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Commissioning in a Cold Climate

Phil Saunders, Editor of the Sitra Bulletin, looks at the financial challenges of an ageing population.

Sitra is a membership organisation that acts as an umbrella body for providers, across all sectors, of housing with care and support. Over the past 10 years, Sitra has been intimately involved with the implementation of the Supporting People (SP) arrangements, for provision of what is now generally termed "Housing Related Support" (HRS). So, in this article, I'm addressing the issue of commissioning in a cold climate primarily from two points of view:

- That providers want and need a mature, trusting, partnership-based relationship with commissioners, which enables them to be creative in meeting the self-expressed needs of service users, with diminishing resources

- That close attention needs to be paid to the light touch, preventative approaches typical of HRS, when devising personalised packages of care and support for older people.

Despite the current controversy around deficit reduction, my argument takes it as given that public expenditure on meeting the needs of older people will be seriously constrained, at a time when demand (in terms of both population and expectations) will be rising.

Commissioners and Providers

As an alternative to out-and-out privatisation, Government, both national and local, want a vibrant "third sector", ideally consisting of "social enterprises", to take on much more of a role in service delivery. However, in making this transition, money has to be saved. The need to save money means that providers need to be able to offer low prices. But many social enterprises, especially small ones, don't have the capacity to do so.

From a purely financial point of view this, arguably, does not matter. In many areas, especially in the field of housing, care and support for older people, there

are enough big providers to supply what is needed - and offer enough choice. The complication comes in wanting a "Big Society". In as much as we understand the term, this entails the existence (or emergence) of smallish, or at least highly localised, providers, who can release social capital through volunteering, user involvement etc.

OK, so many big providers do have significant local presence and many small ones can offer very good value for money. Likewise, big providers can't automatically cut costs to the bone, whilst maintaining the management infrastructure necessary to ensure standards. But the tension between capacity building and driving down costs is a long standing issue. With the sheer scale of the cuts we are now facing, the time is right to make serious efforts to resolve it.

Price, Cost and Outcomes

If we want a viable provider sector, I would argue that we need to radically change the way we look at *how* we save money – at how we regard issues of price and cost. At the moment, I think commissioners of older people's services are too wedded to the concept of the "service hour". Needs are often assessed and expressed in terms of the hours of care and support required by the service user. The provider's hourly inputs are then monitored almost obsessively.

As a knock on effect, Commissioning, Procurement and Contracting exercises also tend to focus in on "price per hour". This further locks us in to input based thinking, at the expense of outcomes. Whilst the purchaser can demonstrate that they have saved money per unit/hour, the obvious strategy for providers becomes to buy hours (of labour) cheap, in volume, and sell them on at a small mark-up. In some provider organisations, this has led to subsidiary companies being set up to employ staff on low hourly rates, with zero-hours contracts.

This can't be good for quality – and, in any case, there are limits to how much money can be saved. After all, what happens once you are getting your paper clips from the cheapest, nastiest factory in China? Once your profit margin is virtually nil, there's no more room to manoeuvre. The same thing will happen in care and support for older people, once minimum wage levels are reached, casualisation has gone as far is as practicable and quality standards cannot be compromised further.

To get out of this downward spiral, I think providers need to be freed up to focus creatively on outcomes. As Jeff Jerome (National Director for Social Care Transformation) says (in the Society Guardian supplement of 29 September 2010) "*we need to move away from the expectations created by councils – that everything should be done on a time and task basis"*. Jerome goes on to say that we need "*dialogue with the service users about what they want and if they want to vary the type of service delivery".* The clear implication here is that services users need not be limited to time and task based choices.

But, most importantly in this context, I think a focus on outcomes is the only way to save money. Let providers come up with innovative ways of facilitating positive outcomes, without merely "putting in the hours". If we are serious about payments by results, let's support obvious solutions like group work, which can help to make services time/cost effective. Let's not follow the lead of the local authority who would not "allow" it, because their contract monitoring hinged on one-to-one hourly service delivery.

Prevention and Personalisation

Group work is just one example. More important will be the integration of, one-off or time-limited interventions (such as those provided by short term HRS) into personalised care and support packages. There is much emerging existing good practice around prevention of long term dependence, such as re-ablement, hospital prevention and home-from-hospital services. But I'm not sure we've thought enough about how these fit in with the machinery of choice and control.

The Office for Disability Issues (ODI) project on the Right to Control (www.odi.gov.uk/working/right-to-control.php) is beginning to examine this problem in more detail. The local authority "trailblazers" involved are beginning to look at how the funding streams for one-off payments (such as Disabled Facilities Grants) time limited interventions (such HRS) and longer term care can be unified in Resource Allocations Systems. Some radical thinking is emerging, such as dis-incentivising long term dependency by awarding relatively greater, immediate resources to those choosing one-off/time limited, preventative services. This works best if the council is happy for service users to choose what works rather than what fits the service specification.

Once a focus on outcomes is agreed by commissioners and providers, I would argue that the dialogue between the provider and the service users becomes paramount. Achieving an upward spiral becomes a matter of aggregating intelligence from outcomes focussed, self directed support plans to form the basis of market management. However, this will take time, so the basic principles need to be agreed at the outset. Just as important as the specifics (say, of outcomes focussed monitoring) will be the culture of trust between all parties to the delivery system.

I recognise that this poses a major challenge. Councils will need to start seeing providers as partners, rather than mere suppliers. Outsourcing to social enterprises will be as much a transfer of responsibilities as a delegation of tasks. In the Big Society, maybe care and support activities will gradually cease to be regarded as "state functions contracted out" all together.

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