EMRAN: Commissioning resilience via third sector

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Commissioning to promote resilience in older people via third sector services

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ABSTRACT

This paper discusses how commissioning processes and third sector services may be able to support the resilience, health, and wellbeing of older people. This is presented in three sections, the first discussing the concept of resilience in older people and how this can be measured. The second section focuses on the commissioning of older people's services including contracts, evidence and outcomes, and partnership working. The final section centres on the contribution of the third sector to older people's activities and services, and the impact the commissioning process may have on third sector organisations and their provision of services.

INTRODUCTION

Maintaining health and well-being, despite the inevitable effects of time and ageing, is a priority for older people and society. Services provided by the health, social and third sectors can play a part in doing so. In the UK, the commissioners of care aiming to maintain the health and well-being of older people need to consider how to commission services from all three sectors. Commissioning care from the third sector is relatively novel in the UK and poses additional challenges to commissioners.

This paper presents a commentary on how commissioners can facilitate the promotion of health and well-being in older people across the three sectors, and in the third sector in particular. The paper represents an extended introduction and background to the SOPRANO project (Supporting Older People's Resilience by Assessing Needs and Outcomes) in the Caring for Older People and Stroke Survivors theme of CLAHRC East Midlands, a research study which aims to improve the advice and evidence available to commissioners. Further information and contact details can be found on the SOPRANO webpage (http://www.clahrc-em.nihr.ac.uk/clahrc-em-nihr/research/caring-for-older-people-and-stroke-survivors/soprano-study.aspx).

This paper first considers the psychosocial notion of resilience. It then summarises the commissioning process, and finally outlines the extent and relevance of the third sector in the care of older people.

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RESILIENCE IN OLDER PEOPLE

The concept of resilience as a human characteristic developed from research with children raised in adverse circumstances, differentiating children who had positive adaption models from those who were less well adapted [1]. More recently resilience has been examined in relation to older people and defined in one review as "the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma", using assets and resources to "bounce back" in the face of adversity [2]. These assets and resources have been described as individual, interactional, and contextual [3] and span a variety of themes such as; self-efficacy, orientation to the future, acceptance, social support, ability to access care, social policy, and the availability of resources [4]. This also suggests that resilience in later life is multi-faceted and it is likely that people will have assets and resources in some areas but not others. This is illustrated by Wild et al [5] who have produced a useful schematic outlining different components of overall resilience in later life (Figure 1). For example an older person may have very active and supportive social relations, but they are finding it difficult to cope with health problems: such people may have social resilience but not physical resilience.
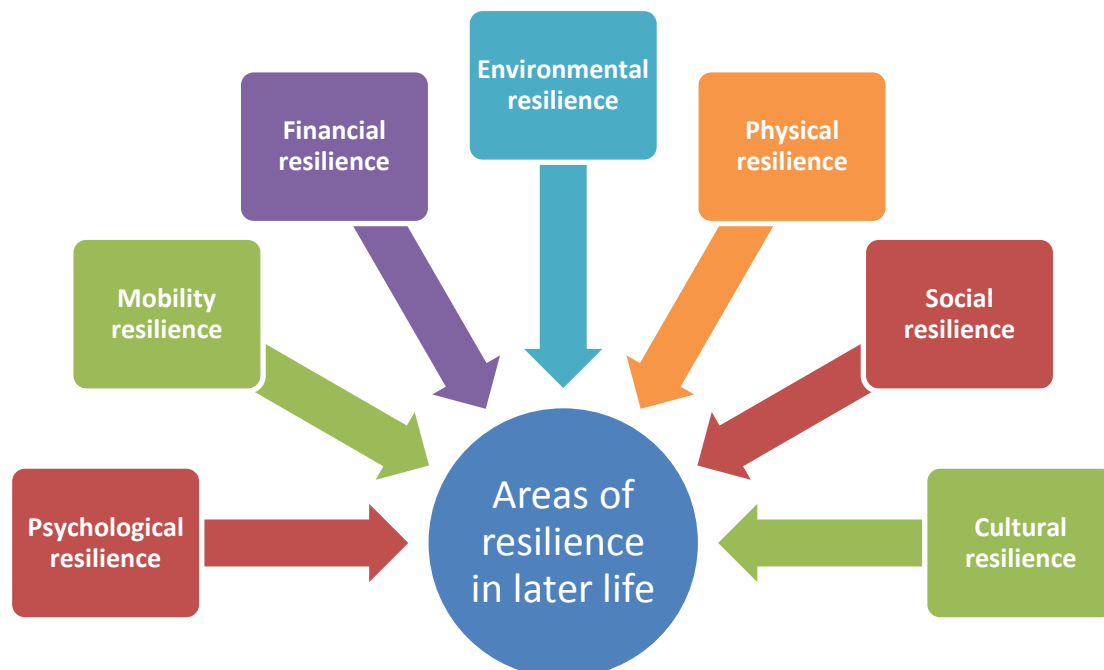
Figure 1 - Areas of resilience in later life (adapted from Wild et al [5], reproduced with permission)

