



Single Point of Access to Third Sector Services: The Conwy Collaborative Approach

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ABSTRACT

The need for joint working between statutory and non-statutory bodies is an important component of policy across the UK. While it is something that governments push for, it has not always been delivered effectively in practice. This paper reports on a project that sought to bring together statutory, voluntary and community sector bodies to help improve and strengthen the planning and commissioning of services from the third sector to support health and social care needs. The model was intended to provide planners with a single reference point for procurement of service packages from a combination of statutory, independent and third-sector organisations for specific regional and local service-user groups. We report on the experience of the first 18 months of this project, indicating that the project has been highly successful in the eyes of a range of stakeholders. Stakeholders from a range of backgrounds were far more positive about the experience than the literature would predict to be the case. Outcomes monitoring suggests that service users were far more independent and had seen improvements on a range of dimensions. The paper finishes by formulating suggestions for the factors which seem to have contributed to its success.

KEY WORDS

partnership; third sector; intermediate care; outcomes

Introduction

The need for collaboration between a range of different statutory bodies is well-established in the health and social care policy and practice literatures (see Glasby & Dickinson, 2008, for an

overview). The requirement for statutory bodies to work with voluntary and community sector bodies has long been recognised as important, but is becoming increasingly crucial in the eyes of the UK governments (Macmillan, 2010;

Alcock, 2010). Wales is no exception to this rule. In Wales reform of the health and social care system has been conceptualised with collaboration firmly at its core.

Our experience shows that improving service delivery will be achieved by more co-ordination between providers to deliver sustainable, top quality, responsive services, rather than by increased competition between providers. (WAG, 2004 p4)

The Welsh Assembly Government (WAG) has been clear about the need for joint working between a range of partners in order to provide the types of service that individuals want and need.

Individuals often have needs which are the responsibility of several local authority departments, different agencies or are provided through a mix of statutory, private and voluntary bodies. This requires joined-up planning, commissioning and delivery of services. (WAG, 2007 p24)

The third sector is seen as an important component of this collaborative effort because it can:

- *Help to diversify the care market which is very dependent on for-profit businesses;*
- *Be flexible innovators in exploring new ways of delivering services and building services around the needs of the citizen;*
- *Be an effective agency to deliver a single service for two or more commissioners;*
- *Provide very specialist services that are more effective or viable when provided over a wider area;*
- *Help communities to find citizen-centred solutions to local needs;*
- *Often be more acceptable to hard-to-reach groups;*
- *Be an articulate champion for those whose voices are rarely heard. (WAG, 2007 p28)*

Although the national policy context encourages joint working, funding regimes do not always encourage third-sector organisations to work collaboratively because they are often competing with each other for smaller and smaller pots of funding (Buckingham, 2009; Milbourne, 2009). With reductions in grant funding, third-sector organisations are extending the scope of the services they deliver in order to fit the criteria of the funding; some organisations are stretching their reach beyond the aims and objectives of their organisations, and sometimes duplicate the work of others (Cairns *et al*, 2006). The third sector is fragmented and independent, making it confusing for funders to understand what services are on offer. Often organisations will provide a service only in a very small geographical area, or to a single section of the population, making it inadequate for the needs of the planner of services, who perhaps is required to provide the service across a region or to more than one section of the population (Macmillan, 2010).

This paper examines an example of a model to help improve and strengthen the planning and commissioning of services from the third sector to support health and social care needs. We describe the Conwy CIC Start Pilot, a new consortium model piloted in Conwy, North Wales, and its experience over 18 months of operation. This model is intended to provide planners with a single reference point for procurement of service packages from a combination of statutory, independent and third-sector organisations for specific service-user groups on a regional and local basis. The purpose of the consortium is to act as a partnership 'clearing house' for its members, who are all involved in delivering services related to specific service areas. Such an approach is thought to make services dynamic and relevant to needs at all times, as well as cost-effective and seamless, so that service users can progress through a framework of services as appropriate. The research sought to examine the

processes and outcomes of the pilot and draw lessons for this project and implications for policy and practice.

