
- Moves towards better definitions and clarity of professional identity, with attempts to establish reputation of different professionals involved in the commissioning process (potentially through marketing campaigns and utilising locally based, trusted networks)
- Building and utilising key inter-organisation relationships

3.6 Soft vs. Hard Evidence: Knowledge and Evidence Exchange

The need for effective evaluation and knowledge exchange is widely recognised in the academic literature; e.g., need to experiment and learn (Bovaird 2016), to systematically gather data on service gaps (McDermott et al 2017) and to integrate research into wider systems, with evaluation outcome measures which are valid, feasible and practicable (Dickerson et al 2019). Articles also stress the need to make evaluation a part of commissioning, making involvement in evaluation a necessary condition of contract reward.

Researchers recognise a difference between soft and hard evidence, alongside different 'evidence cultures' in using different evidence types (e.g. Sanders et al 2017 note the tendency of politicians to prefer soft data, while public health officials prefer hard data, which may link into differing knowledge contexts and backgrounds, plus different motivations). Wilson et al (2017) investigated the use of a demand-led evidence service for commissioners, finding evidence use by commissioners was well-intentioned but ad-hoc, research seeking behaviour was informal (regardless of

evidence briefing services) and the use of research was impossible to trace in decision making processes. The authors suggested strategies were needed to build individual and organisational capacity to use research.

Wye et al (2015b) investigated the use of academic evidence by commissioners, outlining a number of factors affecting commissioner information seeking behaviour:

- Information sought to identify options, navigate, justify decisions and convince others
- Inconclusive and negative research seen as unhelpful (and did not inform disinvestment strategies)
- Information was exchanged through conversation and stories (fast and flexible methods of information transfer)
- Local data and evaluations trumped national or research-based evidence
- 'Evidence' selection was pragmatic

The authors also identify strategies for academics investigating commissioning, concluding researchers into health and social care commissioning need to learn more about policy makers priorities, develop mutual relationships, make more use of verbal communication methods, work with intermediaries (e.g. public health officials) and co-produce local evaluations (Wye et al., 2015b).

Key lessons for best practice:

- Realistic evaluation strategies in place from start of contracting
- Recognition of different evidence types, evidence cultures and how best to present data to different audiences
- Mutual strategies and support between commissioners and providers to promote knowledge exchange and capture learning

4 Content Analysis Findings

4.1 Brightlife's tender application to Ageing Better

The Brightlife Partnership was formed to apply for National Lottery Community Fund funding and was successfully awarded £5 million in 2015. It developed its vision and thinking through collaboration, not only within, but also outwith the Partnership Board by engaging with the wider market. A broad network of third-sector, public and private organisations and groups helped to undertake a community asset gap analysis to explore what could be delivered.

Within the tender application the Brightlife Partnership committed to providing funding for business support, a food sharing project, and marketing and communications. Equally, social prescribing was a key element of the Brightlife project, and an asset mapping exercise was undertaken in the three designated areas to identify potential gaps in provision to support the delivery of social prescribing. Therefore, business support, food sharing, marketing and communications, and projects to deliver social prescribing formed the basis of the first rounds of commissioning.

Additionally, the work to develop the final application to the Ageing Better programme contributed to an 'Ideas Bank', which helped inform Brightlife's commissioning priorities. However, although the Ideas Bank identified potential solutions to reduce social isolation and loneliness, it also created potential conflict of interest whereby organisations involved in developing the bid would be applying for funding to deliver those solutions. Consequently, following discussions between the National Lottery Community Fund and Brightlife it was agreed that, in order to fund local projects, a formal commissioning process would be developed.

4.2 Developing a model for commissioning

The initial commissioning process was developed by:

- engaging with other Ageing Better projects
- the Commissioning Manager's experience
- a Partnership Commissioning Working Group

A formal ‘Commissioning and Procurement Framework’ was adopted by the Brightlife Partnership Board (Brightlife, n.d.-e) and it was agreed all applications for Brightlife funding would be decided through the formal process. Initially this involved two separate approaches:

1. Key Commissions – larger funding awards using a traditional competitive tendering commissioning process
2. Bright Ideas – lower levels of available funding to encourage local groups and organisations to identify and develop solutions to meet a need in their local communities

A further commissioning opportunity was introduced in 2019 called ‘Brighter Ideas’, which was developed following the fourth round of Bright Ideas funding applications.

4.3 Older People’s Alliance

Working with older people to help design and commission services is embedded as one of Brightlife’s core principles. Consequently, an Older People’s Alliance (OPA) was established to ensure the meaningful involvement of older people in influencing the overall project and the commissioning of its services. Members of the OPA were trained in commissioning and appointed to the panels for both Key Commissions and Bright Ideas processes. Support and advice to the OPA is provided by members of the Brightlife Team and Brightlife Partners.

4.4 Key Commissions

The Commissioning and Procurement Framework established two levels of entry point, both through a Pre-Qualifying Questionnaire (PQQ) approach; one for contracts up to and including £50,000, the second for contracts over a value of £50,000. Organisations were able to apply to go onto the framework at any time and those meeting the threshold were accepted. Invitations to tender were publicised to organisations on the framework allowing a minimum of four weeks to submit bids. Received bids were assessed by a panel drawn from the Brightlife Partnership, including members of the OPA and Reference Groups (specific working groups reporting to the main partnership) using criteria included in the procurement

documentation. The initial focus for projects was taken from the Brightlife tender application to the National Lottery Community Fund and the work associated with developing the bid.

4.4.1 First round of key commissions

Eight contracts were awarded in the first round of key commissions, including Cheshire West Voluntary Action (CWVA) who were commissioned to provide free business support to organisations seeking to apply for Brightlife funding through Bright Ideas and subsequent rounds of key commissions (appendix 1). The intention was to ensure applying organisations had sufficient resources, skills, and experience to deliver and sustain activities responsive to the needs of socially isolated older people and thereby contribute to Brightlife's key outcomes.

Support from CVA ranged from signposting to relevant agencies and information sources, access to online resources such as policies and procedures, to intensive in-depth one-to-one development support, access to business mentoring, workshops and networking opportunities.

