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practice

Fragmentation and competition: voluntary organisations' experiences of support for family carers

Jo Moriarty, jo.moriarty@kcl.ac.uk
Jill Manthorpe, jill.manthorpe@kcl.ac.uk
King's College London, UK

In England, voluntary organisations such as the Carers Trust and Alzheimer's Society play major roles in providing practical help and support to family carers. This article draws on a large study looking at social care practice with carers to illustrate how changes in social care commissioning and cuts in funding have created difficulties for organisations such as these. It asks whether contracting policies based on competition between providers threaten collaborative campaigning and strategic alliances.

key words carers • commissioning • markets

Background

For the last 30 years, there has been a steady increase in the number of social care services that English councils outsource to the private and voluntary sectors (Cunningham and James, 2009), but comparatively little research has explored the role of the voluntary sector in delivering these services (Dickinson et al, 2012). More recently, councils have moved away from giving voluntary organisations grants to run services on their behalf in favour of contracts (NCVO UK Civil Society Almanac, 2013). Theoretically, more contracts mean more opportunities for the sector. In practice, organisations may need to spend more time bidding for contracts and monitoring them. Their perceived 'distinctiveness' may also change if voluntary organisations come to be managed by the same rules and assumptions that apply to private sector businesses or public sector agencies (Rochester, 2013).

This article uses data from a study investigating social care support for family carers to demonstrate the difficulties currently faced by voluntary organisations commissioned to provide such support. These include:

- increased uncertainty, particularly in terms of adapting to static or reduced funding;
- changes to the types of support that local councils wish to contract for;
- greater competition between organisations.

These changes are taking place at a time when overall demand for social care is increasing at a rate faster than expenditure (Moriarty et al, 2014).

We conclude that organisations can adopt several strategies in order to survive. These include:

- demonstrating their effectiveness in delivering a broader wellbeing agenda;
- developing co-production models of service provision alongside service users and carers;
- diversifying their funding base and activities to become less reliant on local councils for funding.

However, increased competition may reduce the ability of organisations to campaign collectively on behalf of carers.

Methods

This article uses a subset of data collected in a study looking at social care practice with carers. The study methods have been reported in more detail elsewhere (Moriarty et al, 2014); the data presented here are based on 62 face-to-face semi-structured interviews with:

- eight commissioners responsible for planning social care support for carers;
- 16 representatives of voluntary organisations supporting carers or people likely to have carers, such as the Alzheimer's Society;
- 38 carers' workers, such as staff in carers' centres.

Data collection took place from late 2011 to mid-2012 in four different areas of England. The study design was exploratory. Divergences between the perspective of commissioners and of voluntary organisations were one of the strongest themes that emerged during data analysis, so we decided that this warranted further investigation of the data.

The study was funded by the National Institute for Health Research School for Social Care Research. Ethical approval was given by the Social Care Research Ethics Committee. Permission was also obtained from the Association of Directors of Adult Social Services and the research governance panels in the four localities in which the study was undertaken. Names used in this article are pseudonyms.

Findings

The commissioning process

Existing research (Baines et al, 2008; Dickinson et al, 2012) highlights a lack of mutual understanding between the voluntary and statutory sectors. In the present study, this appeared to stem from the differing levels at which commissioners and representatives

of voluntary organisations thought they operated. Commissioners always described their role as delivering broad strategic objectives at the macro level, while the accounts of most voluntary organisations were concerned with the implications of these strategies for their own organisation and the people they supported at the meso and micro levels. Such distinctions were typified in interviews with a commissioner and the manager of a voluntary organisation from different study areas.