A study investigating older people's thoughts on the concept of resilience through focus groups shows a similarly complex and multi-dimensional view [6]. This included individual physical and psychological aspects; social, cultural and community connections; places and environments; influences of external systems (political, financial, health, social); and having the right attitude to life [6].

Whereas resilience describes a broad and positive set of attributes, it can be contrasted with the narrower and negative concept of frailty. Both concepts deal with vulnerability (frailty) or the lack of it (resilience), but resilience is not restricted to resisting or decompensating in the face of a challenge or threat, but also the process of adapting after having been affected by a challenge or threat ("bouncing back"). Frailty can therefore be seen to some extent as the reverse of physical resilience which is often denoted as the term "robust" although, potentially ambiguously, "resilient" is also sometimes used. In 2013, delegates from 6 major international, European, and US societies reached a consensus to define frailty as "a medical syndrome with multiple causes and contributors that is characterized by diminished strength, endurance, and reduced physiologic function that increases an individual's vulnerability for developing increased dependency and/or death" [7]. There are two main medical models of frailty; the frailty phenotype model, and the frailty index/ cumulative deficit model [8]. The phenotype model, proposed by Fried and colleagues [9], describes frailty as a syndrome where individuals present with at least three of the following five criteria; unintentional weight loss, exhaustion, low physical activity, time to walk 15 feet, and grip strength [9]. The frailty index was developed as part of the 5 year Canadian Study of Health and Ageing (CSHA) which identified 92 symptoms used to define frailty [10]. In this model frailty is defined as the cumulative effect of individual deficits and frailty is calculated as a proportion of the total (e.g. 20 deficits from a possible 92 gives a frailty index of 20/92 = 0.22) [11]. To work towards a more integrated operational model of frailty, in 2010 a literature review and consultation of 17 experts identified twelve broader components of frailty consisting of nutrition, mobility, physical activity, strength, endurance, balance, cognition, sensory functions, mood, coping, social relations and social support [12]. This demonstrates the considerable overlap of both individual and environmental factors in the concepts of frailty and resilience in older people.

RESILIENCE MEASURES

There are a number of tools to measure resilience, and these were reviewed by Windle et al [13] who found no gold standard amongst fifteen measures of resilience. The scales which received the best psychometric ratings were the Connor-Davidson Resilience Scale, the Resilience Scale for Adults, and the Brief Resilience Scale. The Connor-Davidson Resilience Scale (CD-RISC) is a self-reported, five dimension scale for measuring individual resilience in adults [14]. The CD-RISC comprises of 25 questions each rated on a 5-point scale (0-4) with higher scores indicating greater resilience. This scale was designed as a measure of stress coping ability particularly for measuring outcomes of treatment in anxiety, depression, and stress reactions [14]. One of the limitations for this scale identified by Windle et al [13] is the rather narrow focus upon psychological stress. The Resilience Scale for Adults (RSA-Scale) was developed by Friborg et al [15] and consists of five domains; personal competence, social competence, family coherence, social support, and personal structure. The scale is designed to measure the presence of protective factors that promote adult resilience, primarily in relation to mental health [15]. The multi-dimensional aspect of this scale is consistent with the assets and resources which define resilience [13]. The Brief Resilience Scale, designed by Smith et al [16], is a short six item scale focusing on the ability to bounce back or recover from stress. Smith et al argue that this scale is distinct from other resilience scales as it concentrates upon the ability to adapt and thrive following adversity rather than other scales which centre on the resources of the person or environment [16].