Overview of the project

In the policy context set out in the previous section, we described how health and social care agencies in Wales have been attempting to formulate strategies for working more closely together and in conjunction with a range of non-statutory bodies in effective support for individuals and communities. In Conwy this challenge is seen as very real, given the demographic patterns in the local area. The population of Conwy is approximately 111,400, with a slight increase each year due to in-migration of older age groups who move to Conwy to retire. At 28% of the population, Conwy has the largest proportion of post-retirement residents in Wales, and the only areas with larger proportions of the elderly in their population in England are well-established retirement areas such as West Somerset. Life expectancy at birth is 77.0 years for men and 81.3 for women. A large proportion of residents suffer from limiting long-term illness and the incidence of cancer is high; 11.2% of the total population in Conwy (12,300 people) provide unpaid care, compared with 10% in England and Wales. More than a quarter of these carers (more than 3200 people) provide 50 or more hours of care a week (Corporate Research and Information Unit, 2010).

Intermediate care services, as the interface between community services and secondary care, are crucial to relieving the burden on acute care and ensuring that people are helped to maintain their independence (Andrews *et al*, 2004; Barton *et al*, 2006). In Conwy it was established that intermediate care is an area where the third sector has a lot to offer, a finding for other areas too (Nancarrow, 2004; Andrews *et al*, 2003; Pearson, 2002). Building on work already undertaken by the Conwy Maintaining Independence Project in

establishing the Conwy Intermediate Care Service (CICS), this area was selected as a pilot. CICS is a multi-disciplinary statutory sector team, which includes professionals from health and social care co-located and managed as a single entity, that reports to both statutory bodies on its activities. The CICS team had identified that, although service users were being returned to a suitable level of physical health, they required something further to help them regain their independence. When people have an acute episode of a chronic condition and a change in personal circumstances they can become socially inactive, and without the support of friends and family fail to negotiate the means by which they can engage again in a meaningful way in society. This makes them more vulnerable to further problems, loss of confidence and deterioration in their independence.

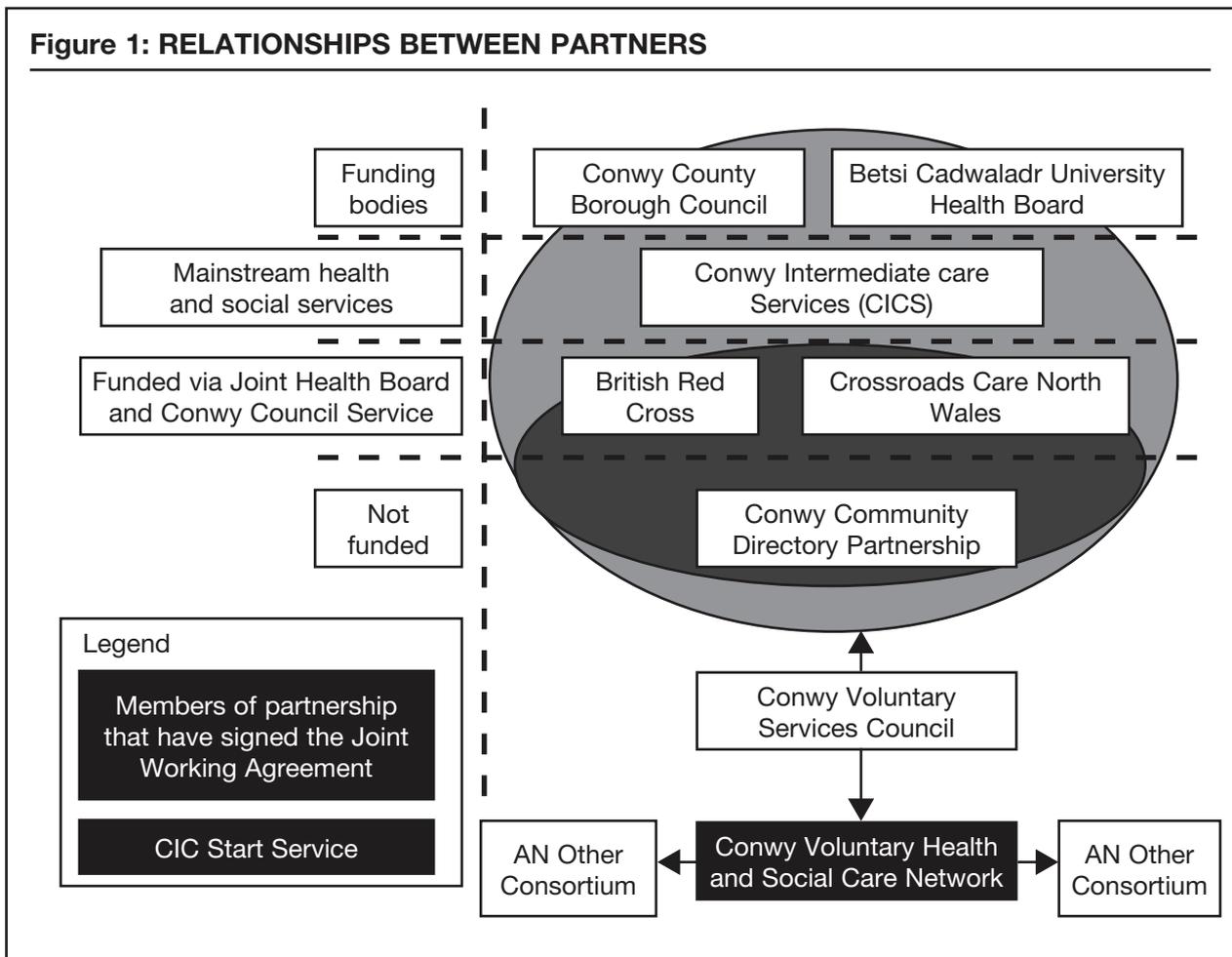
Although there are existing support services in the voluntary sector, such as community transport, luncheon clubs and disease-specific support groups, information about them is often seen as difficult to access. Even where information is forthcoming, it is often daunting for a vulnerable older person to negotiate entry to the service, especially if they have lost confidence as a result of an adverse health situation. The CIC Start Pilot aimed to link the services delivered in the community by third-sector organisations seamlessly with the CICS team. The members of the consortium each retained their own contractual relationships with their funding agencies, but developed shared processes and paperwork to support service delivery. The sharing of client information between organisations was supported by a personal information-sharing protocol as set out in WASPI, the *Wales Accord for the Sharing of Personal Information* (WAG, 2010). The relationship between the organisations was supported by a joint working agreement in which the distinct roles and responsibilities of each partner were made explicit, enabling the consortium to