The commissioner's main priorities centred on integration and rationalisation; reducing multiple contracts to deliver carer support into a single contract with one provider would be simpler for carers but equally importantly would reduce expenditure and create a more integrated service with the National Health Service (NHS):

> 'Both ourselves and the NHS have developed projects or schemes or short-term pieces of work to help support carers … but it has been on an ad-hoc basis….The agreement … was that ourselves and the NHS would combine our various bits of investment and … commission one service. Now that is partly to stop duplication but … by combining our investment, we [can] make it look a bit more substantial , so that carers could have a very clear idea [that] here is a place and here is a service that is specifically for them.' (Nancy)

By contrast, the manager of a long-established local organisation described the destabilising effects that protracted commissioning decisions had on carer choice and workforce stability:

> '[But] the council has also decided that all services for carers will be tendered out. So there's our organisation and another organisation … [that] provide different types of services for carers, and all those services are going to be tendered out under one contract….We've spent the last two years thinking that our life as we know it is going to come to an end very soon….It's been pretty stressful.' (Bethany)

'Out with the old'

The current coalition and previous Labour governments in the United Kingdom have emphasised their commitment to personalisation, whether in the form of allocating individuals a cash budget to purchase their own care or allowing them greater choice over the type of support that they receive. An under-researched but widespread consequence of personalisation and the increasing financial pressure on social care budgets has been a dramatic reduction in traditional forms of social care support such as day services. These services were once the mainstay of support for many older people living at home by providing them with an opportunity to take part in social activities and to share a meal with other older people (Manthorpe and Moriarty, 2013, 2014; Needham, 2014).

The interviews in the present study uncovered tensions between commissioners and voluntary organisations in terms of which approach was better at meeting the needs of carers. For commissioners, personalisation offered greater choice and flexibility. They considered that supporters of day services or home-based breaks, in which a worker stays with someone who is too frail or unwilling to go out, had not kept up

with people's aspirations for greater control over the social care support they receive, as two commissioners interviewed jointly explained:

Timothy: 'Transition-wise, we have got a lot of very verbal ex-carers who want to say what was right for them 10 years ago, which isn't useful for the strategy.'

Marcella: 'And that really isn't useful at all because … services [then] were very, very different to the way that they actually are now. And sometimes people [who] are really stuck in that rut … can actually really muddy the water for those people that are seeking support [now].'

However, participants from voluntary organisations felt that policies aimed at increasing the number of people holding personal budgets failed to recognise that this would be translated into increased workloads for carers if service users lacked capacity to manage a personal budget themselves. Carers would, in effect, have to take on the additional role of employer:

> '[People] don't want to have the control over the services that the government is telling everybody that they want.… Actually what people really want is reliable services. If you say you're going to send someone at 10 o'clock … they don't want to be the person on the phone at five past 10 saying, "Where are you?" They really don't.' (Bethany)

This interviewee was particularly concerned that the needs of carers providing intensive personal care (such as help with going to the lavatory or with eating and drinking) were being neglected and she was busy trying to develop her service in different ways because "our days are numbered" for the home-based service.

Another participant tried a different approach. Her organisation was attempting to bypass commissioners' opposition to communal social activities such as day services by helping carers to club individual personal budgets together to create a pooled budget. This would give carers the purchasing power to buy social activities in group settings on behalf of the people for whom they cared.

Outcome-based commissioning and contracting

The Health and Social Care Act 2012 accelerated a shift away from service *outputs* (such as providing a service to a certain number of people) towards commissioning for *outcomes*. Outcome-based commissioning involves the overall setting of strategic goals while outcome-based contracting concerns individual arrangements with particular providers (Research in Practice for Adults, 2008). Thus, a council may set an overall strategic aim for all carers to feel that they have been able to achieve a 'life of their own' alongside their caring role. In order to realise this aim, the council might give individual carers a personal budget to spend as they choose. In addition, they might contract with an organisation to run a carers' information and support course. The contract could include penalty clauses so that if far fewer carers take up the course than specified in the contract, the council will withhold some of the funding. In this

sense, the financial risk is shared with the provider organisation. While the extent to which local councils have adopted outcome-based commissioning is variable and not all contracts are based on payment by results (Lucas and Carr-West, 2012), all interviewees recognised that this was very much the direction of travel.