Following the first round of Key Commissions (and Bright Ideas – see next section) a review of the commissioning process was undertaken by the Brightlife Commissioning Task and Finish Group. Issues identified included, particular challenges in generating innovative ideas, providers experiencing difficulty in matching proposals to tender specifications, delays between project consultation and implementation impacting on capturing data to support social prescribing and 12 months contract awards not having sufficient time for successful implementation and evaluation. From this review a number of recommendations in relation to the commissioning process were proposed and approved by the Brightlife Partnership Board (Brightlife Partnership Board paper, Proposal for Brightlife Commissioning, January 2017).

These included:

- specifications that clearly communicate requirements, which are outcome based and specify key performance indicators

- utilise a range and variety of approaches to commissioning including; specifications, open calls for innovative ideas, and direct approaches to potential providers
- strengthen communication with providers to support them in bidding for Brightlife funding through presentations, workshops, engagement events, marketing and briefing materials and provider support options
- include face to face conversations with bidders during the application process
- initial sifting by Brightlife Commissioning Manager and OPA commissioner to filter out unsuitable bids
- final assessment of proposals to be made by a panel of the OPA Commissioning Group supported by a statutory partner
- bids to be approved by the Commissioning Group, which has delegated powers from the Partnership
- the Commissioning Group has flexibility to negotiate contract extensions and variations where appropriate, whilst maintaining the integrity of the Brightlife aims
- ensure that all proposals contain a commitment regarding the collection of data for evaluation purposes

4.4.2 Second round of key commissions

The focus for second round of Key Commissions was based on the outcomes from the previous commissioned projects and findings from the learning arising from the delivery of projects thus far. Essentially, these themes were complemented using data from the Common Measurement Framework (CMF) and by working alongside Clinical Commissioning Groups and the Local Authority to consider addressing an under-provision for particular groups. Consequently, concerns that fewer 'men' were accessing services within the Brightlife target group and those with long-term conditions and/or carers became the main focus for the second round of commissioning.

In addition, increasing services focusing dementia care was identified as a key priority. Two workshops were arranged to further develop a specification around this theme

(Brightlife, 2018a). Brightlife engaged with people living with dementia and carers in the first workshop. The second was held for relevant providers, or providers already working with social isolation and/or loneliness, who may be interested in dementia-specific projects.

In total £1,313,039 has been awarded through two rounds of Key Commissions projects by the Brightlife Partnership, see appendix 1 for detailed breakdown.

Two Key Commissions contracts from round one were terminated early due to non-compliance and a proportion of the agreed funding was withheld. However, the need for the provision remained so work on these issues was re-commissioned within round two. It is important to note 'non-compliance' is different from the 'test and learn' principles, which are integral to the Brightlife project and recognise the envisaged outcomes as per the tender application may change during the delivery phase.

4.5 Bright Ideas Commissions

The Bright Ideas commissions were designed to find innovative and community-led initiatives to meet local needs. This round of commissioning was intended to work on the principle that community-based individuals and groups are often ideally placed to identify local need and develop solutions to address those issues. To assist prospective applicants a 'Bright Ideas Guide' was published that detailed the commissioning process for applicants (Brightlife, n.d. -c).

Moreover, potential Bright Ideas providers were able to access the services of Cheshire West Voluntary Action (CWVA) to provide additional support to applicants and help develop ideas prior to making an application.

Funding was available for Bright Ideas projects up to 2 years in length, based on four criteria as agreed by the Brightlife Partnership Board:

1. Cost of project between £5,000 and £20,000
2. The project broadens the reach of the organisation to new target participants
3. Sustainability after Brightlife funding ceases is addressed

4. Commitment was made to engage in Brightlife's evaluation process, which consists of three elements:
   - Test and Learn
   - National Evaluation
   - Local evaluation conducted by the University of Chester

Applicants needed to demonstrate the ability to satisfy all criteria in order to be successful in the funding application. However, due to ethical considerations associated with data collection it was not mandated participants had to engage the national and local elements of the evaluation process. Nevertheless, potential Bight Ideas providers did need to commit to 'test and learn', although only encourage participants to complete the CMF, and be willing to work with the University of Chester.

An application form was developed (Brightlife, n.d. -a) comprising of ten questions with accompanying explanations, and a link to the Bright Ideas Guide for prospective applicants.

4.5.1 Round 1 – Spring 2016

Tenders were invited for the first round of Bright Ideas funding in Spring 2016 and applications considered using the Commissioning and Procurement Framework as previously described in section 3.5. Initially, 22 applications were reviewed by the OPA and where additional support or guidance was required applicants were directed to CWVA. Twelve bids were submitted to a further OPA panel for final decisions and from this process five projects were awarded funding totalling £45,273.

As previously reported, the Bright Ideas commissioning process was included in the overall review into commissioning (Brightlife, 2017). The review considered there was a lack of clarity on available funding levels. Moreover, information needed to be clearer in identifying funding was only available to support new, innovative or enhanced projects rather than the continuation of current projects. Consequently, the recommendations specific to Bright Ideas included:

- continue with the Bright Ideas approach, whilst making it clear that it is a competitive process

- strengthen communication with providers to support them in bidding for Brightlife funding through presentations, workshops, engagement events, marketing and briefing materials and provider support options
- provide two routes for Bright Ideas: a) Those needing further support and development and b) Those whose ideas and organisations are ready for immediate commissioning
- establish a tiered approach to funding including maximum and minimum levels of funding
- retain the option of putting a limit on potential provider's financial turnover to discourage applications from large non-local organisations
- review Business Support role with CWVA regarding working with providers in order to encourage funding applications and facilitate sustainability
- option to move high value Bright Ideas into the general commissioning process
- run an open Bright Ideas process across 12 months with 3 panels and a final end date

Utilising the test and learn approach, a revised Bright Ideas commissioning process was developed, see figure 4.