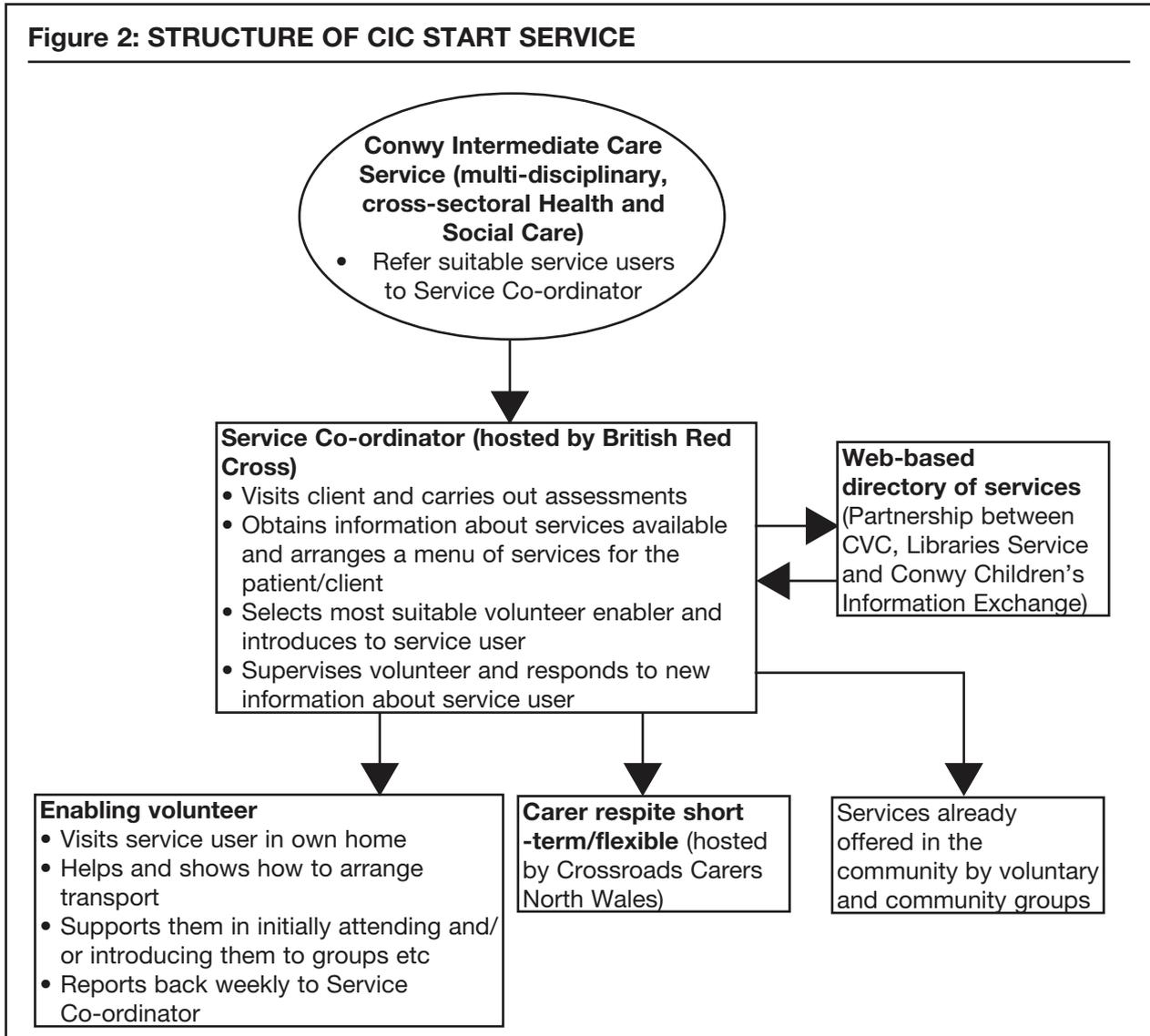
include statutory organisations as equal partners without having to resort to the cumbersome legal arrangements normally associated with traditional consortia models. It also enabled the consortium to be flexible and responsive to need, because it was expected that the number and mix of delivery organisations would develop and change over time. The relationships between the partners are set out in **Figure 1**, below.