Responses were divided between those who thought they had no option but to comply with the new contracts, albeit reluctantly, and those who sought to influence the wider strategic commissioning process beyond the narrow outcomes defined in contracts. A representative from one organisation thought that it would have to compete against other organisations for contracts unless it could recruit enough personal budget holders and self-funders to opt out of this process:

> 'And the [council] will … go to a range of providers, and say, "Okay, we've got [a number of] … people who want this level of service. Can you deliver it? This is the price that we'll give you" … so the voluntary sector will not have secure contracts, most of the contracts will be outcomes based, and if it goes down [that] … route, if you don't hit the outcomes they won't pay you.' (Kay)

In a different study area, another voluntary organisation felt that it had no option but to prioritise the activities it had been contracted to provide:

> 'We've got to make sure that … the contracts we're asked to deliver, we deliver them correctly because otherwise the money will dry up. We won't get the money if we don't deliver what we've been asked to deliver. So that is as important as [our other activities].' (Brooke)

These participants considered that they were improving individual carers' quality of life by meeting the personal care needs of those who were cared for or enabling them to take part in leisure activities. By contrast, a chief executive from a different voluntary organisation described how she had worked hard to convince commissioners that her organisation could meet many of the local council's wider strategic objectives for improving public engagement and community capacity building:

> '[W]e don't see ourselves as a traditional service provider.… We're a capacity-building organisation. We build capacity in communities, we build self-care capacity within families, and … we're also a voice and choice organisation trying to influence policy, carers' issues and so on and so forth.… We're very much about localism in local communities as opposed to top-down models of care.' (Sophie)

Charging policies

Historically, many voluntary organisations have been reluctant to charge people using their services. However, the switch from council grants to contracts has created increased pressure on organisations to achieve full cost recovery. Voluntary organisations expressed fears that carers would be reluctant, or unable, to pay for services that they had previously used for free and that inequities would be created between users who

met the dependency and eligibility criteria to receive services paid for by their local council and those who were meeting the costs of their support themselves:

> 'Nobody really knows for sure [what will happen] right now.… The big question is: will people actually pay … if they've got [used to] something for free or for a very nominal charge? … We've just had to start charging for our [carers'] groups but it doesn't cover our costs.… It's going to have a massive effect on everybody, on the services we provide, on the carers and the people that they care for.' (Brooke)

Outsourcing assessments

More recently, councils have begun to outsource their statutory responsibilities, such as undertaking carers' assessments, in addition to the longer-established contracting out of services. Voluntary organisations held mixed views about the advantages and disadvantages of this shift. For one carer-led organisation, it was an opportunity to redistribute power to people using services and carers: "We actually dared to propose that we should get rid of all care managers, that we should allow all people to self-assess their needs … and that the support for the self-assessment of needs should be [by] an independent service user and carer-led organisation" (representative of voluntary organisation).

However, others were concerned that the advocacy role of voluntary organisations could be compromised if they became gatekeepers controlling access to social care support:

> 'I think it's shirking responsibility.… My colleague [did it in her last job] and she certainly is a supporter of that model. So I guess it depends on your experience.…' (Beth).

Collaboration and competition

Traditionally, voluntary organisations sharing similar aims have campaigned together on issues where they have mutual objectives. More recently, consortia have been advocated as a way for voluntary organisations to respond to funding pressures but their numbers still remain low (NCVO Public Service Delivery Network, 2012). Although participants from voluntary organisations offered examples where they would cross-refer to each other or campaign together on a particular issue, they seemed increasingly consumed by the ways in which they were competing for the same contracts:

> 'It's caused huge competition between the sector, a lot of ill-feeling, because people have to be commercially sensitive … I had many partnership meetings with other [organisations] and they couldn't even get past stage two because they wouldn't talk about their budgets because they were commercially sensitive.' (Sophie)

For workers from an organisation providing home-based breaks for carers who took part in a focus group, competition was about another third sector organisation that

had undercut their own organisation. However, the 'rival' organisation had then sought to recoup its costs by reducing the amount that workers could reclaim for travel and charging service users for the costs that the worker incurred while visiting them.

