GAIN WITHOUT PAIN:

how the voluntary sector can help deliver the social care agenda for people with disabilities

The Voluntary Organisations Disability Group (VODG)

The VODG is the leading umbrella group of voluntary sector providers of social care services for adults with disabilities. Our members' shared aim is to ensure that people with disabilities are supported in ways that they themselves define. We are committed to personalisation and the principle of "no decisions about me, without me".

Our ambition is to shape the development of social care policy, to influence its implementation and to provide sector leading information and research.

VODG members believe that meaningful engagement and fair negotiation between commissioners and providers, focused on the needs of people who rely on social care services, helps build strategic relationships, enhances service design and is more likely to ensure that beneficial outcomes and efficiencies are achieved.

If you're passionate about delivering services that people with disabilities want and are keen to have an influence and say in the wider sector then why not join us?

www.vodg.org.uk

Foreword

As we continue to deliver major transformation of social care in this country, working with people as citizens, and not passive recipients, linking our offer to the places and communities in which citizens live, rather than ignoring the role of community support, we are also learning that collaboration is crucial to getting the most from the capacity that exists and getting best use from the resources that are available.

The leadership task in times of significant change is firstly to engage in conversation and accept that no one on their own has the answers to the challenges we face. Failure to seek collaborative and shared options means we don't effectively engage partners as stakeholders and we exclude both the perspectives they have on possible solutions but also the resources, contribution and commitment they can bring. This is true whether we fail to effectively involve citizens, communities, providers, front line staff or partners and in times of reducing resource and increasing demand we will fail in our shared task of doing more with less, but as importantly, doing something different which reforms our system of care and support.

ADASS welcomes VODG's report and underlines the need for mature collaboration between commissioners and providers which supports effective market intelligence and the development of a vibrant market offer which provides choice for individual citizens but also offers quality, flexibility and innovation. Commissioners need to reinvent themselves as shapers of markets but also acknowledge that innovation comes from providers and a shared focus on listening to what citizens want in order to live their lives and achieve the outcomes they want.

The journey we are on in terms of transformation is a shared enterprise and requires all of us to collaborate and learn if we are to achieve reform and avoid retrenchment, more of the same will not work.

Richard Jones
President
Association of Directors of Adult Social Services

Introduction

Social care faces the toughest challenge of its short history: how to meet rapidly rising demand for better, more imaginative services when the prospects for public spending are bleak. Disabled people will not only feel the squeeze on benefits announced by the Chancellor of the Exchequer, George Osborne, in his first budget, but the services on which many of them depend are bracing themselves for a major reduction in Government expenditure.

Local government clearly expects to share the burden of these cuts over the period 2011-2015 and public sector leaders recognise that they need to both prune existing services and re-design them. The danger, as the think tank Demos suggested, is that the tendency may well be to carry on doing the same things more cheaply and on a smaller scale, saving money initially but piling up problems for the future as demand gets delayed rather than reduced. PricewaterhouseCoopers have observed that councils need to invest in evidence-based early intervention or preventive programmes for adults and children but that:

"Too much is wasted on projects that add little value. The risk, however, is that we see an increase in slash and burn approaches to cost-cutting which is rather like turning off the tap rather than fixing the leak. As a result we may make the savings targets in the short-term but we are banking up a whole load of debt further down the line."[1]

But there are alternatives, as this report commissioned by the Voluntary Organisations Disability Group (VODG) from the Institute of Public Care (IPC), hopes to demonstrate.

This government is no less eager than the last to spread the gospel of personalisation and it is an unprecedented opportunity to unleash the creative talents of the voluntary sector. The demographics indicate a near doubling in the number of over-80s in the next 20 years, while the number of people with physical or learning disabilities who may need care are likely to rise by 10 - 15%.   Services will have to be radically rethought.

Putting people's needs at the heart of commissioning and rewriting the services manual from scratch can achieve remarkable results, as the case studies published here clearly demonstrate. It can increase the independence of service users, ensure more personalised care and support, and save money at the same time. What the case studies have in common is the innovation and expertise of the voluntary sector in working with commissioners, users and their communities to bring about inspired and cost-effective change.

The charities featured are all members of the Voluntary Organisations Disability Group. Our examples include living support networks, facilitated by the charity KeyRing, in which a volunteer assists a group of people with learning disabilities as they gain the confidence to live more independently, build links with their neighbourhoods, and help one another. Another example is the move away from day centres towards services promoting independence in Derbyshire, where the county council has brought in the charity MacIntyre to establish local skills development hubs because service users asked for help to make themselves employable.

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[1]*Amanda Kelly, lead social care partner at PricewaterhouseCoopers, cited in Community Care at http://www.communitycare.co.uk/Articles/2010/06/25/114798/councils-must-transform-not-slash-services-to-meet-cuts.htm*

These case studies, like the others, exemplify the particular qualities that the voluntary sector can offer to commissioners willing to engage in a constructive dialogue with them. They are the added value of volunteers, of long-term investment and occasional financial contributions sometimes from the organisations' own resources, the ability "to do what it takes" for service users flexibly and without unnecessary bureaucracy, and the expertise, enthusiasm and flair that are the hallmark of the sector. Equally distinctive is the role of service users themselves, where those who offer help are frequently also those who receive it.

The other quality brought out by the case studies has an all-too-contemporary feel. All the case study charities were very conscious of funding pressures: for example, KeyRing calculated that their model can equate to a 25% cost reduction on the standard alternatives, while MacIntyre has been able to make efficiency savings of £100,000 a year in Derbyshire. Savings are reported in other case studies too.

Two years ago the Department of Health produced its report "The Case for Change," in which it predicted a £6 billion funding shortfall in social care by 2028 for the same services as people get now. The new government has appointed an independent commission to consider how best to fund long-term care, but any concerted attempt to plug the funding gap may have to wait until the next parliament even though action will be needed sooner rather than later.

The voluntary sector is well placed to help public services achieve efficiencies in a much shorter timescale. However, as this report argues, this will depend on a range of factors:

- **Improving knowledge:** The joint strategic needs assessment to date has been largely a missed opportunity to develop a vision of demand in local communities and too frequently has left the voluntary sector out in the cold. As the Office of Government Commerce has said, voluntary groups may have links to the community that cast light on how best to meet the needs of particular user groups.

- **Changing commissioner-provider relationships:** Our case studies show that successful service transformation and efficiency savings depend on commissioners and providers working together. This still happens all too rarely, despite clear evidence that the greatest hope of more personalised outcomes for service users is that collaboration between commissioners and providers replaces the antagonisms of the past. The alternative is inflexible, ill-informed provision which benefits nobody.

- **Getting personalisation right:** Personal budgets are only the start. The culture of social services has to change too, providing an infrastructure of support, market development and new styles of commissioning. Some of the more innovative providers may need additional support. Without greater business certainty markets will shrink and user choice will suffer.

- **Demonstrating efficiencies:** The most cost-effective models of service delivery are often found when commissioners, service users and providers work together to share their expertise. Value for money usually requires a spirit of trust and openness on all sides. Squeezing price or sudden cuts are not always compatible with quality and choice. Some cost-efficiencies require time, and occasionally investment, to materialise but are the more sustainable in consequence.

These measures will have to be coupled with the drive towards local integration of services, reducing duplication and itself stimulating commissioners and providers to think afresh about what they are doing. National and local leadership is imperative. In its report this year on the latest government-sponsored integration programme, Total Place, the Treasury said that encouraging agencies to put service users centre stage had "helped open the door for local partnerships to discover what can be done to improve the system" and "meant looking for new ways of cooperation, at local level and between local level and Whitehall."

To reduce the costs of more intensive care, prevention and early intervention have been identified as approaches to improve the system. Yet, the concept of prevention remains vague, often unproven and with uncertainty about what interventions at what point are most likely to deliver a successful outcome. However, if front-line health and care services are to be afforded long-term, it will be essential to cut off demand and reduce the period of morbidity prior to death. This will mean a greater emphasis on community-based health improvement programmes which the voluntary sector are well placed to provide.

The financial crisis has made it imperative to find new ways of working. Even if the basis of adult social care funding changes and individuals contribute more of their own money, the potential for partnerships with the voluntary sector to take a creative, more cost-effective approach to services will remain important. Some of our case studies illustrate how the sector can help regenerate mutual help within communities, one of the ideas behind the government's Big Society programme. Others show that what matters is not the volume of provision, but positive outcomes for service users. And, despite the frightening pace of demand, they show that through improved contracting and a tighter focus on community-based provision, it is still possible to save money. Gain can be achieved without pain.

Bill Mumford
Chairman
Voluntary Organisations Disability Group

PAIN

The Demographic challenge – increasing demand

In 2009 birth and death rates overtook immigration as the biggest population growth factor in the UK since 2001, with the population growing by 2 million during that period. The population is expanding at 0.7% per annum, double the rate of the 1990s and triple the rate of the 1980s[2]. The fertility rate is the highest since the 1970s[3], and the mortality rate the lowest ever recorded[4].

The challenges presented by a decreasing mortality rate[5] - or people living longer - have been well documented in recent years[6]. Increased demand for social care and housing has received greatest attention, but all services and benefits that an older population are eligible for are likely to be stretched.

Older people

Chart 1 shows the predicted increase in the population over the next 20 years. In 10 years time it is likely that there will be over 2 million more people over the age of 65 than at present, with a further 2 million predicted by 2030.