Following a phase of preliminary work funded by WAG, funding for a one-year pilot was secured through the NHS Chronic Conditions Management Transitional Funding and was closely linked to achieving the outcomes made explicit in the CCM Local Improvement Plan. The stated outcomes of the project were:

- maintenance of patients' independence and autonomy
- reduction in unscheduled hospital admissions
- prevention of social isolation and empowerment of the individual towards independence and self-management
- reduction in re-referrals to CICS Team
- reduction in admissions to long-term nursing and residential care
- possible reduction in social services costs
- increased uptake of self-management initiatives.

The structure of the service is shown in **Figure 2**, opposite.





To evaluate the pilot, a performance-monitoring framework was established that used data drawn from a variety of sources to assess its success in these key areas:

- the impact on secondary and intermediate health and social care resources for the client group engaged by the pilot
- improved quality of life and independent living for this client group
- an improved model of partnership working between the statutory and third sectors in health and social care.

The pilot phase ran for one year from October 2009 to September 2010, and additional funding to continue the service was secured for a further six months from the Joint Flexibilities funding stream managed by the local authority. It is expected that the service will now be absorbed into mainstream funding and the model replicated in other service areas within the new NHS Community Services structures in North Wales.

Project evaluation

The research reported in this paper is based on data collected by the project team during the one-year piloting process and from a series of focus groups and interviews conducted by a university researcher independent of the project team. In relation to the routine data, under the conditions of their service-level agreement the British Red Cross supplied reports detailing number of referrals received, whether accepted or declined, and the service delivered during the time period. Referrals were broken down to show the male/female mix, age profile, geographical location and source of referrals. Crossroads Care North Wales supplied monthly and quarterly reports detailing the number of hours and types of service delivered. Data relating to outcomes for patients were monitored by the service co-ordinator using the Outcomes Star approach (Triangle Consulting, 2006), which involves individual self-assessing on a scale of 1–10 in the areas set out in **Box 1**, below; the only change to the original framework was substituting the domain of ‘offending’ for ‘isolation’. Each individual was assessed at the beginning and end of the 12-week intervention. Data of ongoing services accessed by clients was collected to establish the number and range of available services for supporting people in the community.