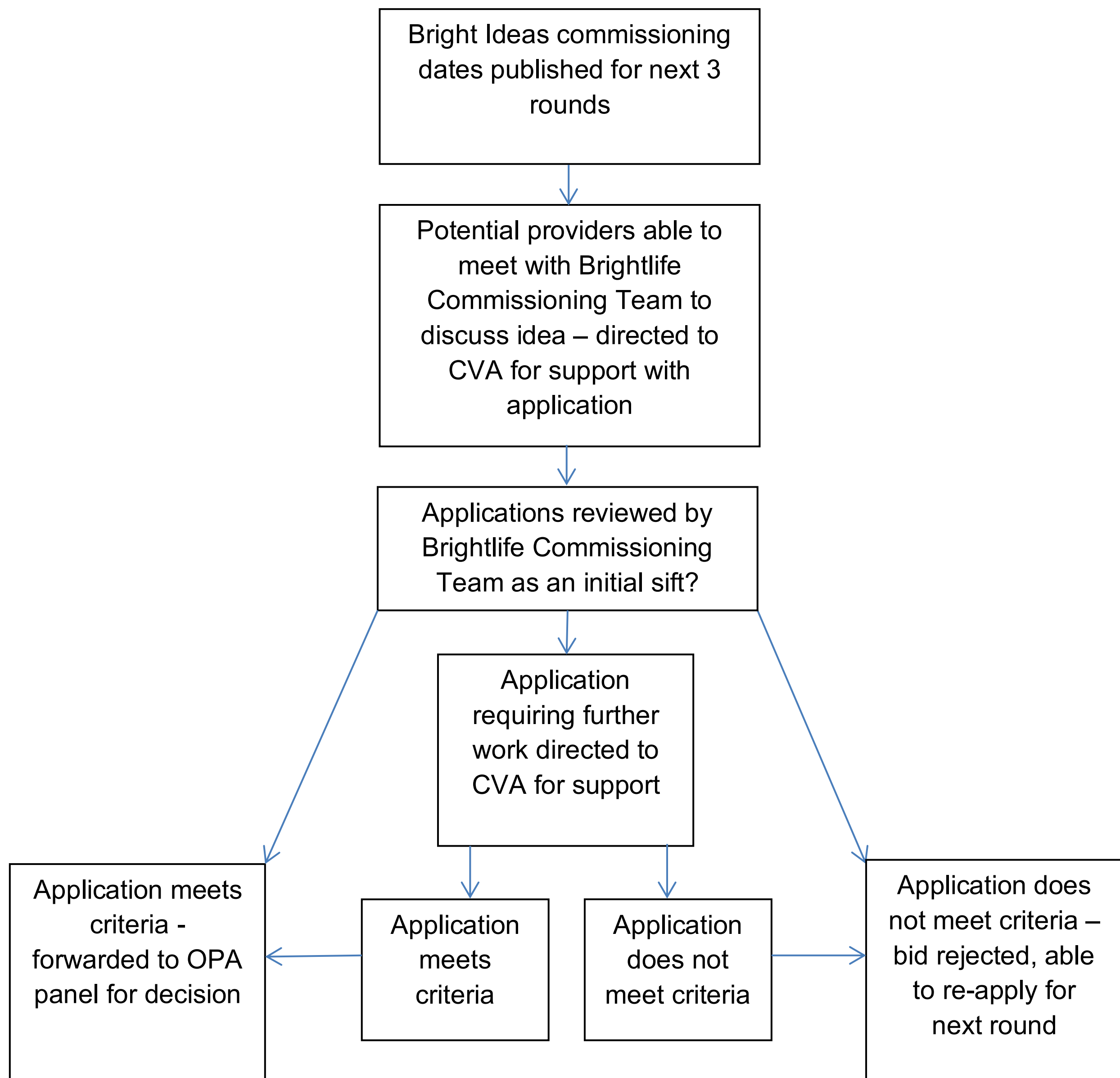


Figure 4 Revised Bright Ideas Commissioning Process

4.5.2 Round 2 – Autumn 2017

Using the revised commissioning process, funding of £238,131 was awarded to thirteen projects

In total there were 27 applications for Bright Ideas funding in Round 2. Thirteen applications were successful and 14 unsuccessful. Three of the unsuccessful applications were considered at the panel stage of selection, although not awarded funding. However, two of these projects were successful in the next round. For further information on funding decisions, see appendix 3. Eight of the 14 unsuccessful applications had consulted CWVA for advice on how to submit a successful bid. The main comments from CWVA in these instances were bids were not suitable for Brightlife and/or alternative funding streams should be explored. The organisations seeking funding were very diverse both in terms of the type of activity and the locations within Cheshire West and Chester (CWaC), see appendix 2.

4.5.3 Round 3 – Winter 2017

Funding of £148,673 was awarded to ten projects including extensions to Body Positive and Muir Housing based on performance as per the contract management arrangements and the opportunity to extend the service to new participants.

In Round 3 of the Bright Ideas funding stream eight applications were successful and six unsuccessful. The activities proposed were diverse, as was the locations in CWaC, see appendix 2. These included Senior Screen in Chester, Sharing Time in Northwich and Ellesmere Port, and a Theatre Arts Club in Neston.

4.5.4 Round 4 – Spring 2018

Funding of £121,878 was awarded to seven projects.

In this round fourteen applications were received, of which nine were successful and five unsuccessful. Comparatively to other bidding rounds, successfully funded projects were geographically spread, see appendix 2. Key aspects of the successful bids included demonstrating good levels of research in preparing the funding application, the involvement of people with lived experience, evidence of previous

fund-raising, targeting of potential participants and strategies to build relationships with wider networks such as pharmacies and GP surgeries.

Unsuccessful bids did not appear to focus sufficiently on social isolation, did not include evaluation plans, failed to demonstrate potential impact and/or lacked clear information regarding sustainability.

Over the four rounds of Bright Ideas commissioning, 35 projects were awarded funding with a total value in excess of £500,000, see appendix 2. Due to the capacity required to contract manage the number of projects already being delivered it was decided to not commission any further Bright Ideas projects after round four. Furthermore, it was considered the issues identified through the Ideas Bank and subsequent learning from project delivery were already being addressed. However, using the principles of 'test and learn' the Brightlife Partnership decided that, with a small amount of additional funding, some Bright Ideas projects could extend their offer. This led to the introduction of 'Brighter Ideas' (Brightlife, n.d. -d).

4.6 Brighter Ideas

Commissioning opportunities for Brighter Ideas funding was only available to existing or previous Bright Ideas providers and based on an agreed application criterion (Brightlife, n.d. -b). A total fund of £80,000 was available and applications invited up to a maximum of £10,000 via a competitive process.

Eligibility for funding stated potential providers had to meet the following criteria in order to apply:

- currently or previously delivering a project funded under Bright Ideas
- existing project is on track to deliver all contracted outcomes and key performance indicators (KPIs), including CMF targets
- the proposed project will deliver additional outcomes and KPIs, and reach new groups of socially isolated older people, incorporating learning from the existing project and generate additional test and learn evidence itself
- the Brighter Ideas project needed to start by 31st March 2019 and will be completed by 31st March 2020

- Funding could not be used to deliver the outcomes and KPIs associated with the existing Bright Ideas project.