Of the 15 measures of resilience reviewed by Windle et al [13], the only one targeted specifically at older people (however most were generically 'adults') was the Psychological Resilience scale developed by Windle et al (the lead author of the review) [17]. This scale is designed to measure individual psychological resilience in the domains of self-esteem, interpersonal control, and personal competence. More recently a new multi-dimensional resilience measure has been developed by Martin et al [18] which is designed for use with older people. This scale is titled the multidimensional individual and interpersonal resilience measure (MIIRM) and covers the domains; self-efficacy, access to social support network, optimism, perceived economic and social resources, spirituality and religiosity, relational accord, emotional expression and communication, and emotional regulation. As this measure is newly developed the authors have recognised the need for further testing to support the reliability and validity of the MIIRM assessment [18].

IMPACT AND CHARACTERISTICS OF RESILIENCE

A number of studies carried out within recent years have investigated the circumstances and characteristics of resilience in older people. Hildon et al [19] described 31% of their older participants (mean age 75 years) as resilient, although resilience was defined as higher than average quality of life rather than measured using a specific resilience scale. They also reported that adversity was typified by functional limitations; decreasing health, stress and general living conditions; and experiencing a negative life event. Indicators of protective attributes included high quality relationships, community integration, and developmental / adaptive coping styles [19]. A large scale (10,753 participants) longitudinal study of older people (mean age 68 years) assessed whether resilience could buffer the impact of chronic disease onset on disability in later life [20]. Resilience was measured using a simplified resilience score broadly based on the Wagnild and Young Resilience Scale [21], which examined five psycho-social domains. Manning et al found that resilience protected against increases in activities of daily living (ADL) and instrumental activities of daily living (IADL) limitations, and helped to mitigate the negative impact of chronic disease on disability in later life [20]. Zeng and Shen also reported positive outcomes in longevity of resilient people, finding that people aged 94-98 years with high resilience were 41% more likely to become a centenarian, compared to those with lower resilience [22].   A qualitative interview study investigated the social aspects of resilience with older people conveying that being engaged in social life was the central factor for a resilient attitude (psychological resilience) [23]. The three key thematic factors identified were socialising, social support networking, and intergenerational bonding [23].

RELEVANCE OF RESILIENCE TO HEALTH AND WELL-BEING OF OLDER PEOPLE

The notion of resilience helps to consider the factors that might maintain health and well-being in older age. Not only do these include traditional public health measures to protect physical health (such as smoking and alcohol reduction, anti-obesity campaigns, etc.), but also measures that increase the assets and resources of older people in other ways, such as those that reduce loneliness or support morale and mental well-being. However, we have not found any interventional cohort studies or randomised controlled trials testing whether interventions can increase resilience, or if doing so leads to greater health and well-being. More research is therefore needed to understand how programmes can be developed to support older people's resilience. The next section of

this discussion paper describes how older people's services are commissioned, and how the commissioning process operates.