Collaboration appeared to be strongest in the most rural of the four study areas. Here, formal and informal mechanisms for joint working between organisations appeared to be stronger and commissioners specifically referred to the council's role in supporting local organisations, for instance in showing them how to calculate unit costs.

Discussion

It is important to acknowledge the limitations of this study. Its remit went beyond looking at relationships between commissioners and the voluntary sector and it is possible that the four study areas and study participants were atypical. Nevertheless, there are some relevant findings for voluntary organisations and social care commissioners as they seek to develop effective responses to the needs of family carers in their locality. The themes raised here are likely to become increasingly important with the passage of the Care Act 2014, which aims to place carers on 'an equal footing' with those they care for in terms of their rights to be assessed and receive support (Lamb, 2014). Voluntary organisations back these changes but are concerned that local councils will not be given sufficient extra funding to implement them.

Our first comments are addressed to commissioners. Less than 7% of central and local government contract spend is won by the voluntary sector (NCVO Public Service Delivery Network, 2012) and the overwhelming majority of social care contracts in terms of overall spend are with the private sector. Following the closure of the Southern Cross care home company (*The Daily Telegraph*, 2011) and subsequent numerous closures and mergers, commissioners and contractors are familiar with the concept of market failure in the private sector. However, it appears that they are less aware of the consequences of market failure in the voluntary sector. The capital of voluntary organisations is not financial but is invested in the human capital of their paid workers, volunteers and supporters, and the social capital they have built up through their perceived record of campaigning, advocacy and service delivery locally and nationally.

It may be that awarding contracts to new providers such as social enterprises or the private sector refreshes the market and stimulates new competition. It is also possible that these organisations cannot sustain the service they are contracted to provide and do not have the groundswell of local support that older, established organisations have. The need for local councils to ensure that their contracting policies sustain local markets is in keeping both with the principle recommended by the National Audit Office (2013: 22) that local councils need to develop sustainable local markets rather than 'putting all their eggs' into the basket of one provider, and with the emphasis in the Care Act 2014 on the role of local councils in 'market shaping'.

Our second set of comments is for voluntary organisations that are considering contracting for outsourced services such as undertaking carer assessments and 'signposting'. Potentially, this route offers new sources of funding but also creates new risks in terms of compromising traditional voluntary sector activities, such as advocacy and campaigning. Organisations need to consider whether these contracts will enhance or detract from their reputation and whether their workforce has the skills to carry out the new tasks. There are lessons here from research highlighting the

dissatisfactions experienced by those who undertake such roles in the statutory sector when they feel deskilled by changes to their work and have fewer opportunities to develop personal relationships with carers and people using services (Postle, 2001).

The voluntary sector has been criticised for its perceived failures in marketing and strategic positioning (NCVO Public Service Delivery Network, 2012). Based on the data in the present study, our final message is that it is not so much that the sector does not possess these skills; it is rather that some organisations lack the confidence and capacity to translate their knowledge into action. The Care Bill places a new emphasis on improving the quality of information about services for people using services and carers and voluntary organisations are increasingly aware of the need to reach out directly to potential users of their services rather than simply relying on referrals from health and social care professionals. The voluntary organisations that were most confident about being able to continue their existence were those that had identified ways of working around local councils' contracting decisions either because they were effective lobbyists in persuading commissioners that their organisation met multiple objectives in terms of the council's wider strategic aims, or because they were finding new ways of working in the era of personalisation, such as helping groups of carers and people using services to increase their choices through pooling budgets. In this sense, the business and marketing skills that they demonstrated were in adaptability and in their understanding of what it was that carers wanted. As voluntary organisations seek to operate in an increasingly cold social care climate, skills such as these will become increasingly important.

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