Box 1: OUTCOMES STAR APPROACH

- Motivation and taking responsibility
- Self-care and living skills
- Managing money and personal administration
- Social networks and relationships
- Drug and alcohol misuse
- Physical health
- Emotional and mental health
- Meaningful use of time
- Managing tenancy and accommodation
- Isolation

To assess impact on clients’ use of acute health services, the pattern of hospital admission of each client from the previous two years at the point of referral was collected by the Health Board with the intention of comparing it with the pattern of hospital admission for the following six months and one year. Continuing health care data already collected by the Health Board was screened to identify CIC Start clients accessing complex care packages or residential care following the CIC Start intervention. Similarly, CIC’s client records were screened to identify re-admissions to the CIC’s service of CIC Start clients. At the end of the intervention each client was given a feedback questionnaire which could be filled in and returned to the Health Board anonymously.

As Nancarrow (2004, p44) observes, practitioner perspectives on intermediate care are often absent and:

the quest for evidence on the delivery of intermediate care has emphasised service effectiveness and outcomes.

This research therefore aimed also to incorporate practitioner and front-line perspectives on the project and their experience of this process. Focus groups were conducted with representatives from Crossroads Care North Wales ($N = 3$ participants), British Red Cross ($N = 2$) and Conwy Intermediate Care Team ($N = 4$). Focus groups were also conducted with some of the volunteers who had delivered the service ($N = 3$) and two of the older people who had received the service. Telephone interviews were conducted with four senior managers who were involved with the establishment and running of the project. Focus groups were conducted in Conwy in the offices of Crossroads Care North Wales, CICS team and the British Red Cross. The researcher made extensive notes, which were analysed for key themes relating to the processes and outcomes of the pilot.

Findings Referrals and service access

During the pilot period 137 people were referred to the service, of whom 136 were accepted; 19 declined the service, ten were admitted to hospital and two died following referral. At the end of the pilot 115 clients had been assisted and 102 were living independently. A full dataset for each client will not be available for the pilot period until October 2011. We can, however, report some early results from the Outcome Star scores, and draw some tentative conclusions by comparing them with the types of service the clients received or to which they were redirected. We can also construct a picture of the client base from their previous two-year hospital admission pattern, gender, age and geographical location which provides a meaningful context.

Referral to the service was via a member of the CIC Team and was open only to clients of the CIC Service. This limited the client base to people who met the CICS referral criteria; that is, resident in Conwy County, and has suffered an acute adverse health episode but has the potential to regain their independence following a period of support in their own home. Although the CIC Service, and consequently CIC Start, are available to anyone over the age of 18, 93.5% of referrals were over 60, 42% were aged between 81 and 90, 13% were aged between 91 and 100 and one person was over 100. Three-quarters (74%) of referrals were female and 26% male. All the referrals came from the northern region of the county, with 92.6% from the more densely populated urban coastal strip. It is of particular significance that 43.3% were from Llandudno, Penrhyn Bay, Rhos on Sea and Colwyn Bay, which are the main areas for the in-migration of older people to retire.

Table 1, below, shows the number of CIC Start clients and their total number of hospital admissions in the two years before referral to the CIC Start project. The table also includes

a breakdown of admission types. As this table shows, a significant number of these individuals had several hospital admissions over this period. The typical client was elderly with a chronic life-limiting condition (or a number of conditions), living alone or caring for an elderly relative. They tended to be home owners with a private income who had moved to the area to retire.

Self-assessment scores

A hundred clients completed the Outcome Star Assessment tool and **Table 2**, overleaf, shows the difference in self-rating between the initial and final assessments. The average difference in self-assessment was 19%, meaning that the

Table 1: HOSPITAL ADMISSIONS BEFORE REFERRAL TO CIC START

Hospital admission two years before referral

Number of clients	Number of admissions
27	0
23	1
28	2
15	3
14	4
8	5
6	6
5	7
1	8
3	9
3	11
1	14
Total	373

Admissions breakdown

Emergency admissions	235
Elective daycase	65
Elective inpatient	61
Other	12
Total	373

majority saw a significant improvement on the areas in the tool. **Table 3**, below, delves into the individual elements of the tool in more detail and the changes in them between assessments. As this tool indicates, improvements seem to have happened in all the elements. The only areas with little improvement are drug and alcohol (which is not an area of great need in this client group), and accommodation.