Providers could not apply if

- the existing project had already been awarded additional funding to extend its work
- the existing project had already been given additional time to deliver current outcomes and KPIs

Applications were initially assessed by the Brightlife Commissioning Team and forwarded to the OPA who scored and ranked bids based on meeting the eligibility criteria. Funding was allocated starting with the highest scoring bid and working down the list until all available funding had been awarded.

4.7 Contract management of commissioned projects

Contracts awarded by Brightlife are managed through a ‘Partnership Supply Agreement’ and monitored by the Brightlife Commissioning Team. This involves:

- developing an early relationship between Brightlife and provider
- initial monthly meetings to ensure project has been established and delivering outcomes. This enables early identification of any potential issues, supports ‘test and learn’ and problem-solving
- formal quarterly monitoring meetings to review delivery against planned outcomes and agreed key performance indicators, budget allocation against actual and planned expenditure, and a project narrative to capture learning and progress
- supply of information from the Common Measurement Framework evaluation process

5 Discussion

Brightlife is a fixed-term project funded by the National Lottery Community Fund 'Ageing Better' programme to improves the lives of people aged 50 and over by addressing social isolation and loneliness within Cheshire West and Chester. It commissions local providers to design innovative solutions using a 'test and learn' approach to service delivery. Within such projects there is a need to employ a suitable and sufficient commissioning process in terms of governance, performance arrangements and transparency, yet flexible enough to deliver projects within a time limited period. Furthermore, the process should be equally accessible to small community groups and projects as well as larger more established organisations. Nevertheless, it is important to recognise the context of the specific environment in which commissioning is being undertaken, in this instance the health and social care sector and this should be carefully considered within future commissioning ventures.

Brightlife's initial bid to the National Lottery Community Fund was developed through a partnership board including potential service providers, which has the potential to maximise the levels of innovation at local level and increase opportunities for lateral working in partnership. Equally, it was recognised the possible tension between collaboration in developing the original submission and competition during subsequent commissioning rounds could have led to a conflict of interest. Therefore, following conversations between the Brightlife Partnership and the National Lottery a Partnership Commissioning Group was convened to develop a formal commissioning and procurement framework. The academic literature suggests it is important to have an awareness of traditional and developing concepts of commissioning particularly as theories are constantly being developed although practice appears to remain stable. Whilst the initial framework was developed by the Partnership Commissioning Group it will be important for subsequent commissioning strategies to reflect developing concepts as well as more traditional models.

A clear appreciation and understanding of the roles and responsibilities of different partners within partnerships is crucial. Thus, it is essential, in the setting up of projects such as Brightlife, the formal mechanisms around commissioning and how funding will

be allocated are established at the outset and the partnership has robust and transparent governance arrangements.

Following the first round of commissioning, and as part of Brightlife's test and learn approach, a full review was conducted by the Brightlife Commissioning Task and Finish Group, which led to changes to both Key Commissioning and Bright Ideas processes. Recommendations focused on the need for greater clarification around the competitive nature of the process, the requirement to strengthen communications with providers and highlight the importance of the involvement of the OPA in commissioning decisions. Again, for future reviews of the commissioning process, it would be sensible to research developing commissioning concepts to inform subsequent policies and procedures.

The literature review identifies the importance of including service-users in service development particularly in respect of empowering potential participants. One of the most valuable aspects of the Brightlife project is the engagement of older people in the design and delivery of services as well as in the decision-making part of the commissioning process. This has been discharged through the OPA who have undergone the relevant training, and have been supported by Brightlife and its partners. One key requirement of the Ageing Better programme was that older people should feel more valued by their community and the involvement of the OPA clearly illustrates the value Brightlife places on their skills, knowledge and abilities. Thus, the role of the OPA is greater than that of simply fulfilling the funding requirements of the National Lottery Community Fund. Indeed, it has been intrinsic to its overall philosophy of Brightlife. It has not only placed older people at the centre of the Brightlife project, but also resulted in establishing expectations that older people are more likely to become part of the co-design and co-production of future activities to meet their needs.

However, membership of Commissioning Panels or Boards may want to reflect a diversity of representation that includes 'commissioning professionals' and other stakeholders, notwithstanding giving due diligence to any conflicts of interest. Equally, given the potential within commissioning groups for personnel turnover, consideration may want to be given to a programme of commissioning succession planning.

The importance of effective monitoring of commissioned services was highlighted in the literature review and at the time of this report two provider contracts were terminated due to non-compliance. This is not the same as ‘test and learn’, whereby providers are able to change delivery, amend expectations and/or make other changes based on learning, although do so in close consultation with Brightlife. The monitoring and performance management of awarded contracts is a crucial part of the commissioning process and on-going support and communications between commissioners and providers will help to mitigate any problems. Nonetheless, action needs to be taken where the contract is not being delivered as agreed. The development of clear decommissioning and disinvestment procedures will assist in any disputes regarding the unsatisfactory delivery of projects by commissioned providers. The termination of contracts can be problematic but it is essential awarded contracts have clear procedures for issues of unsatisfactory performance or non-compliance. Equally, providers are aware of the consequences of a failure to deliver and commissioners act accordingly in these circumstances.

6 Recommendations for a successful funding application

In terms of recommendations it is important to highlight Brightlife developed, reviewed and adapted its Commissioning process in a considered and logical manner including elements of good practice as identified through the literature review such as:

- Involvement of local providers in developing the original funding submission to the National Lottery Community Fund and identifying potential services to reduce social isolation and loneliness for older people in Cheshire West and Chester
- Recognised a potential for a conflict of interest between stakeholders who helped scope the early specifications for delivery and subsequent bids for funding, so developed a commissioning framework and introduced commissioning governance arrangements
- Through the OPA put older people, not only at the centre of its commissioning process, but also the project overall

- Reviewed the original commissioning process and introduced changes based on 'test and learn'
- Commissioned a mixture of Key Commissions, Bright Ideas and Brighter Ideas based on local needs
- Terminated two projects due to poor performance
- Have on-going commissioning monitoring arrangements

For all intents and purposes Brightlife has ceased commissioning activity other than the on-going project monitoring for commissioned services already being delivered. Therefore, the recommendations from this report are for consideration for future commissioning thinking and development in a way that complements the approach taken by Brightlife or adds further knowledge based on academic literature and from the benefit of hindsight by reflecting on past practice to inform future delivery.