Chart 1: Predicted change in population from 2010 to 2030
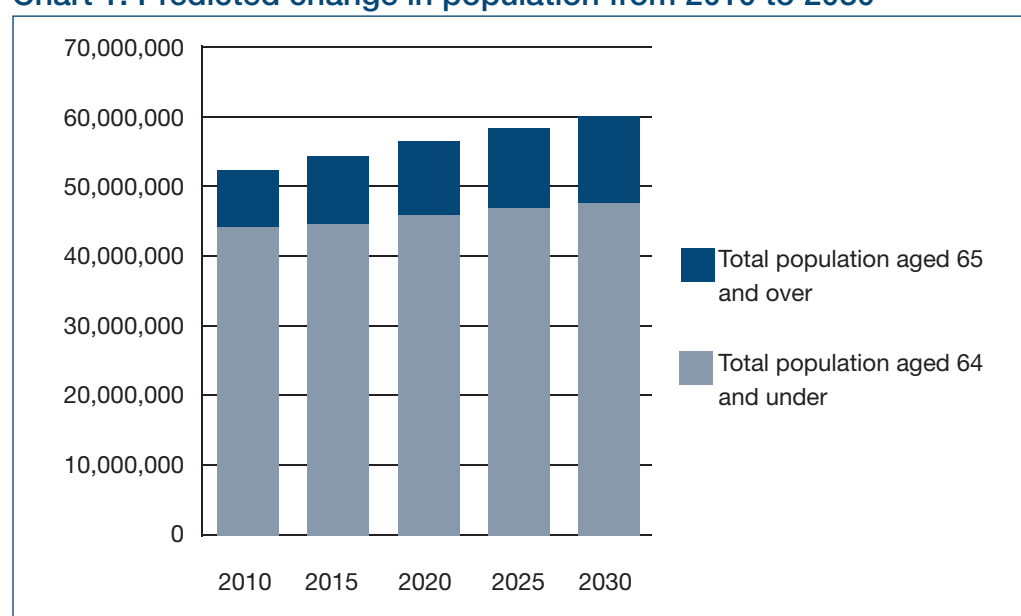
Source: poppi.org.uk and pansi.org.uk

Chart 2 shows the percentage increase in population over the next 20 years for different ages. As might be expected from the decreasing mortality rate, there is a substantial rise in those surviving to age 80 and above. The total population of England is predicted to rise by 15% over the 20 year period, and yet the increase in those aged 80 and older is predicted to rise by 83%. By 2030 there will be a total of nearly 4.4 million older people over the age of 80, an increase of over 2 million on today's figure.

[2] See http://www.statistics.gov.uk/cci/nugget.asp?ID=950
[3] See http://www.statistics.gov.uk/cci/nugget.asp?ID=951
[4]See http://www.statistics.gov.uk/cci/nugget.asp?id=952
[5]See http://www.statistics.gov.uk/cci/nugget.asp?id=2157
[6]Audit Commission (2010), Under Pressure: tackling the financial challenge for councils of an ageing population.

Chart 2: Predicted percentage change in population from 2010 to 2030
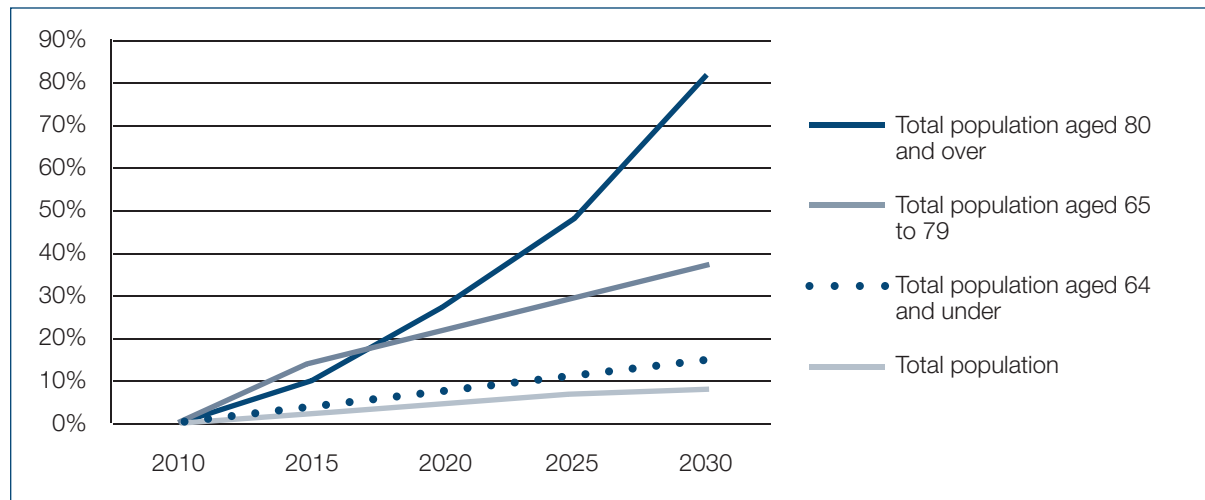
Source: poppi.org.uk and pansi.org.uk

However, the distribution of older people varies significantly across the country. For example, those aged 65 and over currently make up 6.8% of the London Borough of Tower Hamlets population. This is expected to decrease slightly to 6.42% by 2030. In contrast, in Northumberland, the same age group currently make up 19.94% of the population (expected to increase to 29.31% in 2030), nearly 3 times that of Tower Hamlets[7].

Individual wealth also varies across the country. Taking people of pensionable age and in receipt of at least one other benefit[8], offers a proxy indicator of low income. In Tower Hamlets, 63.64% of those receiving a state pension also received at least one other state benefit, whilst in Northumberland the figure was only 35.29%.

People with a disability

With the increasing fertility rate over the last ten years, and increased life expectancy for many of those with disabilities, a rise can be expected amongst people with physical or learning disabilities in the adult (18-64) population.

Assuming prevalence rates for physical disabilities remain the same as at present, given the population growth, this would result in an additional 170,000 adults aged 18-64 with a moderate or serious physical disability by 2020.

[7] *Figures from Projecting Older People Population Information System at www.poppi.org.uk*
[8] *Benefits covered include: Incapacity, carer, income related, disability, bereavement. It does not include housing benefit.*

Chart 3 shows the increase in those predicted to have a moderate or severe physical difficulty over the next twenty years, together with those predicted to have a moderate or serious physical disability requiring personal care. The greatest increase in demand is likely to be in the next 10-15 years, with 150,000 more adults with physical disabilities requiring personal care than at present.

Chart 3: Predicated change in population of adults with moderate or severe physical disabilities from 2010 to 2030
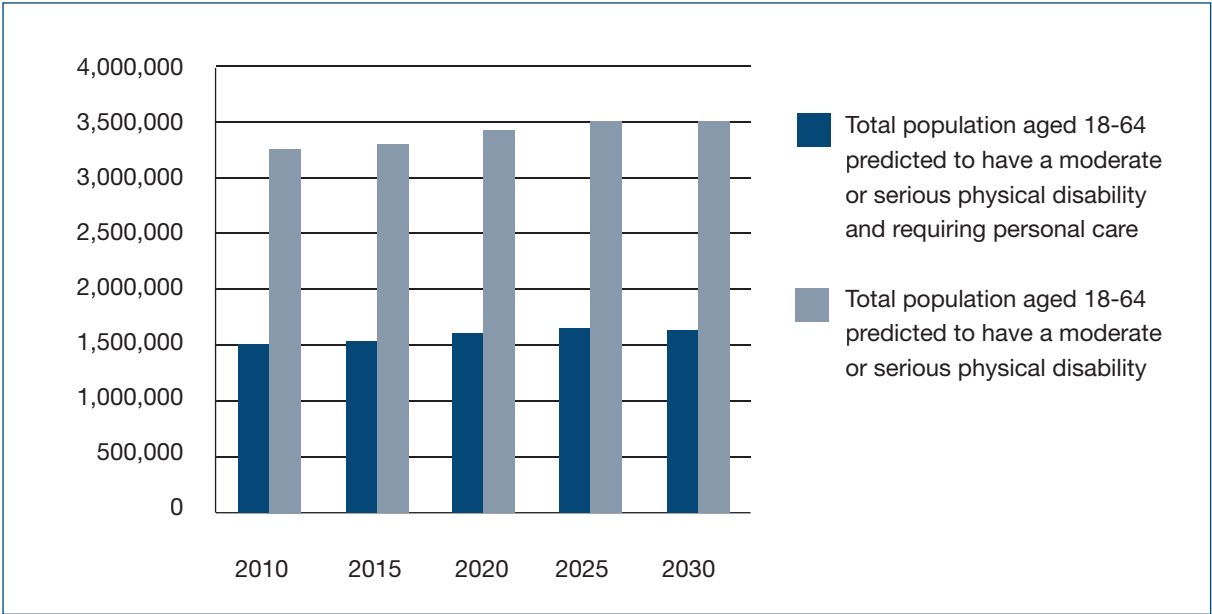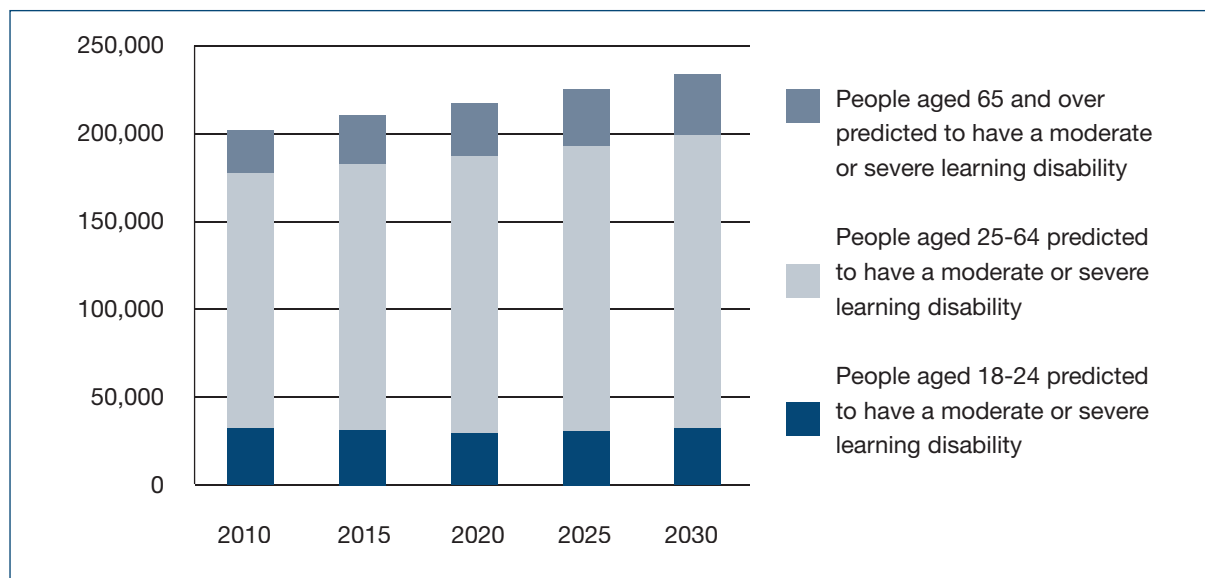

Source: pansi.org.uk

In terms of learning disability although the proportion of people born with LD is not likely to change, there are predicted to be an additional 156,000 adults aged 18-64 with a learning disability in the next twenty years, with over 30,000 having a moderate or severe learning disability. This increase is primarily due to two key factors: firstly, people with a learning disabilities living longer, and secondly, an increase in the numbers of live births surviving with profound and multiple disabilities[9]. The number of those with autistic spectrum disorder is also predicted to rise in line with the general population, with a population of around 351,000 adults aged 18-64 in 2030, compared to around 327,000 today[10].