Volunteer services

A total of 61 clients were assigned a volunteer enabler. These individuals were usually involved in signposting services in the community. It is impossible to say with certainty how many of these signposting suggestions were acted upon, but where the service co-ordinator was aware

that a suggestion had been followed up and the client had benefited from the information/service, it has been recorded and indicates a high take-up of community transport, welfare rights and pension services. There is also a high take-up of carers' support services and schemes. In addition to the free services available, the results show some take-up of private services such as cleaner, gardener, carer respite and hot meal delivery service. This is in keeping with the large number of referrals from the popular retirement areas where there is a predominance of elderly people who are home owners and have private pension income to support a degree of self-funded care.

In addition to signposting, volunteers offered telephone contact, visits, companionship and support, escorting, shopping and paperwork. These activities to some extent support the improvements in mental and emotional health and well-being which were noted in the self-assessments. Many of the schemes taken up have been relatively simple solutions about home safety. In encouraging people to make very small simple changes, the service has had a big impact on their confidence, sense of security and well-being. Given the age profile of the client base, it is interesting that 75% of accepted referrals were discharged from the service to living independently in their own homes and

Table 2: PERCENTAGE CHANGE IN OUTCOME STAR SELF-ASSESSMENT

Number of clients	% difference
5	-10%–0%
16	1%–10%
34	11%–20%
37	21%–30%
3	31%–40%
4	41%–50%
1	+ 50%

Table 3: INDIVIDUAL ELEMENTS OF SELF-ASSESSMENT SCORES

Indicator	Initial assessment	Final assessment	Value difference	% difference
Motivation	579	797	218	38%
Self-care	704	870	166	24%
Money	793	896	103	13%
Social	592	765	173	29%
Drug & alcohol	988	998	10	1%
Physical health	536	719	183	34%
Emotional health	539	741	202	37%
Use of time	540	742	202	37%
Accommodation	759	873	114	15%
Isolation	563	759	196	35%

that, to January 2011, none has been admitted to residential care or been in receipt of a complex care package.

Perceptions of the pilot

The stakeholders who took place in focus groups and interviews were resoundingly positive about the pilot project and their experiences. The responses suggested that the project itself was a success, but that there was another dimension of success in terms of the relationship between partners. The project was seen as crucial in filling a gap that had previously been unaddressed in the local area and, for the statutory bodies involved, had provided a clear process for referring individuals on to services that had previously been difficult to access. Individuals who had used the service found it invaluable, and that their confidence had returned hugely over the period of the programme. These individuals suggested that, without the support, they would not have returned to the same level of independence. Volunteers who were involved in visiting these individuals greatly enjoyed the experience and could see clearly the difference it made. They sometimes found it difficult to break contact after 12 weeks of social contact with an individual, but the training they received taught them to expect and plan for this. The person-centred nature of the project was welcomed by all, and the use of the self-assessment process was seen as an excellent way of being able to tailor support to individual wants and needs, in line with a personalised approach to support. The project was clear from the outset what it set out to achieve, and all agencies bought into this. This was cited as important in facilitating joint working. The co-location of the intermediate care team and the referral co-ordinator for the project was also seen as an important factor. Working together in this way allowed professionals to discuss individuals and make sure that referrals to the project were appropriate.

Before this project most of the stakeholders reflected on the fact that they had previously not had a great history of working relations between the various bodies involved in the project. Several reflected that the process of working together had been positive, and should result in working together more closely in the future. In terms of what had been important in creating this positive experience of joint working, various stakeholders highlighted the same sorts of factor. All stakeholders felt that it had been a very well-designed and managed project, but that it had taken a lot of input. This was a pilot project that had significant resources of time and money invested in it, which was seen as crucial to its facilitation. Without the resources to plan and set it up, some felt that it would not have gone ahead at all or could have taken much longer to establish. A role was created for an 'honest broker' who nurtured the partnership but was also an outside party who did not have a direct interest in service delivery. This role was as a matchmaker to develop potential partnerships, a diplomat to arbitrate in difficult situations and a midwife to support the partners to give birth to the new service. A member of the County Voluntary Council played this role to drive and project-manage this initiative.

