

Modernising Commissioning

-consultation response by 5th January 2011

Contact:

Bernd Sass, Policy & External Relations Manager
National Centre for Independent Living (NCIL)

Please note: We predominantly respond from the perspective of health & social care markets. Comments are limited to those questions which we feel able to answer and which are within our remit as a national infrastructure body and human rights campaigning user-led organisation (ULO) for disabled people (including older people and people with mental health difficulties). The wider points on the consultation are made first followed by responses to the actual questions further down below.

About NCIL and RADAR

The National Centre for Independent Living (NCIL) and the Royal Association for Disability Rights (RADAR) are user-led organisations established to campaign for equality and justice for disabled people and promote independent living. Together we directly represent over 500 local disability groups (including Centres for Independent Living (CILs) and user-led organisations (ULOs) and many national disability organisations as well as hundreds of individual disabled people. Through our organisational members we reach several million disabled people.

We believe radical reform of care and support is vital not just for the achievement of equal citizenship for disabled people but for stamping out age discrimination, promoting gender equality, eradicating abuses of children's human rights (when forced to act as carers), promoting equality for carers, strengthening families and local communities and boosting our economy.

Introduction

We welcome that this Green Paper is aimed at "increasing the role of charities, social enterprises, mutuals and cooperatives in public service delivery". It will be important to

feed back what we as user-led organisations (ULOs) can contribute to this agenda and what our requirements are.

Cuts to services and support for disabled people do not need to happen to the extent announced in the comprehensive spending review. If choice and control are shifted to disabled people, any type of support becomes increasingly demand-led and no longer just driven by the capacity of staff who need to do work regardless of actual demand from disabled people.

We would want the 'right to challenge' to become meaningful so that – where there is scope to do this – that challenge can amount to replacing services which have failed. If the 'right to provide' through employee-led mutuals would be extended to a right for disabled people to provide (paid!) support for and by themselves, we would see a considerable reduction of waste and an increase in choice & control with more disabled people leading full economic, social and cultural lives. There have already been successful examples, eg of disabled people who set up a cycling and cycle repair scheme in conjunction with a school which now operates as a user-led mutual fully controlled and run by people themselves. Most user-led mutuals will be best placed in health & social care, though.

Sub-question: What are the implications of payment by results for civil society organisations?

Nearly all ULOs and a lot of TSOs will not be able to entertain PbR (payment by results) because they won't have the necessary reserves to underwrite service delivery in advance of payment. See also further barriers to a more level playing field on pages 5 and 6.

Co-produced Commissioning

We do not believe that the presented commissioning frameworks (through GPs or traditional commissioners or provision based on the 'right to request / provide') will bring about the necessary improvements to engage disabled people or user-led organisations (ULOs) as co-commissioners. Instead, this Green Paper seems to predominantly address profit-making mutuals as opposed to user-led mutuals or ULOs. Crucially, we would want to be sure that individual service users are involved and able to directly influence if not take over the commissioning of some of the services they use. Without such a commitment from government we are concerned that the delivery of the Big Society and of personal (health) budgets and choice and control (in terms of scale, meaningfulness and purchasing power) will not become a reality.

Sub-question: How can we encourage more existing civil society organisations to team up with new employee-led mutuals?

Sub-question: What issues should commissioners take into account in order to increase civil society organisations' involvement in existing public service markets?

Sub-question: What role and contributions could civil society organisations play, through Local HealthWatch, in informing the local consumer voice about commissioning?

There is currently a huge gap between the ventures which cooperative development agencies commonly support and the initiatives of disabled people who want to pool their personal budgets potentially to the extent of setting up their own user-led mutuals.

The potential impact of user-led mutuals is manifold:

1. The government's choice & control agenda places huge opportunities and responsibilities on disabled people in terms of making their own involvement meaningful; this transition needs to be facilitated by peers from which people can learn that it pays off to exercise choice & control
2. To open up new services or business opportunities that further independent living and employment of disabled people on their own terms
3. To facilitate the transition from public service provision that is capacity-driven to provision that is led by demand and thus cuts waste and improves efficiency

If we consider the health & social care sector, it seems advisable to start involvement at a lower level of (social care) needs rather than leaving this to life-threatening situations. ULOs are in a very good position to facilitate and strengthen involvement channels early on locally. In such areas there would be scope for co-commissioning and co-designing services between GPs and ULOs.

In each locality there should be independent information, support, advice and public education made available to people – this can be provided from 'pan-disability or condition-specific user-led organisations (ULO) and third sector organisations (TSOs).

ULO are well placed to work across health and social care sectors which would ensure some strategic overview across 'care areas', a focus on aspirations rather than just needs and some independence in the bottom-up process of the proposed integration of health & social care; 'bottom-up' would then mean driven by people themselves rather than by public sector or Third Sector Organisations. A strong ULO voice would also help to balance out the different views and experiences that GPs will have within their consortia about different patient groups and health inequalities spread across any single locality.

A further part of the work of many of those ULOs already is in the delivery of personal budgets, including outreach/information, self-assessment, support planning, brokerage, monitoring and review, and pooling budgets. Some ULOs have additionally been commissioned by PCTs to support personal health budgets across 'care areas' and/or to provide information and advice on equipment for example. We feel it is important that this expertise should be built on and used to benefit both those using services and GPs in fulfilling their commissioning role.