Chart 4 shows the predicted increase of those with moderate or severe learning disabilities over the next twenty years. Whilst the figures show a steady increase in population, it is worth noting that there is a predicted drop in those aged 18-24 in the next 15 years. However, behind the figures are a number of issues for the learning disability population.

[9] *Costeloe K, Gibson AT, Marlow N, Wilkinson AR (2000) The EPICure Study: Outcome to discharge from hospital for babies born at the threshold of viability. Pediatrics 2000;106(4):659-71*
[10] *Pansi.org.uk Prevalence of autistic spectrum disorder is at 1% of the population, as a whole, but 1.8% for men and 0.2% for women.*

Chart 4: Predicted change in population of adults with moderate or severe learning disabilities from 2010 to 2030

People aged 65 and over predicted to have a moderate or severe learning disability

People aged 25-64 predicted to have a moderate or severe learning disability

People aged 18-24 predicted to have a moderate or severe learning disability

Source: pansi.org.uk

All too often people with learning disabilities fall through the system after they leave children's services, never making it through the transition into adult's services. They often reappear on the radar later in life as adults with more developed needs and problems, and thus costing the government more in the long term – as well has having had a lower quality of life along the way.

A study of three prisons in North West England identified the prevalence of learning disability as 6.7%, and of learning difficulty as 25.4%; almost a third of the prison population. This is around 10 times the prevalence in the general population. For women the proportions were higher, with a total of 40% of those in prison assessed as either learning disabled or experiencing learning difficulty[11]. An earlier report from the VODG in 2008 highlighted the lack of reliable data about young people with disabilities and noted that there is "little longitudinal data which follows the pathways of young disabled people as they move from childhood to adult life"[12].

The increased longevity of people with learning disabilities creates new issues to be managed, such as people with Down's syndrome getting early onset dementia, and some people with a learning disability outliving their primary carers. There are currently estimated to be 167,000 adults with learning disabilities living with carers aged 70 plus[13]. These issues present challenges to commissioners and providers. Services explicitly designed for people with Down's syndrome and dementia will need to be developed. Those outliving their primary carers, some of whom will not be known to social care, may be losing their family home and a familiar world turned upside down.

[11] *Mottram, P. G. (2007) HMP Liverpool, Styal and Hindley, Study Report. Liverpool: University of Liverpool.*
[12] *Institute of Public Care (2008) Shadowlands. Report commissioned by the Voluntary Organisations Disability Group.*
[13] *Brindle D (2010) Elderly carers: how will the state cope when they are gone? At http://www.guardian.co.uk/society/2010/jun/30/learning-disabled-adults-elderly-carers*

■■■■ The Financial challenge – decreasing funds

With the demand for social care services predicted to rise as a result of the steep increase in people aged 80 and above, how social care is to be funded has been a mounting problem even prior to the financial collapse in 2008. With a likely considerable reduction in social care expenditure following the budget announcement the need for a solution for the future funding of care becomes even more critical.

The Wanless report in 2005[14], commissioned by the Kings Fund, looked at the issue in depth and advocated a 'partnership' model of funding with government delivering a minimum level of care which people would then top-up from their own resources. In the last decade there has also been a Royal Commission the 'Big Care Debate' and a number of studies looking at the nature and scale of the issue[15]. The significance of the problem was illustrated by the fact that for the first time the future funding of social care was an issue in the General Election in 2010, indicating the gravity of the problem in terms of future funding and impact on people's lives. Since the election the Coalition Government has announced that it will *"establish an independent Commission to consider how we ensure responsible and sustainable funding for long-term care"*[16] to report within a year.

Although the population of those with learning or physical disabilities is predicted to broadly rise in line with the general population they do make up a significant proportion of social care spending in local authorities. As Chart 5 shows, in 2008-9, spending on services for older people amounted to 56% of expenditure, with 24% on adults aged 18-64 with learning disabilities, and 10% on adults with physical and sensory impairments. Learning disability spending in particular has grown year on year with an increase in expenditure of 28% in real terms between 2003-4 and 2008-9[17], although whether this represents real growth, a switch of health care funding or a change in the balance of need within the LD population is far from clear.
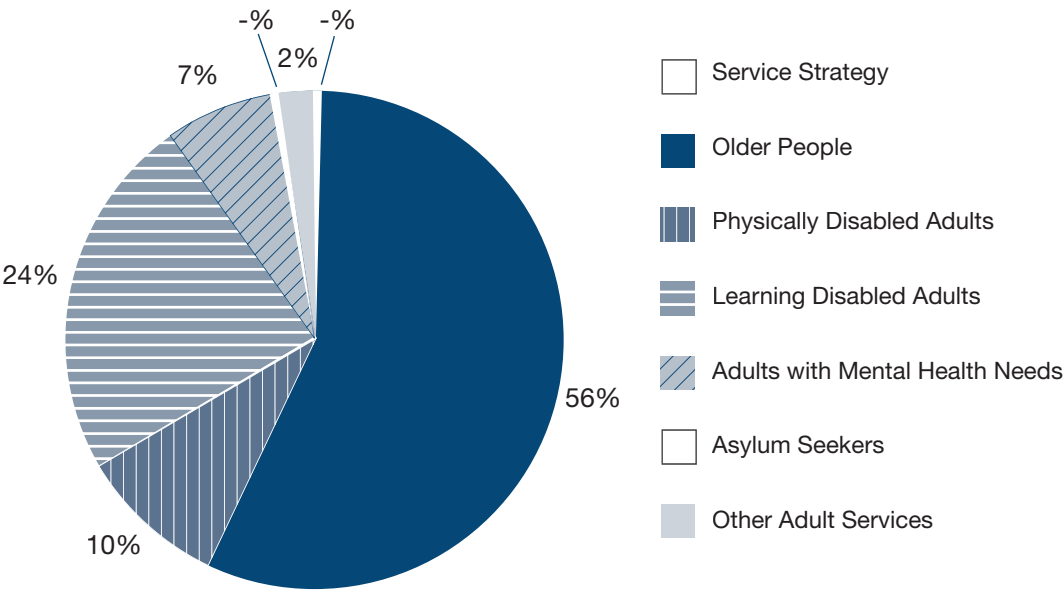
[14] *Kings Fund (2005) Securing Good Care for Older People*
[15] *For example: Audit Commission (2010), Under Pressure: Tackling the financial challenge for councils of an ageing population; Personal Social Services Research Unit (2009) Analysing the Costs and Benefits of Social Care Funding Arrangements in England: Technical Report.*
[16] *See Queen's Speech 25th May 2010 http://www.number10.gov.uk/queens- speech/2010/05/queens-speech-social-care-50632*
[17] *NHS Information Centre (2010) Personal Social Services Expenditure and Unit Costs England, 2008-09*

Chart 5: Client group as a percentage of gross current expenditure, 2008-09

Pie chart segments:
- 56%
- 10%
- 24%
- 7%
- -%
- 2%
- -%

Legend:
- Service Strategy
- Older People
- Physically Disabled Adults
- Learning Disabled Adults
- Adults with Mental Health Needs
- Asylum Seekers
- Other Adult Services

Reproduced from Personal Social Services Expenditure and Unit Costs, England 2008-09

With increasing numbers of people with learning and physical disabilities in the future will come increased demands for funding, even for services to operate at the current level.

◼◼◼ The challenge of changing expectations

Over the last thirty years there has been a plethora of policy initiatives from central and local government, yet underpinning these has been a much more limited set of overarching themes, albeit that the emphasis has shifted from time to time. These themes can be summarised as follows:

- Changing the balance of relationships between purchasers, providers and users of care.

- Tackling duplication of services.

- Focusing on prevention and the role of communities.

Changing the balance of relationships between purchasers, providers and users of care.

Since the 1980's there has been a steady shift in the balance of relationships between the three key actors in the social care market. This shift can best be represented by the increasing 'marketisation' of social care.

Table 1: The change in the local authority role

'Provider' Pre 1980's	'Purchaser' 1980's- 2008	'Personaliser' 2008 onwards
Prior to the 1980's the provision of social care was clearly a task that fell to the state. This changed dramatically following the Griffiths Report in 1988[18] and subsequent legislation. Even by 1990 only 20 percent of residents in care homes were in the independent sector; that proportion now stands at 90 percent.	From the 1980's onwards the role of the local authority increasingly developed into one of being a purchaser. During this time the roles of strategic commissioner and contractor gradually emerged as one of the primary functions of adult social care.	The role of the LA has now begun to shift towards acting as a facilitator of a social care market. The LA will be neither providing nor purchasing but encouraging and stimulating the market to offer a range of provision from which people can choose the services they wish to purchase.