In summarising the National Lottery Community Fund specifications for Ageing Better, the principle requirements were:

Reduced social isolation amongst older people, achieved in a process that engaged the views and participation of older people in determining what activities/services were to be provided. Equally, older people should feel more valued by the community. The projects were to be community-led, either working in partnership with established organisations or utilising local providers. The benefits of projects were to continue after funding ended.

When assessing the features of successful funding applications to Brightlife it is possible to identify a list of the top ten elements required for being awarded funding.

Top ten tips for winning Brightlife funding for community projects

1. Ensure a focus on socially isolated older people
2. Demonstrate an ability to recruit socially isolated older people
3. Conduct thorough research as part of the application and verify local need
4. Offer innovative projects, including targeting of previously uncatered for individuals/groups
5. Provide evidence of established links with local organisations and knowledge of the local community

6. Clarify the actions required to ensure sustainability
7. Outline the process by which evaluation procedures will be undertaken
8. Highlight working with volunteers and how training will be delivered
9. Deliver an enthusiastic presentation demonstrating commitment and passion
10. Ensure all the required information is provided in the application.

Top ten tips when commissioning a service(s)

1. Tender specifications need to make explicit the objectives of the programme e.g. reducing social isolation in the over 50s
2. Key terms need to be clearly defined e.g. how is social isolation defined
3. Commissioning arrangements need to support and encourage smaller providers to participate in the bid process
4. Involve people with lived experience to ensure commissioned services reflect need and are appropriate for the target group
5. Clear insight needed into the local area and recognise different localities can have different requirements i.e. one size does not fit all
6. An ability for the commissioning process to be modified over time to reflect feedback and learning from previous experiences
7. Support for writing a successful bid is essential, smaller potential providers may not have the capacity or expertise to write a bid
8. Once commissioned, robust monitoring of the implementation of the contract should be in place and support provided if needed
9. Clawback procedures for non-implementation of the contract should be made explicit in the bid process and action taken if required
10. Effective marketing of the programme to ensure it is advertised widely thus attracting a broadest range of potential providers

Content Analysis References

Brightlife. (n.d.-a). Bright Ideas Application Form. http://www.brightlifecheshire.org.uk/wp-content/uploads/Brightlife_Bright_Ideas_campaign_application_form_V3.pdf

Brightlife. (n.d.-b). Brighter Ideas Application Form. Brightlife Internal Report. Unpublished.

Brightlife. (n.d.-c). Bright Ideas Guidance. http://www.brightlifecheshire.org.uk/wp-content/uploads/Brightlife_Bright_Ideas_guide_V4.pdf

Brightlife. (n.d.-d). Brighter Ideas Guide. Brightlife Internal Report. Unpublished.

Brightlife. (n.d.-e). *Commissioning and Procurement Framework.* Brightlife Internal Report. Unpublished.

Brightlife. (2018a). *Dementia, social isolation and loneliness in Winsford and Chester.* Brightlife Internal Report. Unpublished.

Brightlife. (2018b). *Interim Report.* Brightlife Internal Report. http://www.brightlifecheshire.org.uk/wp-content/uploads/Brightlife_Interim_report_24pp_v8.pdf

Brightlife. (2017). Proposal for Brightlife Commissioning, Partnership Board Paper. Brightlife Internal Report. Unpublished.

Brightlife. (n.d.-f). *Review of the Commissioning and Bright Ideas.* Brightlife Internal Report. Unpublished.

Bryman. A. (2012). *Social Research Methods.* (4th ed.). Oxford, United Kingdom: Oxford University Press.

Literature Review References

Addicott, R. (2016). Challenges of commissioning and contracting for integrated care in the National Health Service (NHS) in England. *Aust J Prim Health, 22*(1), 50-54. doi:10.1071/py15067

Allen, P., Osipovic, D., Shepherd, E., Coleman, A., Perkins, N., Garnett, E., & Williams, L. (2017). Commissioning through competition and cooperation in the English NHS under the Health and Social Care Act 2012: evidence from a qualitative study of four clinical commissioning groups. *BMJ Open, 7*(2), e011745. doi:10.1136/bmjopen-2016-011745

Bach-Mortensen, A. M., & Montgomery, P. (2018). What are the barriers and facilitators for third sector organisations (non-profits) to evaluate their services? A systematic review. *Syst Rev, 7*(1), 13. doi:10.1186/s13643-018-0681-1

Bovaird, T. (2016). The ins and outs of outsourcing and insourcing: what have we learnt from the past 30 years? *Public Money & Management, 36*(1), 67-74. doi:10.1080/09540962.2015.1093298

Bovaird, T., Briggs, I., & Willis, M. (2014). Strategic Commissioning in the UK: Service Improvement Cycle or Just Going Round in Circles? *Local Government Studies, 40*(4), 533-559. doi:10.1080/03003930.2013.805689

Cameron, A., Brangan, E., Gabbay, J., Klein, J. H., Pope, C., & Wye, L. (2018). Discourses of joint commissioning. *Health Soc Care Community, 26*(1), 65-71. doi:10.1111/hsc.12462

Checkland, K., Dam, R., Hammond, J. O. N., Coleman, A., Segar, J., Mays, N., & Allen, P. (2017). Being Autonomous and Having Space in which to Act: Commissioning in the 'New NHS' in England. *Journal of Social Policy, 47*(2), 377-395. doi:10.1017/S0047279417000587

Checkland, K., McDermott, I., Coleman, A., & Perkins, N. (2016). Complexity in the new NHS: longitudinal case studies of CCGs in England. *BMJ Open, 6*(1), e010199. doi:10.1136/bmjopen-2015-010199

Checkland, K., Segar, J., Voorhees, J., & Coleman, A. (2015). 'Like a Circle in a Spiral, Like a Wheel within a Wheel': The Layers of Complexity and Challenge for Devolution of

Health and Social Care in Greater Manchester. *Representation, 51*(4), 453-469. doi:10.1080/00344893.2016.1165514

Cheetham, M., Van der Graaf, P., Khazaeli, B., Gibson, E., Wiseman, A., & Rushmer, R. (2018). “It was the whole picture” a mixed methods study of successful components in an integrated wellness service in North East England. *BMC Health Serv Res, 18*(1), 200. doi:10.1186/s12913-018-3007-z