COMMISSIONING OLDER PEOPLE'S SERVICES

Commissioning in the UK National Health Service (NHS) refers to the process of planning, purchasing, and contracting health services to ensure high quality care meeting patient needs which is value for money [24]. Although the NHS and local authority (social) services are publically-funded and were initially state-provided, over recent years there have been drives to create a form of a market in which the purchasers of health and social care (commissioners) are organisationally distinct from the providers of such care, known as the "purchaser – provider split". The organisational forms of commissioning in the NHS have changed considerably over the past two decades, with structures including Health Authorities, Primary Care Groups, Primary Care Trusts (PCTs) and now Clinical Commissioning Groups (CCGs) [25]. There is no one way of commissioning which is favoured by the evidence, however the basic commissioning cycle of needs assessment, priority setting, service development, procurement and review is well established [26]. Therefore the UK Department of Health have traditionally encouraged commissioners in the NHS to follow the steps shown in Figure 2 [24].

Figure 2 - Commissioning cycle (adapted from Shaw et al [24])

TENDERING AND CONTRACTS

Despite the notion of a health and social care market, and the purchaser-provider split, a national survey of local authority arrangements for commissioning older people's services found that only 40% of local authorities selected providers through open tendering, with 35% establishing a list of providers based on quality and/or business checks, and the remaining 25% using other mechanisms [27]. A two year ethnographic study observing commissioning for long term conditions found that commissioning was mostly relational, and based on trust and collaboration with existing providers [28]. Porter et al also reported that commissioners rarely challenged providers, changed providers, or decommissioned services [28]. Additionally another qualitative study reported that transparent competitive processes for securing statutory funding were not the norm, with informal methods such as networking and prior relationships being commonplace [29]. Such practices and arrangements could be seen as undermining the notion of a health and social care market and hence its potential efficiencies (for example by discriminating against a private or third sector provider). However, they can also be seen as recognising the interdependence of purchasers and providers, and the merits of sharing between both parties the inherent risk that comes with developing new and innovative projects.

EVIDENCE BASED COMMISSIONING AND OUTCOME DATA

However friendly their relationship is with providers, commissioners will need to ensure that what they commission has a satisfactory evidence base, but the assessment of what is satisfactory varies. A recent survey by Clarke et al (2013) studying the importance of different sources of evidence for commissioning decisions, found variation across a number of factors [30]. Those trained in public health were more likely to make commissioning decisions using external empirical evidence, and senior commissioners were more likely to use practical evidence [30]. Miller et al reported that commissioners particularly draw on published evidence deriving from central and local government, and third sector organisations with specialist knowledge [31]. It was also found that decision making processes were influenced by other factors (political, personal, and relational), and that local evidence was generated through pilots and performance data [31]. By collecting outcomes and performance data either through their own resources or via the service provider's contract, commissioning bodies are able to assess the effectiveness of services for future decision making. However Miller et al stated that generally local

authorities were not prescriptive or overbearing about the performance data and outcomes of third sector organisations that they commissioned, rather they trusted the organisations to know how to best meet the needs of older people [31]. This in turn allowed third sector organisations to keep their independence and values, rather than needing to stray from their original goal in an attempt to satisfy funders [31].

WORKING IN PARTNERSHIP

Commissioning bodies often work in partnership with the service providers (many in the third sector), which can give rise to problems communicating across very different organisational cultures and structures. Therefore in 2006 the Office of the Third Sector aimed to facilitate better partnership by proposing some 'commissioning principles' for government dealing with the third sector [32]. These included the strategic planning process revolving around outcomes for users, encouraging involvement from a wide range of suppliers, and seeking feedback from all stakeholders (services users, communities, and providers) to review the effectiveness of commissioning to meet local needs [33]. In addition to engaging with service providers and other external organisations, many commissioning bodies recognise the value of involving patients and public in the commissioning procedure. The Joseph Rowntree Foundation (JRF) investigated the systems and processes for engaging with older people in two local authorities in England [34]. From a series of focus groups, they found that for true engagement a high level of commitment is required from both agencies and older people, especially in the case of 'hard to reach' groups. The JRF also noted the need for a systematic approach to targeting particular populations and greater transparency to demonstrate that older people's input truly makes a difference to outcomes [34].