At the heart of the personalisation approach has been the desire to offer users choice and control over the services they choose to receive, with the mechanics of this to be achieved through a personal budget. Its aim was summed up by the Social Care Transformation circular in 2008:

" ...everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered"[19]

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[18] *The Griffiths Report (1988) Community care: agenda for action*
[19] *LAC Circular 1 (2008) Transforming Social Care, Department of Health January 2008*

The mechanism for achieving this goal of choice and control was to be by the allocation of a personal budget:

"In the future, all individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being."[20]

At the same time, as Table 1 illustrates, the role of the local authority towards the market was to change to one of ensuring sufficiency of provision was available from which people could choose their services.

Despite the all party enthusiasm for the personalised approach, its implementation still throws up a number of issues. As the IBSEN report[21] revealed, whilst individual budgets worked well for people with a physical disability and some people with a learning disability, it was not readily accepted or welcomed by older people. Since then other concerns have arisen:

- If the level of public funding diminishes, people may not be able to afford sufficient care to meet their needs or compete against self funders. Consequently, more people may fall back onto universal provision from the health service.

- Many voluntary agencies have in the past had contracts for volumes of service with the local authority. This has given providers the security to invest in the service. If these contracts are terminated and funding passed to individual service users, the lack of certainty about the level of take up may lead to a contraction in the market as providers become more risk adverse. In general, the greater the degree of uncertainty in the market place then the more the market is likely to contract.

- Presenting a choice of service in rural areas may be difficult given that it is sometimes challenging to even provide a service.

Duplication of service provision

The need to avoid duplication and bring services together in a seamless way has been a theme of social policy since the inception of the welfare state. During that time there have been numerous policy documents that have aimed to lessen the potential for fragmentation or duplication of services, and to better 'integrate' the variety of services that people have contact with.

For example; Opportunity Age[22], published in 2005, was a multifaceted strategy that sought to address a spectrum of issues for older people covering work and income, active ageing and services, and was followed up in 2009 by Building a Society for All Ages that sought to improve planning for older age and improving well-being. The National Health Service Act 2006 and

[20] *LAC Circular 1 (2008) Transforming Social Care, Department of Health January 2008*
[21] *Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008) Evaluation of the Individual Budgets Pilot Programme: Final Report. Social Policy Research Unit: University of York.*
[22] *Department for Work and Pensions (2005) Opportunity Age*

Local Government and Public Involvement in Health Act 2007 both sought to bring PCTs and local authorities together to analyse, plan, do and review their services with the aim of providing a seamless coherent set of health and well-being services.

Whilst the fragmentation of services leaves the potential for individuals to fall through the system, as evidenced by the continuing issues around transition arrangements for people with learning disabilities, so duplication of services represents an ineffective use of public money when budgets are at their tightest.

The introduction of the Joint Strategic Needs Assessment (JSNA) in the Local Government and Public Involvement in Health Act 2007 should have provided a common view of demand across public health local authorities and PCTs although its capacity to drive commissioning decisions has not been fully delivered. Putting People First[23] also advocated needs based commissioning to provide equitable access to services and *"a single community based support system focussed on the health and wellbeing of the local population".*

Joint commissioning arrangements and the use of pooled budgets are becoming more commonplace although as the Audit Commission recently noted they only represent a small proportion of total funding:

"In 2004, based on the DH register of flexibility notifications formally integrated health and social care arrangements accounted for £2 billion. By March 2009, this figure had almost doubled to £3.9 billion, rising at a faster rate than both NHS and adult social care spend over the same period. It was reported to have risen to £4.4 billion by the end of 2008/09. However, formal joint financing expenditure was still only a small proportion – an estimated 3.4 per cent – of the total health and social care expenditure in 2007/08."[24]

Within these arrangements, pooled funding for learning disability services was the most common, followed by mental health services and community equipment. In addition to the joint funding arrangements between social care and health, the Department of Health, in seeking to stimulate the growth of extra care housing, has also engaged in a significant funding programme for new housing over the last five years.

However, despite the concerted push from Government, various toolkits and best practice guidance, it is clear that there is no simple formula for how best to integrate services and no simple manner with which to kick start the process. A recent review of integration in six European countries highlighted that integration is not just dependent on the achieving co-ordinated management structures, but also crucially on the professional values and interests of those involved.[25]

More recently, Total Place, billed as the *"whole approach to public services"*, has come as a natural successor to the drivers for integration that have gone before. Pushing for all services to put the service user at their heart has *"has helped open the door for local partnerships to discover what can be done to improve the system"* and *"has meant looking for new ways of co-operation, at local level and between local level and Whitehall".[26]*

[23] HM Government (2007), Putting People First: a vision and commitment for the transformation of adult social care
[24] Audit Commission (2009) Means to an End: Joint financing across health and social care
[25] Mur-Veeman I, van Raak A, and Paulus A (2008) Comparing integrated care policy in Europe: Does policy matter? Health Policy. 85: 172-183
[26] HM Treasury (2010) Total Place: a whole area approach to public services.

Prevention and the role of communities

Prevention and early intervention are increasingly emphasised as a means of tackling progressive illnesses or disabilities, and thereby reducing the costs of care and support. The importance of prevention was emphasised by the Transforming Social Care Circular.

"Create a strategic shift in resources and culture from intervention at the point of crisis towards prevention and early intervention, focusing on promoting independence and improved wellbeing in line with the needs of the local population, reaching out to those at risk of poor outcomes".[27]

Yet despite the rhetoric of prevention, there have been few structured attempts to quantify what an effective approach should consist of - this despite considerable expenditure on initiatives such as the POPPS programme.[28] The current vogue is for a strong emphasis on reablement, but this is only one aspect of prevention even given that its long term capacity to 'prevent' the need for further intervention is yet to be proven. Table 2 shows a potential framework for considering a range of preventative provision.

Table 2: Populations and provision for health and social care prevention

Universal populations	Vulnerable populations	Targeted populations	Deferred populations
Broad based provision that has an impact on health and social care but is available to an entire community. Such interventions tend to focus on well being and improving the overall life of people within a given community	Low intensity services that have a solely health and social care focus. Many of these services are provided by voluntary organisations or private companies.	Health and social care services targeted on specific problems or issues which if unaddressed would have a considerable likelihood of leading to high intensity health and social care provision.	Services that defer from or often more likely, delay further high intensity provision. These populations may already have had 'a taste' of high end provision, perhaps through respite or intermediate care. This group may also include those who receive high intensity provision from family carers.

Examples

Bus Passes	Toe nail clipping service for older people	Falls service in a care home	Intermediate Care or respite care.

[27] *Transforming Social Care (LAC) (DH) (1) 2009*
[28] *Partnership for Older People Projects*

Currently, most preventative provision falls at either end of the table: low level universal provision or high intensity services that attempt to divert from care at the last moment. There is a need to develop a wider range of:

- Community based provision for vulnerable people but making sure that it increases people's potential for independent living rather than acting as a stepping stone to dependency.

- Targeted provision focusing on particular issues that lead to a care home or hospital admission. Some of these issues may be where preventative interventions are not fully maximised eg, continence care, or simply where there significance on a pathway of decline is not fully recognised, eg, death of a spouse.

In terms of community based provision then the voluntary sector is already well placed to bring added value to care. However, as stated above there is a need to make sure this provision encourages independence. In terms of targeting then again the sector has a potentially crucial role to play in delivering evidence based innovative services.

GAIN

The voluntary sector

Government policy in the past decade has been for local authorities to improve their procurement practice and relationships with providers.[29] The dominant policy on procurement for local authorities is to achieve 'value for money' (VFM), which is defined as the optimum combination of whole life costs and quality to meet the user's requirement.[30] The Office of Government Commerce has produced valuable work to promote a fair, proportionate, cost effective and mutually beneficial procurement process.[31]

The creation of the Office of Third Sector in 2006, now renamed the Office of Civil Society, reflected the increasing policy drive towards, and commissioning reliance on the 'third sector' to deliver public services, particularly in health, social care, community justice and well-being. Many third sector organisations graduated from receiving small grant funding for existing projects, to being commissioned to deliver core public services.

Increased monies have been awarded to the voluntary sector from government. Local government spending on the sector is estimated to have risen by 500% since 1984/5.[32] In the previous administration some of this money was channelled via the Futurebuilders approach. The current government also sees the voluntary sector as important, stating:

"We will support the creation and expansion of mutuals, co-operatives, charities and social enterprises, and enable these groups to have much greater involvement in the running of public services".

"We will train a new generation of community organisers and support the creation of neighbourhood groups across the UK, especially in the most deprived areas".[33]

A large proportion of the voluntary sector are concerned with providing health or social care services. In 2008, the QLFS[34] identified that 62% of Voluntary and Community Sector organisations worked in 'health and social work'.[35] The NCVO found when looking at the total income of charities, that social services charities had a total income of £8.3billion, more than double the income of each of the next biggest sectors, culture (£3.3 billion) and health (£3.0 billion).[36]

[29] ODPM (2003) National Procurement Strategy for Local Government
[30] OGC (2004) Think Smart...Think Voluntary Sector! Good practice guidance on the procurement of services from the voluntary and community sector
[31] OGC (2004) Think Smart...Think Voluntary Sector! Good practice guidance on the procurement of services from the voluntary and community sector
[32] Local government spending on voluntary and community organisations rose by about 62% in real terms between 2001/02 and 2003/04, from £2.6 billion to £4.2 billion (both in 2002 prices) local government spending on the sector is estimated to have risen five- fold since 1984/85. www.cabinetoffice.gov.uk/media/cabinetoffice/third_sector/assets/central_and_local_gov_expenditure_summary.pdf
[33] HM Government (2010) The Coalition: our programme for government
[34] Quarterly Labour Force Survey
[35] Third Sector Research Centre (2009), Briefing Paper 28: The growing workforce in the voluntary and community sector: analysis of the Labour Force Survey, 1993-2009.
[36] National Council for Voluntary Organisations (2009) UK Civil Society Almanac, cited in House of Commons Library (2010) Voluntary sector statistics

One of the selling points of the voluntary sector has been the quality of its paid staff and the added value of its volunteers. In England in 2008/09, 26% of adults reported volunteering formally at least once a month.[37] The economic value of formal volunteering was estimated as being around £40 billion in 2006/07.[38] A higher number at 35% volunteered informally at least once a month.