From services that are driven by staff capacity to services that are demand-led – strengthening Service Users as ‘Change Agents’ of the public service landscape

We highly welcome the ‘right to choose to register with any GP practice’ and the envisaged ‘right to a personal health budget’. We would hope that personal health budgets will be extended beyond the existing pilot schemes to become the norm. In some respect, the service user is becoming a change agent to ensure a great deal of the requirements for quality and continuity of care to take place. We hope that ULOs will be equipped to stand by service users in this change agent role, inform them and support both shaping new ideas for support and making them happen.

To be effective in this transition, resources must be freed up to benefit new demand-led types of support and care. As yet, de-commissioning of costly traditional block contracts or in-house provision is either avoided or rushed without clear and comprehensive transition plans that make full use of the savings and pass them on to more innovative types of support.

The NHS and councils should redesign parts of their business processes and focus on support that is demand-led and not driven by staff capacity. There is as yet no indication of innovative approaches which allow both choice & control at a larger scale and the required shift in power – central government has not put in place effective levers that require councils and other service providers to co-produce new types of support together with user-led organisations. Instead, disabled people are served packaged choice options if anything. Yet, we could go even further than merely co-producing new services. If the ‘right to request’ (NHS) and the ‘right to provide’ (Adult Social Care) through employee-led mutuals would be extended to a ‘right for disabled people to provide (paid!) support for and by themselves’, we would see a considerable reduction of waste and increased choice & control and more disabled people leading full economic, social and cultural lives. This prospect would also give some practical meaning to the proposed ‘right to challenge’ by replacing services that are not demand-led and lack sufficient quality and continuity of care.

To this end, patient support and information to facilitate choice should become integral, recognised and paid parts of any health and social care pathway. These parts should be separately commissioned to ULOs or patient-led organisations or subcontracted to them by healthcare providers. This staged approach needs to be reflected in extensive staff engagement to bring about cultural change from within the NHS and provider organisations. It is certainly not sufficient to make it a requirement for a provider to be listed under ‘Choose and Book’. In addition, any provider should be allocated a percentage for facilitation of choice and should be required to report on how this amount has been spent. However, any technical or system (eg software) changes should be supported by an extensive, parallel cultural change programme, in order to approach and overcome staff resistance effectively. It is certainly beneficial to map and think through the relevant systems and processes (eg ‘money follows the patient’), however all good health and social care starts and ends with good relationships, and this aspect we consider very neglected in this Greater Choices paper.

Many ULOs and also patient-led support organisations form and build on these relationships, and their focus is on the person in context. They have widened access to their support services to accommodate for and actively reach out to individuals with any of the protected characteristics. It will be particularly crucial to engage seldom heard or reached groups via other community links. For instance, there are very successful partnerships between community hubs that are good at engaging with specific ethnic minorities (where people would gather for social activities) and NHS services that are good at providing secondary care or crisis treatment. Joint employment of staff and co-location are often very effective drivers to enable people from all backgrounds to exercise choice in their 'natural' environment and at their pace and on their own terms.

By comparison, the proposed Local HealthWatches (to be built on existing LINKs) lack democratic legitimacy and are widely unknown to the public unlike ULOs which have grown out of shared local interests and networks and are built on democratic consensus. Either way, due to obvious conflicts of interests, local authorities should not be the commissioners for advocacy as that support may well be targeted against them.

Sub-question: What issues should the Civil Society Red Tape Taskforce consider in order to reduce the bureaucratic burden of commissioning?

Sub-question: What issues should Government consider in taking forward the Public Services (Social Enterprise and Social Value) Bill?

We welcome the considerations to make the existing public service markets more accessible. However, we fear that the highly beneficial contributions of ULOs and mutuals have not been addressed and incorporated into the outline provided. Further criteria which we would expect to be considered for a provider's fitness and actual ability to provide services are:

- 'Social return on investment' that can reasonably be claimed for previous work by any provider should become an essential criterion for fitness - as featured in the recent Public Services Private Member's Bill, and upcoming user-led mutuals and ULOs need to be trained in corresponding methods to flag up their unique benefits
- Service agreements or preferred provider lists need to be opened up to more flexible and informal types of support, user-led mutuals, self-employed people or micro enterprises and all those support services that are exempt from CQC regulation
- For any 'willing provider', proven ability and willingness to cooperate with information & support providers on a level playing field OR clear accounting of how a percentage of unit costs would be or has been spent on information and support to facilitate effective choice

- Wherever possible, the 'right to a personal health budget' should be applicable so that the service or support concerned can be paid out of personal (health) budgets, either directly as a cash payment or through third party organisations

Furthermore, small providers should be supported in the following ways in order to create a more level playing field:

- CQC to set out 'softer' requirements at an affordable cost for emerging small providers
- CRB checks – which often 'passport' contracts – must be provided to everyone including self-employed people who currently cannot request CRB checks on themselves (which CQC requires them to have)
- Improving 'test-trading' and permitted earning provisions to enable people to make the transition from benefits to becoming a small provider
- Start-up or transition funding would enable the necessary fitness for emerging support & information facilitators in the community or existing ULOs and patient-led support organisations intending to widen their remit
- Private Hire Vehicle Legislation should not prevent willing providers from occasional transport of people just because they do not reach the economies of scale required to pay such expenditure
- A directory with all providers should be established
- The approach to 'willing' providers should be varied depending on size, types and units of support provided and (reasonably claimed) social return on investment