THIRD SECTOR DELIVERY OF OLDER PEOPLE'S SERVICES

The public sector is keen to engage with the third sector to provide efficient, cost effective, and responsive services, often reaching people which public services cannot [29]. The International Longevity Centre describes the voluntary sector as being "ideally placed to deliver the cost-effective, early interventions that are needed to support people to stay healthy, connected and engaged throughout their lives" [35]. They further comment that to take a whole life approach for people to stay active and healthy, will

require the third sector to try out new things and comprehensively test effectiveness [35].

The third sector provides a wide range of services and activities for older people, often including the type of low-level support that promotes greater independence. Some of these services can also be provided by the public and private sector, such as housing or transport which may sit alongside other provision to accommodate particular individual, group, or community needs [36]. There are other services or activities which tend to be provided exclusively by the third sector, these may include: social activities, befriending, practical support (e.g. care and repair, shopping), community based programmes, needs of particular groups (e.g. dementia), and particular issues (e.g. food) [36]. Additionally there are third sector organisations providing activities to promote healthy living and offering vital support to carers who may also be older people themselves.

Despite the willingness to engage with the third sector, and despite the potential value of doing so, research in recent years has questioned whether many third sector organisations are 'commissioning-ready' and have the abilities needed to win contracts for services [37]. Changes to funding are also causing concern in the third sector and Table 1 outlines the different types of government funding available (adapted from Hedley and Joy [38]). It seems that charities prefer the traditional forms of funding, with 75% of charities stating that block contracts and grants have a positive impact on the people they serve [38]. Only half of charities expressed a positive opinion about the more conditional contracts such as payment by results or tariff-based contracts [38].

Table 1 - Summary of government funding types (adapted from Hedley and Joy [38])

· *Grant:* Charitable funding either unrestricted for the charity to use as they see require, or restricted for a certain purpose (including service level agreements).
· *Block contract:* A term of contract with a certain amount of business guaranteed.
· *Payment by results contract:* A proportion of funding conditional on achieving an agreed output or target.
· *Tariff-based contract:* A fixed fee for each activity undertaken.
· *Personal budget:* The service user having control over what services are delivered and by which organisation (including direct payments and individual budgets)
· *Spot contract:* Funding and contract terms on a one-off basis for a single unit of services (e.g. caring for one older person).

The third sector has also commented on other negative aspects of engaging with the public sector, including; threats to their independence, uncertainty of funding due to changing policy, threats to their reputation, and disproportionately sharing risk [29]. This combined with higher administrative burden and more intense accountability practices may make the prospect of being commissioned by the public sector unappealing to some organisations [29]. However benefits of working with the public sector such as organisational growth, improved focus, learning, and reputation have also been highlighted [29].

CONCLUSION

This paper has provided a summary of the evidence relating to resilience in older people, commissioning older people's services, and the third sector delivery of those services. Resilience is potentially a useful theoretical position from which to consider how the health and well-being of older people might be maximised. The notion helps to explain why the third sector could play an important part in the process, and hence why the commissioners in health and social care need to consider this sector.

This paper illustrates that commissioning to promote resilience for older people via third sector services is somewhat different from commissioning from usual provider organisations such as NHS trusts. The fact that most of the papers cited here come from within the last decade, this paper also indicates that this process represents a relatively recent challenge to commissioners.

The objectives of the SOPRANO project (Supporting Older People's Resilience by Assessing Needs and Outcomes) are, in the East Midlands in the middle of the second decade of the 21st century, to establish what is being commissioned to promote the health and well-being of older people (i.e. to promote their resilience), with a particular focus upon how engagement with the third sector and its integration into the wider effort is managed. The overall aim of SOPRANO is to provide guidance to commissioners in the UK, and potentially elsewhere, about how best to facilitate the public health ambition of providing services that promote the resilience of older people.

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ETHICAL APPROVAL

This discussion paper has been authored in alignment with the SOPRANO study, which has received appropriate scientific committee and ethical approval.

CONFLICTS OF INTERESTS

None declared.

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