The honest broker was seen as providing strong and consistent leadership, which was seen as crucial in keeping going and pushing through any obstacles that did arise. The project was co-planned with input from all stakeholders, which was crucial to the success, and the honest broker ensured that all partners contributed from their own area of specialism. Each partner needed the assurance that anyone drawn into the partnership would respect proper service delivery boundaries and would not stray into areas of service delivery outside their organisational aims and objectives and compete for resources against a partner organisation. This built an atmosphere of trust and openness, and willingness to share resources and information.

There was rather less in the interviews on negative experiences associated with the project, although the significant paperwork associated with the project was sometimes mentioned. The bigger issue for most stakeholders was about the sustainability of the project. The resources to establish the project had come from sources that were time-limited and so the future of the project was not assured at any time. As a number of stakeholders suggested, this added to a sense of insecurity and posed some difficulties. Individuals employed by the project did not know whether their employment would continue or they would need to find other employment. A number of those interviewed highlighted the importance of making sure that issues of budget and sustainability were thought about from day 1 and that the ongoing security of the project was there so that it was taken seriously and not simply seen as a 'flash in the pan'. There were mixed views on the sustainability of the project. Most saw the model of working as transferable, although it would have to adapt and extend to other geographical and service areas. Additional resources were provided for the pilot project and were needed to establish and test the model and monitor the success of the project. These additional resources would not be available in the longer term, but the actual cost of service delivery is reasonable, particularly given the additional resource levered in from the community. All hoped that the project would become mainstreamed, but voiced concerns that the context of financial hardship would make this difficult.

Conclusions

Overall, the findings are very positive, particularly when considered against a background of the difficulties that are often reported in making partnerships work across organisational and sectoral boundaries (Macmillan, 2010) and the lack of evidence on the effectiveness of partnerships

for service-user outcomes (Dickinson, 2008).

The self-reported assessments give a picture of a service that has demonstrated improvements in various dimensions of the lives of individuals with significant needs, and the routine data collected and the perspectives of all uncovered during the research suggest a very positive picture. This is despite the relatively small scale of the project, which is dealing predominantly with preventative and emotional well-being interventions for which it is notoriously difficult to demonstrate outcomes. It often takes time for longer-term outcomes to become clear, and it is difficult to prove events that have not actually happened in the case of preventative services (Dickinson, 2008), but through an innovative combination of approaches the project has managed to demonstrate impact in the local area. Those who had accessed services were positive about the impact that it had had, and the main partners worked together effectively across organisational, sectoral and client group boundaries.

This could be a starting point for relationships between voluntary and community organisations and statutory bodies in the local area, and a model that can be rolled out to other client groups in the future, building on this good work. As a result of this project individuals are being signposted to a range of other services that might not be funded by health boards or local authorities and which also have a preventative effect. It is these links that the project has tried to capture, but which will ultimately be difficult to measure effectively in the short term. This illustrates well the difficulty of evaluating integrated initiatives effectively when they are part of wider social and political systems (Jöel & Dickinson, 2009). **Box 2**, opposite, sets out the factors that were crucial in the development of the consortium in Conwy. They will be helpful in developing other such partnerships in the local area, and some may have salience in other health and social care economies.

Box 2: CRUCIAL FACTORS FOR THE CONSORTIUM

- Considerable commitment in time and energy was gained from all partners
- A shared vision of what success would look like was established at the beginning, as were leadership structures
- An inclusive co-planning approach was adopted to ensure that representatives from both sectors met to discuss and shape the proposed service, which led to a strong sense of shared ownership of the service by all participating organisations
- The project was careful to maintain the integrity of partners and not stray into the service areas of other partners. Organisations delivering a service as part of a consortium are not in direct competition with each other for a single source of funding, they are not compelled to extend the services they offer in order to meet funding criteria, and the risk of duplicating the work of another organisation is greatly diminished
- Consortia enable organisations to deliver services which call for a range of activities without resorting to the need to divert resources away from their core activities. Instead, individual organisations assume responsibility for delivering discrete elements of that service. As a consortium, they are responsible for the entirety of service provision, but in essence each organisation is able to continue to work within its own field of expertise
- Joint governance arrangements were established early on (for example joint working agreements, information-sharing protocols)
- The consortium structure was kept simple – management by mandate in most cases will be all that is needed if each organisation keeps its existing funding arrangements
- Co-location of partners
- The honest broker role was specified, and time and resources were dedicated to the development and the supporting function this role provided. The time, effort and resources necessary for this to work effectively should not be under-estimated, but they are a worthwhile investment

Note

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