Coleman, A., Checkland, K., Segar, J., McDermott, I., Harrison, S., & Peckham, S. (2014). Joining it up? Health and Wellbeing Boards in English Local Governance: Evidence from Clinical Commissioning Groups and Shadow Health and Wellbeing Boards. *Local Government Studies, 40*(4), 560-580. doi:10.1080/03003930.2013.841578

Coleman, A., Segar, J., Checkland, K., McDermott, I., Harrison, S., & Peckham, S. (2015). Leadership for health commissioning in the new NHS. *Journal of Health Organization and Management, 29*(1), 75-91. doi:http://dx.doi.org/10.1108/JHOM-04-2013-0075

Croft, C., Currie, G., & Staniszewska, S. (2016). Moving from rational to normative ideologies of control over public involvement: A case of continued managerial dominance. *Social Science & Medicine, 162*, 124-132. doi:https://doi.org/10.1016/j.socscimed.2016.06.010

Dickerson, E., Fenge, L. A., & Rosenorn-Lanng, E. (2017). The impact of leadership development on GP mental health commissioning. *Leadersh Health Serv (Bradf Engl), 30*(3), 343-351. doi:10.1108/lhs-09-2016-0046

Dickerson, J., Bird, P. K., Bryant, M., Dharni, N., Bridges, S., Willan, K., Ahern, S., Dunn, A., Nielsen, D., Uphoff, E., P., Bywater, T., Bowyer-Crane, C., Sahota, P., Small, N., Howell, M., Thornton, G., Pickett, K., E., McEachan, R., R., C. & Wright, J. (2019). Integrating research and system-wide practice in public health: lessons learnt from Better Start Bradford. *BMC Public Health, 19*(1), 260. doi:10.1186/s12889-019-6554-2

Gadsby, E. W., Peckham, S., Coleman, A., Bramwell, D., Perkins, N., & Jenkins, L. M. (2017). Commissioning for health improvement following the 2012 health and social care reforms in England: what has changed? *BMC Public Health, 17*(1), 211. doi:10.1186/s12889-017-4122-1

Garnett, E., Baeza, J., Trenholm, S., Gulliford, M., & Green, J. (2018). Social enterprises and public health improvement in England: a qualitative case study. *Public Health, 161*, 99-105. doi:10.1016/j.puhe.2018.04.019

Hamilton-West, K., Gadsby, E., Zaremba, N., & Jaswal, S. (2019). Evaluability assessments as an approach to examining social prescribing. *Health Soc Care Community*. doi:10.1111/hsc.12726

Hammond, J., Coleman, A., & Checkland, K. (2018). Enacting localist health policy in the English NHS: the 'governing assemblage' of Clinical Commissioning Groups. *J Health Serv Res Policy, 23*(1), 49-56. doi:10.1177/1355819617739039

Krachler, N., & Greer, I. (2015). When does marketisation lead to privatisation? Profit-making in English health services after the 2012 Health and Social Care Act. *Social Science & Medicine, 124*, 215-223. doi:https://doi.org/10.1016/j.socscimed.2014.11.045

Lipman, V. (2015). Contracts and commissioning: what's happening to social care services for black and minority ethnic older people. *Working with Older People: Community Care Policy & Practice, 19*(2), 85-93. doi:10.1108/WWOP-09-2014-0028

McDermott, I., Checkland, K., Coleman, A., Osipovič, D., Petsoulas, C., & Perkins, N. (2017). Engaging GPs in commissioning: realist evaluation of the early experiences of Clinical Commissioning Groups in the English NHS. *J Health Serv Res Policy, 22*(1), 4-11. doi:10.1177/1355819616648352

Moran, V., Allen, P., McDermott, I., Checkland, K., Warwick-Giles, L., Gore, O., Bramwell, D. & Coleman, A. (2017a). How are clinical commissioning groups managing conflicts of interest under primary care co-commissioning in England? A qualitative analysis. *BMJ Open, 7*(11), e018422. doi:10.1136/bmjopen-2017-018422

Moran, V., Checkland, K., Coleman, A., Spooner, S., Gibson, J., & Sutton, M. (2017b). General practitioners' views of clinically led commissioning: cross-sectional survey in England. *BMJ Open, 7*(6), e015464. doi:10.1136/bmjopen-2016-015464

Morris, R., Kirk, S., Kennedy, A., Vassilev, I., Mathieson, A., Jeffries, M., Blickem, C., Brooks, H., Sanders, C. and Rogers, A. (2015). Connecting local support: A qualitative

study exploring the role of voluntary organisations in long-term condition management. *Chronic Illn, 11*(2), 140-155. doi:10.1177/1742395314551098

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-1251.

O'Shea, A., Chambers, M., & Boaz, A. (2017). Whose voices? Patient and public involvement in clinical commissioning. *Health Expectations, 20*(3), 484-494. doi:10.1111/hex.12475

Osipovič, D., Allen, P., Shepherd, E., Coleman, A., Perkins, N., Williams, L., Sanderson, M and Checkland, K. (2016). Interrogating Institutional Change: Actors' Attitudes to Competition and Cooperation in Commissioning Health Services in England. *Public Administration, 94*(3), 823-838. doi:10.1111/padm.12268

Pescheny, J. V., Pappas, Y., & Randhawa, G. (2018). Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. *BMC Health Serv Res, 18*(1), 86. doi:10.1186/s12913-018-2893-4

Petsoulas, C., Allen, P., Checkland, K., Coleman, A., Segar, J., Peckham, S., & McDermott, I. (2014). Views of NHS commissioners on commissioning support provision. Evidence from a qualitative study examining the early development of clinical commissioning groups in England. *BMJ Open, 4*(10), e005970. doi:10.1136/bmjopen-2014-005970

Petsoulas, C., Peckham, S., Smiddy, J., & Wilson, P. (2015). Primary care-led commissioning and public involvement in the English National Health Service. Lessons from the past. *Prim Health Care Res Dev, 16*(3), 289-303. doi:10.1017/s1463423614000486

Rees, J. (2014). Public sector commissioning and the third sector: Old wine in new bottles? *Public Policy and Administration, 29*(1), 45-63. doi:10.1177/0952076713510345

Rees, J., Miller, R., & Buckingham, H. (2016). Commission incomplete: exploring the new model for purchasing public services from the third sector. *Journal of Social Policy, 46*(1), 175-194. doi:10.1017/S0047279416000362