The voluntary sector as an employer has a reputation for being a flexible employer with 63% of those in the VCS working part-time, compared with around 23% of employees as a whole.[39] The number of employees grew from just under 350,000 in 1993 to 750,000 in June 2009.[40]

Those that work in the voluntary sector tend to be more educated and skilled than in other sectors, with nearly four in ten holding a degree or higher compared, twice that of the private sector, and fractionally higher than the public sector.[41]

The following case studies from VODG members provide examples of what the voluntary sector can achieve.

[37] *Citizenship Survey: April 2008 - March 2009, England*
[38] *Helping out: a national survey of volunteering and charitable giving*
[39] *Third Sector Research Centre (2009), Briefing Paper 28: The growing workforce in the voluntary and community sector: analysis of the Labour Force Survey, 1993-2009.*
[40] *Third Sector Research Centre (2009), Briefing Paper 28: The growing workforce in the voluntary and community sector: analysis of the Labour Force Survey, 1993-2009.*
[41] *Third Sector Research Centre (2009), Briefing Paper 28: The growing workforce in the voluntary and community sector: analysis of the Labour Force Survey, 1993-2009.*

Case Study 1: MS Society

Key Gains:
- Health Care Savings
- Improved end of life care
- Service user involvement and determination of provision

Project

Neurological Commissioning Support is a joint initiative of the Motor Neurone Disease Association, the MS Society and the Parkinson's Disease Society. The initiative works to ensure the needs of people with long-term neurological conditions are at the heart of commissioning. NCS works alongside PCTs, County Councils and service users. It produces clear recommendations for PCTs to deliver better outcomes for services in neurology.

For example, in Bath & North East Somerset the scheme focused on palliative and end of life care for people with neurological conditions. The NCS worked as a broker between the service users and PCT commissioners, and obtained the views of service users in a variety of ways in order to try and reflect the diversity of the group living with neurological conditions. They found out what service users felt about the services they received and what they would like to receive in the future, managing service user expectations. A report was produced for commissioners containing recommendations.

One recurring issue for people with motor neurone disease for example is that managing end of life care is difficult as their breathing is compromised as chest muscles weaken. Many people who have expressed a desire to die at home, end up dying in hospital.

Benefits

1. The cost of providing respiratory support to assist this is considered expensive by some: invasive ventilation equipment (NIPPV)[42] at home for a person with MND and a visiting respiratory therapist for a twelve month period is £12,000. However if a person is admitted as an emergency into an acute hospital intensive care unit the cost for this is around £1,500 per night .

2. Unplanned emergency care costs the NHS thousands of pounds for a single case, typically £45,000 per month for the ICU admission alone. The cost of providing NIPPV at home is £44,000 per month less than the ICU admission or a saving of £528,000 per annum – for one person.

3. An additional benefit of NIPPV equipment is that it can be reused by other patients for up to 8 years.

[42] *Non-invasive positive pressure ventilation*

Case Study 2: KeyRing

Key Gains:
- Flexibility of provision
- Increased independence of service users
- Use of volunteers to add value
- Building links with the community

Project

KeyRing facilitate Living Support Networks comprised of 10 people in each network in a defined geographic area. The Networks operate across the country in inner cities, market towns and rural areas.

People with support needs occupy 9 of the properties, from all types of tenure, and a Community Living Volunteer (CLV) lives rent free in the tenth. The CLV, as suggested by the title, is a volunteer and will provide at least 12 hours of their time a week to flexibly support the members, facilitate mutual member to member support, and build links with the neighbourhood. A paid supported Living Manager supports each CLV and manages a cluster of networks. If further additional support is needed it can be provided flexibly by a paid worker.

The Networks encourage members to develop their skills and confidence to become more independent over time. This often leads to additional (non-KeyRing) specialist support being reduced over time. Members who need less support from the CLV can become 'associates' who count as 0.5fte member.

Initially KeyRing focused on people with learning disabilities, but membership has extended to other clients groups such as those with mental health needs in the last few years.

Benefits

1. KeyRing's network model of supporting people with learning disabilities has been recognised by the Department of Health's Care Services Efficiency Delivery (CSED) programme as being cost-effective, as the costs of the Network are more than offset by reductions in other forms of support as members become more self-sufficient. Further savings are also realised such as preventing an escalation of need and reduction in tenancy turnover.

2. KeyRing have calculated that their model can equate to around 25% sustainable savings over alternative models depending on geographical area and if the Network is running at full capacity. For example, CSED studied a network in a market town that had an annual running cost of £38,090. Alternative support would have cost £55,430, a net saving of £17,340 or 31%.

3. Not only do the Networks demonstrably save money over other forms of support, but they also improve individual's social life and confidence, enabling members to be more resilient in terms of living independently in the community. KeyRing believe that is significant potential for these networks to expand, not only amongst those with learning disabilities but also those with mental illness living in the community and older people who are isolated.

Case Study 3: mcch

Key Gains:
- Increased independence of service users
- Service user involvement and determination of provision
- Social care savings

Project

mcch have a 10 year block contract with the London Borough of Bexley which began in 2002 for the modernisation and reconfiguration of services for people with learning disabilities.

One of the services provided was residential accommodation for 8 individuals with a broad range of learning disabilities, challenging behaviour and physical health needs aged 28-62. Although they lived in residential accommodation rated as good by CQC there was little opportunity for them to develop independent living skills or personalised support packages.

In 2008, through mapping exercises of person centre plans they found that the needs of many service users had changed and the majority did not require registered care. It was decided to apply for deregistration and reconfigure the service to meet each individual's specific needs, as identified within the person centred plans.

After extensive and continuing involvement of service users, family, and other partners, they moved away from a fixed level of support hours to a tailored support contract. This lead to a considerable reduction in the amount of funded support hours, particularly as waking night support hours were removed and replaced with sleep-in staff.

Benefits

1. The annual budget for staffing costs reduced dramatically, but the quality of support was enhanced and focused in areas of specific and identified need.

2. The cost of the old service under the block contract was £1,056 per service user per week. The new service cost £18 per hour and the average number of supported living hours used per week was 27. In addition the new service drew down £157 per week for housing benefit making the total weekly unit cost per service user of £642 per week. In addition the personal income of service users went up from an average of £27 a week to £160 as they were all eligible for increased welfare benefits. The saving to local authority commissioners by adopting the new service for the 8 service users was £173,004 per annum. Even if the increase in welfare benefits are taken into account this still represents a saving of £117,337.

3. The significant increases in personal income allowed services users to enjoy a more substantive activity and social events programme, leading to greater choice in how they spent their time, facilitating more independence. The reconfiguration created a step change in the expectations service users had of themselves. They developed autonomy and skills in daily living as they planned their own budgets, including food shopping, became more involved in meal preparation and diet choice, as they had access to income that supported these activities.

Case Study 4: Papworth Trust

Key Gains:
- Increased independence of service users and better outcomes
- Social care savings

Project

In 2008, the Papworth Trust took on two contracts for the re-provision of NHS services in Suffolk and Bedfordshire offering personal care and support for people with learning disabilities, who predominantly have complex needs, including autistic spectrum disorder, and mental health issues.

The majority of individuals had lived all of their lives as 'patients' within the NHS. Whilst some of the individuals do have 24 hour support needs they do not require round the clock nursing care. In consultation with individuals and families, Papworth supported service users to move from being patients in NHS accommodation towards living in the community as ordinary citizens with their own homes. The Papworth Trust TUPE'd in over 100 former NHS staff and in the in first year carried out a major staff restructuring, reducing the management and staffing layers from seven to three.

Benefits

1. With the change from 'NHS continuing care' status to 'tenants' came access to bank accounts, to tenancy rights, to benefits, alongside choice and responsibility. The homes are entirely integrated within the local community with each service user having their own tenancy agreement which could be from renting a room in a shared house, to renting through single occupancy. Some individuals are purchasing their own homes via mortgages.

2. Papworth is working closely with social care commissioners to make best use of transferred funding to improve the quality of housing for people moving out of NHS services. Over the coming year tenants will see their homes upgraded and fitted with telecare and other appropriate IT to further increase their independence.

3. The difference between paying for residential care and supporting living where various benefits could be accessed[43] is significant. Papworth estimate that in some cases this could represent a saving to commissioners of as much as £385 per week per service user.

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[43] *When moved out of residential care, service users would be able to access some or all of the following: housing benefit, Independent Living Allowance (ILA), Disability Living Allowance (DLA), Mobility Allowance and possibly ILF funding.*

Case Study 5: MacIntyre

Key Gains:
- Increased independence of service users
- Service user involvement and determination of provision
- Investment from both commissioner and provider
- Social care savings

Project

In 2004 Derbyshire County Council identified a potential gain from working with an independent partner organisation. The contract to tender was for 10 years worth £1.8m a year, with MacIntyre contributing an additional million over the lifetime of the contract, to start in 2008.

The Council wanted the partner to enact a cultural change; away from traditional day centre provision and towards services that promoted independence, enabling people to develop skills and potential through greater choice of activities and stronger support for pathways to work.

Service users were involved in a large study that showed they wanted a larger number of smaller local facilities that helped them learn and develop skills to make them employable. The last of the two large day centres that is due to close in the summer received funding from MacIntyre in order to create step change and a more suitable environment for service users while they waited to move on to their new provision. There will be 6 new smaller hubs to replace the two day centres, providing activities and learning opportunities for between 20 and 30 individuals each.

Benefits

1. The hubs allow for a balance of specialism within them. For example individuals can learn independent living skills or vocational skills at some hubs. Service users have been able to go and work/volunteer in cafes/catering and retail (second hand shops) and gardening (one service user, previously denied the opportunity to operate a chain saw on health and safety grounds has acquired a licence/qualification to do so).