Reidy, C., Kennedy, A., Pope, C., Ballinger, C., Vassilev, I., & Rogers, A. (2016). Commissioning of self-management support for people with long-term conditions: an exploration of commissioning aspirations and processes. *BMJ Open, 6*(7), e010853. doi:10.1136/bmjopen-2015-010853

Rooshenas, L., Owen-Smith, A., Hollingworth, W., Badrinath, P., Beynon, C., & Donovan, J. L. (2015). “I won't call it rationing…”: An ethnographic study of healthcare disinvestment in theory and practice. *Social Science & Medicine, 128*, 273-281. doi:https://doi.org/10.1016/j.socscimed.2015.01.020

Sanders, T., Grove, A., Salway, S., Hampshaw, S., & Goyder, E. (2017). Incorporation of a health economic modelling tool into public health commissioning: Evidence use in a politicised context. *Social Science & Medicine, 186*, 122-129. doi:https://doi.org/10.1016/j.socscimed.2017.06.011

Smith, J., Wistow, G., Holder, H., & Gaskins, M. (2019). Evaluating the design and implementation of the whole systems integrated care programme in North West London: why commissioning proved (again) to be the weakest link. *BMC Health Serv Res, 19*(1), 228. doi:10.1186/s12913-019-4013-5

Warwick-Giles, L., Coleman, A., & Checkland, K. (2016). Co-owner, service provider, critical friend? The role of public health in clinical commissioning groups. *J Public Health (Oxf), 38*(4), 633-634. doi:10.1093/pubmed/fdv137

Warwick-Giles, L., Coleman, A., & Checkland, K. (2017). Making Sense of Inequalities: How Do Clinical Commissioning Groups in England Understand their New Role? *Social Policy & Administration, 51*(7), 1231-1247. doi:10.1111/spol.12227

Wilson, P. M., Farley, K., Bickerdike, L., Booth, A., Chambers, D., Lambert, M., Thompson, C., Turner, R. & Watt, I. S. (2017). Does access to a demand-led evidence briefing service improve uptake and use of research evidence by health service commissioners? A controlled before and after study. *Implement Sci, 12*(1), 20. doi:10.1186/s13012-017-0545-4

Wye, L., Brangan, E., Cameron, A., Gabbay, J., Klein, J. H., Anthwal, R., & Pope, C. (2015a). What do external consultants from private and not-for-profit companies offer

healthcare commissioners? A qualitative study of knowledge exchange. *BMJ Open, 5*(2), e006558-e006558. doi:10.1136/bmjopen-2014-006558

Wye, L., Brangan, E., Cameron, A., Gabbay, J., Klein, J. H., & Pope, C. (2015b). Evidence based policy making and the 'art' of commissioning - how English healthcare commissioners access and use information and academic research in 'real life' decision-making: an empirical qualitative study. *BMC Health Serv Res, 15*, 430. doi:10.1186/s12913-015-1091-x

Appendix 1 – Key Commissions

Details of specific funding can be accessed Brightlife Legacy Report at

http://www.brightlifecheshire.org.uk/wp-content/uploads/Brightlife-end-of-project-report-Low-Res.pdf

Key Commissions Round 1 – December 2015 - October 2016

Organisation	Activity
Cheshire West Voluntary Action	Chester Asset Mapping
Cheshire West Voluntary Action	Business Support
Community Compass	Social Activity Malpas
Community Compass	Social Activity Winsford
Cheshire Wildlife Trust	Malpas Great Outdoors
Retain Wellbeing CIC	New Beginnings
Royal Voluntary Service	Buddy Scheme
Here and Now Chester	Digital Buddies

Key Commissions Round 2 – October 2016 - January 2019

Organisation	Activity
Workers' Educational Assoc	The Arts of Ageing
Community Compass	Share Club
Age UK Cheshire	Winsford Super Shed
Cheshire & Warrington Carers Trust	Bright Memories
Cheshire Community Development Trust	Buddying and Befriending Scheme
Listening Ear	Men's Mental Health
Cheshire & Warrington Carers Trust	Connecting Carers
Neuromuscular Centre	Connect Up

Appendix 2 – Bright Ideas

Bright Ideas Round 1 – Spring 2016

Organisation	Activity
Abbot's Wood	Digital Peer Training
Muir Housing	Brighter Days
Older People Active Lives (OPAL)	New Horizons
OPAL	What's Cooking
Body Positive	Silver Rainbows

Bright Ideas Round 2 – Autumn 2017

Organisation	Activity
LIVE!	Bridging the Gap
Cheshire and Warrington Race and Equality Centre	CommUnity Kitchen
Holy Trinity Church	Blacon on the Move
The Welding Academy	Fabweld 50+
Flatt Lane and Stanney Grange Community Centre	– Lite Bites Lunch Club
Active Cheshire	Sporting Memories
Cheshire Deaf Society / Deafness Support Network	Sparkle Cafe
Cheshire Wildlife Trust	Create For Nature
Vision Support	Vision Supported Communities
Groundwork Cheshire Lancashire and Merseyside	Growing Connections
MHA Ellesmere Port and Neston Live at Home Scheme	Not Ready Yet
Motherwell Cheshire CIO	Bright Stars
The Neuromuscular Centre, Cheshire Centre for Independent Living, Cheshire and Warrington Carers Trust	Read and Connect

Bright Ideas Round 3 – Winter 2017 funding

Organisation	Activity
The Conservation Volunteers	Young and Green at Heart
Bright Lights Theatre Company	Neston Theatre Art Club
EPNAVCO	Lively Lunchtime
Vicars Cross Community Centre	Senior Screen
Heal Earth	Women Makers Fab Club 50+
Age UK Cheshire	Sharing Time
Listening Ear	Fab Cheshire West
DIAL West Cheshire	Dial House "T" Club
Body Positive	Silver Rainbows
Muir Housing	Brighter Days

Bright Ideas Round 4 – Spring 2018

Organisation	Activity
The Reader	Brightening Lives with Shared Reading
Snow Angels	Happy Mondays
Malpas Cancer Friends	
Haylo Theatre	Gather Together
We Embrace CIC	Caring Companions Cheshire
Bridge Wellness Gardens	Better Lives Club for over 50s
Cheshire Agricultural Chaplaincy	Meet and Eat

Appendix 3 – information on successful and unsuccessful Bright Ideas funding bids