2. The new service has developed some innovative spin off projects such as a person-centred transition scheme for school leavers so that the right level of support is in place before moving from children's to adults services.

3. The project is much more integrated and engaged with the local community, working actively with a Community Action Neighbourhood Group and also with Chesterfield Football Club in respect of their new Community Stand. (The service users will be employed there and offered voluntary opportunities and given chance to use their newly learnt catering and retail skills, etc.)

4. MacIntyre have been able to make efficiency savings of £100,000 a year. These have come from a variety of sources including through personalised contracts so that there are no longer big contracts with one or two suppliers, and by re-defining staffing roles and structures. These savings are then reinvested in the service. Reinvesting money saved from efficiency savings has provided an added incentive to work as efficiently as possible. The commitment and financial investment from both commissioner and provider and a transparent relationship has created a sound environment for transforming service provision.

Case Study 6: Brandon Trust

Key Gains:
- Building links with the community
- A collaborative approach to shaping the market
- Social care savings

Project

The Brandon Trust won a 15 year contract with Gloucestershire to deliver services for people with learning disabilities in 2005. The project agreement is an umbrella agreement for the whole project offering the Brandon Trust a block contract for the delivery and eventual change of services in Gloucestershire.

The main rationale for the project was to modernise the service provision available in the area. This was to be done by reducing the amount of registered care and provide alternative services for approximately half of the service users within 10 years. The contract is being used to shape the market and encourage change while providing stability for the provider (through the length of the contract).

The project looked to develop a range of service options to suit the needs of the local community, to modernise services, to ensure more effective use of funding streams and to enable stakeholders to meet financial pressures. The services were expected to include a variety of lifestyle options such as supported living and home ownership.

They run a number of different projects in the area and so communication with commissioners is high.

They key challenge they have found so far is the in finding suitable housing stock for people as there is a real shortage of shared-setting accommodation.

Benefits

1. So far, they have moved close to 50 people into accommodation with their own tenancy, with the figure projected to rise to 90 in the next year.

2. The pricing mechanism for the project is designed so that no one party can benefit in isolation to the others. Accordingly there is a high level of communication between commissioners and providers and past efficiencies are run at 3% a year.

3. They have found that quite often staffing levels of services are historical and tied into established and often un-refreshed levels and patterns of support. A review of Care Management Assessments led to an increase in assistive technologies to promote greater independence. As a result of these changes 3 out of 30 services no longer have waking night support saving £150k - and promoting increased personal independence.

Case Study 7: Affinity Trust

Key Gains:
- Service user involvement and determination of provision
- Increased independence of service users and better outcomes
- Community engagement

Project

Affinity Trust took on a number of registered care services for people with learning disabilities as part of the Kent NHS Campus Re-Provision Programme. NHS staff were TUPE-d across to the provider.

The focus of the project was to transform services from residential care to a supported living model. An extensive consultation process and continuing communication with all stakeholders throughout the transition planning and implementation was done. Family days were held involving the people they support, families, staff, advocates, architects, housing providers, care managers and key professionals. No decisions were made without Best Interests Meetings and once suitable accommodation was found, a thorough transition planning process was followed.

For the first time in years the hours of support needed for the individuals has been tested. Some people have been benefited from a significant increase in support, while others have had a considered reduction. The process was very much a joint approach between the Care Managers and the Service Managers. The contract saw an increase of 220 hours of support for 28 people, with the understanding that over the next few years the Affinity Trust would act responsibly to reduce hours when safe and right to do so.

Benefits

1. Initial feedback, supported by evidence from person-centred plan meetings, surveys and quality assurance systems is that people are engaged in a wider range of activities, are happier with their housing choices, have higher levels of income, are more engaged with the community, and are having more positive interactions with staff.

2. Levels of challenging behaviour have significantly decreased. There is a sense that that when people have a staff team there just for them there is less need to compete with others for attention as when in a large care home.

Case Study 8: Crossroads Care and Norfolk Young Carers

Key Gains:
- Flexible and cost effective support
- Prevents family breakdown and higher long-term costs

Project

Crossroads first started providing services in Norfolk in 1996 when Norfolk County Council funded one support worker to raise awareness about young carers issues.

There is now a team of support workers that receive referrals from across the community, for example from GPs, schools and youth groups. When a young person is referred to the workers, an assessment will be carried out of their needs. They will continue to work with the young person until they are at a point of needing less support; they then step back as the young person enters the support worker led support group with other young carers. This enables them to move their caseload along whilst still providing support and keeping the door open for those who need it.

Benefits

1. These layers of support allow the young people to move along the pathway reducing the cost of their individual care. In 2008-9 the cost of providing 1:1 support for a young person for the year was £657. The cost of providing support for each young people in a group per year is significantly lower at £84. However the costs to commissioners if the carer could no longer cope would be much higher, both for the person they care for and the potential fall-out for the carer.

2. The provision of group work in addition to the one-to-one support ensures that those in need of support are able to receive it, whilst keeping the cost of the service realistic for commissioners.

Case Study 9: Hft[44]

Key Gains:
- Service user involvement and determination of provision
- Social care savings
- Increased independence of service users

Project

Hft recognise that when helping people live more independently that in the short term costs for individuals may actually increase as it is important that people get the right level of support in order to enable them to develop their skills, increase their independence and give them the confidence to move on. The level of support can then be scaled down as skills increase.

One example is of a married couple in Devon with learning disabilities. Initially they met, and married whilst living in a registered care service offering 24 hour care. The service managed to provide them with private living accommodation in a one bedroom self contained flat. However whilst they held a tenancy agreement and were being supported to increase their skills, the flat was on the site of a residential service.

The couple were supported to draw up a person centred plan and to develop goals specifically around where they would like to live, the housing options available to them and the support they would need to achieve and maintain these goals.

The couple moved into their own 2 bed house which they purchased through Advance Housing about 15 months ago.

Benefits

1. The couple's sense of achievement and increased self confidence as a result of this move is described as immeasurable. They are now well integrated into their local community and making use of local facilities has enabled them to build social networks.

2. The package of support they receive from the local authority has reduced over time to 3.5 hours a week at a cost of £55. Before the project described above they received funding of £523 per week from the local authority.

[44] *Formerly known as Home Farm Trust*

Case Study 10: RNID

Key Gains:
- • Increased independence and wellbeing of service users
- • Health care savings

Project

RNID run Hear to Help projects in response to evidence and research that shows that hearing aid users can need additional support. 40% of those who receiving a hearing aid can cope with effectively including how to maintain the aid and how to manage their hearing loss effectively.

The Hear to Help projects provide support to hearing aid users in accessible venues in local communities. The service particularly focuses on providing services in outlying areas where access to the main audiology department may be difficult. In addition to providing routine hearing aid maintenance, Hear to Help volunteers train hearing aid users to maintain the hearing aid themselves. Hear to Help is also able to signpost people to other local services as well as providing information on equipment available to help in the home.

Hear to Help projects are delivered in partnership with the NHS and projects work closely with local audiology departments taking referrals from audiology as well as referring people back to audiology as required. Hear to Help also takes referrals from Sensory and Adults Services teams in Social Services.

Benefits

1. Hear to Help eases the demand on hospital audiology departments as coping with the demand for routine hearing aid maintenance work can put a pressure on these departments and use resources which could be used for diagnostic and assessment work. Hear to Help also carry out home visits which significantly ease the pressure on the audiology department's domiciliary service.

2. In 2009/10, RNID carried out over 8,000 Hear to Help interventions.

3. For people who have mobility issues or find it difficult to access the hospital, making several visits to the audiology department when ongoing support is needed can be problematic. Without support, hearing aid users can give up on wearing their hearing aids and this can lead to the hearing aid user becoming isolated and vulnerable to developing further support needs.

Building on the Gains

The case studies above drew out key gains that have been made by VODG members in some of their projects and initiatives. These range from the ability to create a sustainable service model that can generate efficiencies, to engaging with the community and using volunteers, to promoting the independence and self-determination of service users. In terms of stimulating the voluntary sector then these gains can be built into tests that commissioners might wish to apply before offering to help support organisations as Figure 1 illustrates.

Figure 1: The funding challenge

Outcomes: Is there clarity over the outcomes the project will achieve, and do these increase people's independence?

Evidence: Does the project present an evidence base to support its interventions?

Partnership: Does the project reflect or promote whole systems working?

Project

Business Planning: Is the project sustainable in terms of resources and commitment?

Added value: Are there elements of reciprocity and mutual support in the project and does it promote volunterism?

Leadership: Is there strong evidence of leadership in addition to management skills?

GAIN
WITHOUT
PAIN

The Voluntary Sector Offer

So far this report has concentrated on two key areas: the changing balance between demand, supply and expectations; and what VODG members and the voluntary sector can offer, as summarised below.

The balance between demand supply and changed expectations: As the first section demonstrated, demand is increasing and will continue to increase in the foreseeable future, in some parts of the country more than others and for some groups of users of social care more than others. At the same time although increased wealth and assets amongst the older people's population will undoubtedly contribute to the overall social care 'pot', there is still likely to be a considerable shortfall in funding for services. Finally, expectations about care and support, how it is funded and who delivers what, is subject to considerable change and review. As 'The Case for Change'[45] put it in 2008:

"The existing care and support system is not sustainable, because of the massive challenge that changing demographics represent for our society. In 20 years' time, the cost of disability benefits could increase by almost 50%. We expect a £6 billion 'funding gap' in social care, just to deliver the same level of support that people experience now, if expenditure on social care rises at the same pace as anticipated economic growth".

Given the economic crisis since that date, the only difference is likely to be that the spending gap will have increased.

What the voluntary sector can offer: Hopefully the preceding case studies have demonstrated that the voluntary sector has a considerable amount to offer, despite the difficulties of the current economic climate. This is not to argue that all things the voluntary sector does are automatically good. There are examples where their services are inefficient just as there are many good examples of public care that are sound, cost effective and highly beneficial.

However, in general the voluntary sector brings to the table three vital benefits.

Value added: In very simple terms the voluntary sector frequently adds value to service provision, through co-production and the voluntary contribution that many people make in terms of time and effort as well as through the long term investment that they can make to the provision of services.

Flexibility: Because many voluntary organisations are not bound up in local authority procedures and processes they can often provide a quicker more flexible response to service provision through flexible, person centred deployment of staff. There is frequently an underlying motivation of 'doing what it takes'.

Enthusiasm and expertise: Most people identify the enthusiasm that voluntary organisations bring to projects as one of their strengths. Sometimes this comes from managers, who combine a mixture of social conscience with entrepreneurialism, sometimes through being single issue

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[45] Department of Health (2008) The Case for Change

organisations that focus on a particular problem or condition. A common feature is often reciprocity or mutualism, where those that offer help are also those who receive it.

However, if the voluntary sector is to realise its full potential then as described below a number of potential impediments need to be addressed.

Improving knowledge

The JSNA is an exercise that could have produced in local communities a common view of demand and an agreement about the best approaches to deliver the most positive outcomes. Instead in many places it has become more of a listing of a large collection of predominately health based needs. For the JSNA to deliver its full potential many more voluntary organisations must be engaged by commissioners and local planners in actively developing this vision of demand. The OGC in 2008 observed the value that voluntary organisations can bring:

 "While this must not give any provider a competitive advantage, third sector organisations may have specialist knowledge and links to the community that are useful in helping to understand how best to meet the needs of certain user groups."[46]

However, demand is only half the equation. There is a clear need across local authorities to develop a coherent view of supply – what is the evidence about what works best, and how is that implemented in the most cost effective way.

In particular work on costs-benefits by local authorities could help to identify the value added approach that many voluntary organisations bring.

Changing Commissioner – Provider Relationships

The benefits of commissioners of services in the public sector, and of providers working together have been well documented and strongly encouraged by the Department of Health and others:

"We believe it is essential, and entirely consistent with good procurement practice, for commissioners to develop effective and strong partnerships with current and potential providers. This includes more strategic, earlier discussion with provider communities about what they need."[47]

In some authorities these relationships are beginning to shift as both the case studies demonstrate and as DH recently reported:

"A common feature underpinning the changes in each council has been a shift from traditional and often adversarial relationships toward collaborative and constructive partnerships between commissioners and providers."[48]

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[46] *Office of Government Commerce submission to Public Administration Select Committee (2008) Public Services and the Third Sector: Rhetoric and Reality para 155*
[47] *DH (2007), Commissioning Framework for Health and Wellbeing*
[48] *DH (2009), Contracting for personalised outcomes: learning from emerging practice.*

In a paper for the Care Services Improvement Partnership in 2009[49] IPC outlined some basic guidelines for procurement and tendering that are likely to improve relationship where there is to be an agreement between a provider and a commissioning body.

- *"Commissioners understanding the commercial drivers of suppliers.*

- *Testing out through discussion with providers how easy or difficult requirements are to deliver and whether there is an established market.*

- *Engaging early and widely with the supply side; giving providers an opportunity to shape requirements and scope.*

- *Working with the supply side on an equal basis: ensuring openness of access to staff and information; establishing good communications channels and keeping bidders informed.*

- *Not leaving bidders in the competition if they are not capable of winning the contract.*

- *Being transparent about the procedures and top-level criteria for evaluation of bids.*

- *Offering good quality feedback – a provider may not meet the requirements this time but with help may be able to do so in the future.*

- *Being open to alternative means of achieving the same ends – particularly important when moving to an outcomes based approach.*

- *Applying rigorous project management procedures to the procurement exercise, and making these visible to the supply side.*

- *A deliverable and 'stickable to' timetable for the tender process that suits both parties.*

- *Developmental approaches to risk i.e. more risk with the commissioner initially, to launch providers in the direction of travel needed, then planned opportunities to reassess and realign risk as the service develops.*

- *Incentives to minimise or make risk more manageable for providers such as offering guaranteed volumes of work or time limited premiums on the cost of care to off-set additional costs".*

As the case studies show where service transformation had been successful, better outcomes for service users achieved, and efficiency savings found, it was often through the combined skills of commissioners and providers working together and with a shared and common understanding of actual and potential service users needs.

There is plenty of anecdotal evidence that suggests if providers and commissioners only have arms length contact through formal, non discursive contracting processes then often this fails to deliver the best deal and only offers inflexible provision, which neither service users nor providers benefit from. However, as some of the case studies demonstrate, good provision does not always come from service users only being able to make spot purchases of care on the open market. Carefully constructed contracts can offer providers the continuity they need if they are to invest in long term high quality provision whilst at the same time still providing service users with flexible choice over the service they receive and a choice of worker.

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[49] *CSIP (2009) Perspectives on Market Facilitation – Commissioner/ provider views.*

Avoiding the mechanistic implementation of personalisation

Person centred planning has been effectively practiced for years by a range of providers. However, as the case studies show, the sector is currently adapting to the challenge of making personalisation work in practice across the country.

Throughout the case studies, there are examples of where large centralised services are being replaced by smaller, more individualised accessible services.

In many cases the function of the service has been expanded to enable people to develop skills that will lead to greater independence.

However, personalisation is not about simply giving every existing service user a personal budget and leaving people to purchase their own care, as the ADASS perceptively commented.

"Councils are encouraged to provide personal budgets within the spirit of personalisation i.e. by enabling people to take the greatest possible degree of choice and control over their care and support. Councils are therefore exhorted to avoid 'schemes' to bolster personal budgets numbers at the expense of the wider Putting People First agenda. This includes simply converting existing users' services to a monetary (£) figure and sending correspondence to say that this amount is now their personal budget. Without changing processes and culture, establishing support services, developing markets and altering commissioning arrangements, it is highly unlikely that real choice and control and better outcomes will result".[50]

For some voluntary sector organisations personal budgets represent a potential problem in funding. Although supporting user choice, uncertainty over continued funding may prevent organisations from making the long term investment in services that they may otherwise have done under block contracts. Perversely these may well be the small local organisations that adult social care commissioners are keen to encourage. Clearly nobody wins if the market shrinks in size and choice gets less.

Demonstrating efficiencies

Often the most cost effective models of service delivery are when commissioners, service users and providers work together to share their expertise and perspectives on how best to manage the challenges facing them. It is also often when the issue of price is put to one side by declaring what is available at the start of a procurement process and then looking at what is the best that can be delivered within a given pricing structure.

Squeezing price or sudden cuts may also not always be compatible with providing quality or delivering choice. Efficiencies that are dictated at short notice to providers can allow for little or no time for any necessary service redesign or intelligent planning. Some cost-efficiencies require time, and occasionally investment, to materialise but are sustainable savings because of that.

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[50] *ADASS (2010) Personal Budgets: Council Commissioned Services Advice Note*

As DEMOS noted:

"The real question is: where will public spending be cut and on what basis will these decisions be made? The natural tendency will be for the government to continue what it is doing, only more cheaply: by reducing unit costs in procurement; by cutting up-front investment for long-term change; or, even worse, by 'salami slicing' — which means making across-the-board percentage cuts in departmental budgets.

"These strategies might secure initial savings, but will make things more expensive in the long term. No matter how 'efficient' you make a public service in monetary terms, if it does not solve the problem it is intended to, or does not achieve the desired outcomes, it is a poor use of public money. More importantly, it will also end up costing more, because either unhappy citizens who are not getting what they want will make repeated demands of the service, or the cost will simply be pushed elsewhere".[51]

For services to deliver maximum benefits for individuals at a lowest cost, a thorough understanding by commissioners and providers of the costs and benefits of those services is needed. Some of the case studies demonstrated savings through comparing costs of the previous service against the costs of the remodelled service and the benefits to the service users of having a service they want. However, if commissioners and providers are going to be able to assess the real cost-benefit of services in the future, then more detailed information to support this will be required.

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[51] Bartlett, Jamie (2009) Getting more for less: Efficiency in the Public Sector. DEMOS

■■■■■ Conclusions

Earlier this document defined the pain to come: in terms of the three challenges of more demand, less funding and changed expectations. As exemplified by the case studies the VODG believes that the voluntary sector has much to offer to make the challenges less painful and the gains greater.

Challenge 1: More demand

Response: Even without the financial crisis it is likely that the scale of demographic change would have forced the development of new approaches to social care. With the crisis the need to find new ways of working have become imperative. Even if the basis of adult social care funding changes, through a greater contribution being made by individuals, the potential to deliver more for less through the voluntary sector will remain important.

It is important that the rise in the numbers of older people does not overshadow the rise in numbers in amongst other groups even if that increase is only in line with overall population growth. For example, there will be new challenges in learning disability as that population lives longer. These challenges may centre on managing the early onset of old age conditions such as dementia or they may focus on managing and delivering care where for the first time parents of people with a learning disability die before their offspring.

A key element of the voluntary sector has always been mutualism - people not being divided into 'helper' and 'helped'. The voluntary sector will have an important role to play in regenerating mutual help within communities as evidenced by the KeyRing approach, Circles of Support[52] and others. These kinds of schemes will be important as part of avoiding state intervention and in providing low level help and support.

Challenge 2: Less money

Response: The voluntary sector can bring a value added approach to care provision and are often far more flexible in thinking 'outside the box' about new ways of delivering care and support services.

Whilst some of the rise in learning disability expenditure may be down to increased demand and a higher level of dependency, as the case studies show through improved contracting and a tighter focus on community based provision it is still possible to save money.

Part of improved efficiency is about switching indicators and judgements about services away from outputs and on to outcomes – not what is the volume of provision, but does it deliver results! The voluntary sector in a number of projects has led the way in outcome or results based thinking.