Bright Ideas funding round	Successful	Unsuccessful
Round 2	• Intergenerational projects (3) • Working with groups who traditionally are hard to reach or not catered for e.g. ethnic minorities, men aged 50 to 65, people with vision or hearing difficulties, those socially isolated in rural areas (7) • Proven track record of working in this field (3) • Thorough research (5) • Sustainability clearly shown (4) • Provision of transport to the activity (3)	• Failure to demonstrate how the participants fit the Brightlife criteria either in terms of age or social isolation (4) • Evaluation plans were not appropriate (4) • Recruitment relied on using referrals from existing Brightlife projects (4) • Sustainability plans were unclear (2)
Round 3	• Ability to recruit socially isolated older people (4) • Research that demonstrated local need (3) • Established links with local organisations or knowledge of the community (4) • Good use of volunteers (2) • A good sustainability plan (1)	• Not giving good value for money (2) • Lack of research to demonstrate feasibility or projected participant numbers (2) • Weak sustainability plan (2) • Insufficient focus on social isolation or on the over 50 age group (6) • Insufficient evidence of how the CMFs would be administered (2)
Round 4	• Clear links with social isolation • Skills to engage with target audience clearly demonstrated • Innovative projects targeting groups that had not been previously catered for e.g. farmers and those with learning difficulties	• Insufficient focus on social isolation (2) • Lack of evaluation plans (1) • Length of intervention too short to have impact (2) • Sustainability insufficiently considered (3) • Recruitment from existing Brightlife providers (1)

Appendix 4 – Expanded Literature Review Methodology

A literature review was conducted between April and August 2019 to investigate evidence of best practise of health and social care related commissioning across public, private and third sector actors, as evidenced in academic literature. As this is a literature review and not a full systematic review or meta-analysis, a basic version of the PRISMA guidelines were followed:

- Identification
- Screening
- Eligibility Assessment
- Appraisal and Synthesis

Inclusion Criteria

The following limits were used:

- Date range: date limits of publication were set from January 2014 to May 2019 for threefold reasons; to investigate the latest research in a quickly changing field, to extrapolate academic research directions regarding commissioning during the lifetime of the Brightlife Project, and to contextualise literature in the aftermath of commissioning changes following the Health and Social Care Act of 2012.

- Location limits: geographic limits were placed on research study area of articles; only articles regarding England were included, as commissioning practices and policy vary across the different nations of the UK (for commentary articles covering background, the general term 'UK' was permitted).

- Source Type: sources were restricted to peer-reviewed journal articles, as the aim was to see how commissioning was being investigated and presented in academic literature.

Sources

Database and snowball searches were planned out and conducted from 8th April to 31st May 2019.

The following journal databases were searched:

- Cinahl
- Cochrane
- Emerald insight
- Evidently Cochrane
- Medline
- Proquest
- Pubmed
- Science Direct (Elsevier)
- SocIndex
- Web of science
- Wiley
- Zetoc

When searching, date limits (January 2014 to May 2019) were set using advanced search options. Where the option was available, searches were also restricted to articles only (this feature depended on search criteria options of each database, so was not always possible).

Discipline specific and more general databases were searched in an attempt to gauge cross-discipline research and evidence linked to commissioning practices (i.e., not solely from a clinical perspective).

A 'snowball' approach was also utilised whereby relevant articles reference lists were hand searched to highlight further potential inclusions.

As the search progressed, it was observed that the articles were tending towards a clinical / health sector focus. In response, a further focussed search of 21 social policy related journals was conducted.

Search Terminology

The following search terms were used:

- Social Commission*
- Social & Commission*
- Practice & Commission*
- Public & Social & Commission*
- Private & Social & Commission*
- Third & Social & Commission*
- Voluntary & Social & Commission*
- Public Sector & Social & Commission*
- Private Sector & Social & Commission*
- Third Sector & Social & Commission*
- Voluntary Sector & Social & Commission*

In databases where the truncation function asterisk (*) was not available, combinations of stem word terminations were used instead, i.e., Commission, Commissions, Commissioning, and Commissioner.

When searching journals and databases which did not have a health / social care focus (e.g., general government policy related journals), the terms ‘health’, ‘elderly’ and ‘older people’ were appended to search terms to try to achieve better relevancy of search results.

Screening and Eligibility Assessment

Endnote X9 was used to compile results.

Following the principles set out in the data compilation process outlined in section X, and following the removal of duplicates, 254 data sources were collected. These were processed to remove any sources which were not peer reviewed articles (reports, grey literature, conference abstracts, editorials, letters, non-academic journal articles).

Articles without full text access were then excluded, leaving 153 peer reviewed articles with full text access (i.e., able to be reviewed).

These articles were subjected to preliminary screening. Abstracts were used to split the articles into 5 categories:

A- Very relevant (e.g., article focussed on commissioning)
B- Moderately relevant (e.g., commissioning not focus, but prominent link / key word related)
C- Tangentially relevant (e.g., background or contextual material)
R- Systematic Review / Meta Analyses

X- No relevance to review (i.e., on closer inspection does not fit inclusion criteria)

After categorisation, categories B and R were reassessed, and articles were either rejected or added to category A, giving a total of 60 articles.

The abstracts of the 61 articles in this amended category A were then assessed for eligibility against the inclusion criteria and key aims of the review. This examination gave rise to 42 relevant articles, which were taken forward for whole text appraisal.

Appraisal Tool

As the search aimed to find practice with regards to multiple sectors (public, private, third), journals fell into multiple disciplines, making many commonly used clinical article appraisal tools inadequate to capture the full range of sources. For this reason, an adapted version of the Standards for Reporting Qualitative Research (SRQR) was used (O'Brien, Harris, Beckman, Reed & Cook 2014) to check the 34 articles included in the review.

Article Appraisal

Data gathering, appraisal, review and synthesis was conducted intermittently between June and August 2019.

Using the Appraisal Tool, articles were appraised and synthesised into tabular form.

Methodological Limitations

- The following systemic limitations are acknowledged:
- Experience level of researcher (early career researcher)
- Search limited to sources / databases available through the University of Chester subscriptions (i.e., no access to articles hosted by databases or publishers to whom Chester University Library has no subscription)
- Inclusions based on full text articles available through Chester Library Services, or through online open access (i.e., exclusion of articles which were under embargo, or for which only abstracts or citations available)