[52] *A circle of support, is a group of people who meet together regularly to help somebody accomplish their personal goals in life. The circle acts as a community around that person who, for one reason or another, is unable to achieve what they want in life on their own and decides to ask others for help. That person is in charge, both in deciding who to invite to be in the circle, and also in the direction that the circle's energy is employed, although a facilitator is normally chosen from within the circle to take care of the work required to keep it running. See http://www.circlesnetwork.org.uk/circles_of_support.htm*

Another way in which the voluntary sector contribution can be enhanced, is by local authorities streamlining their tendering and procurement processes, even if the end point of that process only results in a framework agreement or preferred supplier status as compared to a contract. The process needs to be proportionate to the size of the contract. Creating large hoops to jump through only to obtain small amounts of funding is only likely to deter smaller voluntary providers from making bids.

Similarly it would also be helpful if a national agreement could be reached about the financial information to be disclosed in tendering for contracts and a central depository created in which such information could be held and accessed by any local authority. This would avoid voluntary sector providers having to spend sometimes considerable amounts of time and money producing a number of documents that seek the same information – is the organisation financially sound?

Challenge 3: Changed expectations

Response: If front line health and care services are to be afforded long term, then the key will be in cutting off demand and reducing the period of morbidity for many people prior to death. This will inevitably mean both targeting and broadening community based health improvement programmes. Voluntary sector organisations are well placed to help deliver these kinds of services.

The current coalition government has already emphasised the importance it ascribes to the voluntary sector and to developing communities and neighbourhoods. These are areas where voluntary sector organisations have much to contribute. Now the sector needs to respond by showing that it can deliver evidence based results that demonstrate value for money and outcome focussed results. Particularly in terms of health and care projects, the emphasis needs to be on encouraging independence rather than creating dependency. The best of the sector already does this.

Personalisation needs to be about more than a mechanism for aligning who pays for care. Real change may mean not only a choice between agencies but choice between when services are offered, the types of services available and a choice of worker. Nothing can be more humiliating than receiving highly personal care from an individual that you don't like, but on whom you feel dependent and who you have no potentiality to change. Simply giving people money to buy services will not alter this situation if there is no choice of worker, agency or service.

Both commissioners and providers need to rise up to these challenges. Mature collaboration between commissioners and providers is needed to assemble effective market intelligence from which responsive markets can be developed. Whilst commissioners need to embrace their responsibility as shapers of the market, ensuring that a choice of high quality, efficient and flexible services are on offer for individuals, providers need to be given freedom to innovate to create those services. Both commissioners and providers play a shared role in listening to the needs and priorities of service users, and jointly translating these into a choice of services that deliver the outcomes people want. By working together, it is possible to make gain without pain.

APPENDIX A: Participating organisations and case studies

For further information about any of the case studies mentioned this report please contact info@vodg.org.uk

Case studies

The MS Society: Neurological Commissioning Support
Neurological Commissioning Support is a joint initiative of the Motor Neurone Disease Association, the MS Society and the Parkinson's Disease Society. The initiative works to ensure the needs of people with long-term neurological conditions are at the heart of commissioning. NCS works alongside PCTs, County Councils and service users. It produces clear recommendations for PCTs to deliver better outcomes for services in neurology.

KeyRing Living Support Networks
KeyRing's Network model was established to support adults with learning disabilities to have a place of their own. The Department of Health's Care Services Efficiency Delivery department (CSED) recently recognised that the model helps adults with support needs to achieve more than traditional forms of support. It reported cost effectiveness, as the costs of a Network are more than offset by reductions in other forms of support as Members become more self-sufficient. For the full CSED case study go to:
http://www.keyring.org/DocumentDownload.axd?documentresourceid=19

mcch: From Erith to Supported Living
As part of a 10 year contract between MCCH and the London Borough of Bexley for provision of services for those with a learning disability, individuals were moved from an old registered care home into new-build supported living suitable to their needs. Instead of applying a fixed level of support hours to the service, each service had a tailored support contract.

Papworth Trust
In 2008, Papworth Trust was awarded two new contracts for the re-provision of NHS services in Suffolk and Bedfordshire. Service users are now tenants living in their own homes, rather than patients in NHS accommodation. Personal care and support are provided for 50 individuals with learning disabilities, who predominantly have complex needs, including autism spectrum disorder, and mental health issues.

MacIntyre: Derbyshire Learning Disability Services
MacIntyre were contracted by Derbyshire County Council to enact a cultural change; away from traditional day centre provision and towards services that promoted independence, enabling people to develop skills and potential through greater choice of activities and stronger support for pathways to work.

Brandon Trust – Contracting for Change and Innovation
The Brandon Trust has a 15 year contract to provide services for people with learning disabilities in Gloucestershire. They won the £10m project in 2005. The main rationale for the project was to modernise the service provision available in the area. This was to be done by reducing the amount of registered care and provide alternative services for approximately half of the service users within 10 years.

Affinity Trust

Affinity Trust took on a number of registered care services for people with learning disabilities as part of the Kent NHS Campus Re-Provision Programme. The focus of the project was to transform services from residential care to a supported living model. For the first time in years the hours of support needed for the individuals has been tested. Some people have been benefited from a significant increase in support, while others have had a considered reduction.

Crossroads Care and Norfolk Young Carers

Crossroads first started providing services in the area in 1996. The new contact with the Council began in 2003 and saw increased one-to-one support, combined with group work. The team has recently expanded enabling them to create a two-tier service of one-to-one and group work. The team will work with the young person until they are at a point of needing less support; they then step back as the young person enters the support worker led support group with other young carers. This enables them to move their caseload along whilst still providing support and keeping the door open for those who need it.

Hft - Devon

A married couple, both of whom have a learning disability, lived within a registered care service offering 24 hour care. The couple were supported to draw up a person centred plan and moved into their own 2 bed roomed house which they purchased through Advance Housing approximately 15 months ago. The package of support they receive from the local authority has reduced.

RNID – Hear to Help

RNID run Hear to Help projects to provide support to hearing aid users in accessible venues in local communities. The service particularly focuses on providing services in outlying areas where access to the main audiology department may be difficult. In addition to providing routine hearing aid maintenance, Hear to Help volunteers train hearing aid users to maintain the hearing aid themselves. Hear to Help is also able to signpost people to other local services as well as providing information on equipment available to help in the home.

Other work that informed this report

Crossroads Care Norfolk Ltd - Palliative Care Service for Carers

The Palliative Care Service, new to Norfolk, provides emotional and practical support to carers of people with all end of life conditions in West, Central and South Norfolk. Carers of people at end of life require emotional and practical support to enable them to continue to deliver quality care to their "loved ones" and to avoid carers experiencing total breakdown which would put a greater burden on statutory agencies to provide care and support services.

Hft – Cornwall

Seven people with learning disabilities living in residential house in Cornwall were given complete choice, after extensive consultation with residents, families and through partnership work with commissioners and other professionals, as to where they lived and who they lived with. During the 18 month process all seven individuals moved on from the residential service which has now closed. The move was cost neutral for the local authority.

Liveability

People sustaining a physical disability due to serious accident and/or injury often remain in hospital following the acute episode because they are unable to be cared for safely in a nursing home or at home. It was with this in mind that Treetops a nursing home for people with physical disabilities, run by disability charity Livability, reviewed its admissions criteria, and the core skills of its nursing staff and decided to offer a more specialised service to the local Health Authority and other rehabilitation hospitals including Stoke Mandeville, Homerton and the Putney hospital in order to admit patients far earlier than previously.

MacIntyre - Warrington

MacIntyre has supported people within Supported Living in Warrington for a number of years and via PCP and PCR, individuals have been able to take varying levels of control over their lives. A traditional supported living contract/service is being transformed into a personalised and enabling model of support for the people with learning disabilities.

RNIB

Adults who were blind or partially sighted, with additional learning disabilities, physical disabilities or autism had been living in a number of small registered care homes with 5 other residents for a number of years. Although the service had a developmental approach to care and support, the natural "next step" was to have a tenancy, either in a shared house or a flat. RNIB developed opportunities for individuals to take this next step. Initially a transition service was established, and individuals were able to have "trials" in, studio flats within the provision. The small block of studio flats were adapted, and a communal area was established to support the prevention of isolation.

National Autistic Society: Ty Mynydd

NAS decided to design and build two state of the art Autism specific homes after it was decided that provision in North Wales was no longer fit for purpose. The needs of the service users were considered when the building was designed. Individuals who had displayed challenging behaviour have had less incidents as they now have the facilities to suit their needs.

The VODG is extremely grateful to those members who submitted case studies and to Blanche Jones, Public Affairs and Policy Officer at Sue Ryder Care, for her considerable help in collating them.

APPENDIX B – definitions of disability used

Moderate or serious physical disability

Moderate or severe physical disability is defined using five 'core' dimensions of disability - locomotion, personal care, seeing, hearing, communication. Individuals are scored in all areas with either '0' - no disability, '1' – some, '2' serious disability. A score of 2 for any question under the five dimensions indicated the person had a serious physical disability. A respondent with an answer of 1, but not 2, for any question, indicated a moderate physical disability. Further detail can be found here - http://www.archive2.official-documents.co.uk/document/deps/doh/survey01/disa/disa07.htm#a5We

Moderate or serious physical disability requiring personal care
Adults with physical disabilities requiring personal care: also referred to as personal care disability. Includes problems with: getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet. A moderate personal care disability means the task can be performed with some difficulty; a severe personal care disability means that the task requires someone else to help.

Moderate or severe learning disability
Disability levels are defined using the Sheffield categories which group Social and Physical Incapacity (SPI) diagnostic ratings, which identify the nature and severity of people's disabilities. Severe Disability will include those with severe incontinence, severe behaviour problems, at least partly mobile with severe incontinence and severe behaviour problems, non-ambulant. Moderate Disability will include those with mild incontinence problem only, mild behaviour problem only, ambulant but mild behaviour and incontinence problems, no severe problems but only partly mobile.

Further information about prevalence rates and populations can be found at www.pansi.org.uk and www.poppi.org.uk.

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