Principles for the Delivery of Prevention Support Funding

- **Jon Clemo**, Lead, Prevention and Early Intervention Working Group: Norfolk Older People's Strategic Partnership 11.08.11

Introduction

This document was produced by the Norfolk Older Peoples Strategic Partnership Board Prevention Agenda sub-group with input from other members of the board. It details principles for the delivery of funding into preventative services.

Whilst developed with the forthcoming Norfolk County Council Prevention Fund in mind it has been written to reflect key principles that should be incorporated into the delivery of all prevention services funding both locally and further afield.

The document is divided into two substantive sections; the first deals with the purpose and priorities for the fund and the second section is focused on the pragmatic administration of the funding.

Purposes and Priorities

Reflect the full spectrum of prevention

Any program of prevention funding should reflect the broadness of the prevention agenda and seek an appropriate distribution of resources across the range of possible services.

We characterise prevention services along two axes:

Intensity of the intervention
This relates to the relative cost of the intervention and the likely numbers of beneficiaries it will seek to target. At one end there are lower cost initiatives provided to a broader population, at the other high cost initiatives delivered to a limited eligible group.

The timeframe for the impact of the benefit
Whilst some preventative services have an immediate impact, such as preventing an unplanned hospital admission, other may provide benefit over a longer period by supporting changes in lifestyle or facilitating self-help. The challenge with these longer term impact services is that benefits may be more difficult to express quantitatively, and therefore less attractive to commissioners.

The combination of these two axes provides a two by two matrix

Long Term/High Intensity An intensive/high cost intervention whose benefit is realised over a longer period. Likely only available to a limited grouping. For Example; Significant aids or adaptations Specialist intervention for someone highly obese	**Short Term/High Intensity** A high costs service providing an immediate impact but likely only available in specialist cases. For Example; An admission prevention services
Long Term/Low Intensity A low cost solution probably openly available but where the preventative impact is delivered either a long time after the delivery or at a low level over a long period. For Example; A healthy walking group	**Short Term/Low Intensity** A low cost service but where the impact in terms of preventing more acute needs is provided in the short term. For Example; Community Transport service that facilitates regular health access preventing an escalation of issue.

Need and Evidence Led in achieving clear outcomes
There should be a clear need for a service or project. That need should be evidenced but with flexibility on the way sources of that evidence:

- Underlying needs demonstrated by statistical data
- Analyse gaps in existing provision
- Feedback from users on the value, impact and limitation of existing services

All services should be outcome focused. Whilst there is a clear public sector driver around cost savings evidence of need should focus on improving the outcomes for individuals ahead of cost reduction.

Outcomes are an expression of the difference services or support makes to peoples lives, for example that it improved confidence, decreased loneliness etc. These are distinct from the outputs of a service, which are the quantified measures of delivery, such as number of support sessions, number of clients etc.

Link to existing prioritise
Significant time and resources have been expended by various partnerships and organisations in terms of identifying local priorities. Any new preventative program should seek to draw on these or utilise them directly rather than creating a new set of priorities.

As well as reflecting priorities at a county level there should be flexibility to incorporate more locally developed strategic prioritise.

Specifically this group would seek the use of prioritise presented in the Living Longer Living Well 2011-2014 recommendations to commissioners produced in December 2010.

Non- prescriptive in delivery model
New models of prevention services may not conform to existing structures. Whilst there is a need to ensure financial and management competence together with quality assurance, prevention funding programs should avoid being prescriptive on the type of delivery models they expect to be used.

Track Record and Value for Money
Whilst a program should seek to innovate and improve on existing provision given a context of limited resources it should not seek to trial a wide range of entirely untested models. Weight should be given to models that have already been shown to deliver successful outcomes.

Innovation includes completely new models of delivery but also should encompass drawing in alternative models of proven best practice from other areas to be delivered locally or adapting existing tested models to meet changing local needs.

Costs should be proportionate to the likely benefits produced but crude value for money analysis is unlikely to fit with a program that covers the full spectrum of prevention, since improved wellbeing does not always create measurably cost savings.

All services should be effectively monitored and evaluated.

Sustainable
Any prevention funding program should have sustainability at its core. However, sustainability is not just the responsibility of the service provider. Clear thought should be given by the funder as to continuity of service, expectations management and the necessity of an exit strategy.

Links should be made to commission cycles that will allow further funding for projects with successful delivery and that set timescales that allow for continuity of delivery.

Integration – pathways of referral
The delivery of a prevention funding program should promote linkages with existing delivery. Specifically new services should have clear pathways of

referrals into both existing prevention services and more acute support. Care should be taken that in the establishment of new services, decommissioning of old initiatives or any other transitional processes that client contact is maintained and support is provided particularly where client groups may find change challenging.

Information and Advice
Lack of effective information and advice is a significant barrier to accessing appropriate prevention services. In the delivery of prevention funding a proportion of resources should be allocated to information and advice. In allocating funding the managing body should take pro-active steps to ensure other providers, partners and potential end users are aware of the new service. This should go further than simply circulating information through generic channels, for example leaflet distribution.

Living Longer, Living well 2011-2014 makes specific recommendations for Information and advice services under 1.2 and 1.4 and these should be noted.

Value placed on existing high quality provision
Prevention funding programs should seek to provide continuity and maintain existing services that remain relevant and have a proven track record of delivery.

In addition prevention funding should be specifically allocated to existing projects where a change program is required to adjust to a changing context or improve integration with existing services.

Accessibility and Equality
Any funding program should promote through the services it funds principles of equality and accessibility. Specific barriers to access should be addressed across the program as a whole; these include but are not limited to:

- Geographical isolation
- Language barriers
- Physical and mental disabilities
- Physical and mental health conditions
- Cultural differences
- Poverty

The program should embrace all 7 strands of equality within the Equalities Act.

Geographical spread of resources should be commensurate with levels of need.

Partnership and Engagement
Prevention funding programs should require demonstration of existing working relationships with local partners and of engagement and consultation with communities and end users.

Open Data
Programs should seek from the outset to a manage clients data in a way that is both consistent with their wishes and requirements under data protection but that facilitates co-ordinated inter-agency and inter-disciplinary working in order to provide the very highest levels of integrated care.

Management and administration

- Funding arrangements should be Voluntary Sector Compact compliant. Specifically 3 year secure funding with payment in advance available.

- Application processes should promote accessibility for all organisations. This includes having application forms, reporting and evaluation systems that are proportionate to the level of funding awarded. Small grassroots grants require a simplified process .

- Funding programs should take a partnership approach to decision making with a panel having final application approval.

- Processes should be clear and transparent with publicised assessment criteria and scoring

- Once awarded a clear agreement should be signed setting out roles and responsibilities and all monitoring and reporting requirements. As above these should be reasonable and not amended without agreement by both parties.

- There should be a clear and independent appeals procedure

- The process should be open allowing any organisation to apply

- Any managing body should be competent with appropriate systems, processes and safeguards in place. In addition they should have the appropriate skills to engage effectively with potential applicants.

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Beyond consultation: A co-production partnership

Mark Harrison – Chief Executive Officer
Norfolk Coalition of Disabled People

Catherine Underwood – Director of Community Care and Health
Norfolk County Council and NHS Norfolk

What do we mean by co-production?

- At its most effective, co-production can involve the transformation of services. The transformative level of co-production requires a relocation of power and control, through the development of new user-led mechanisms of planning, delivery, management and governance. It involves new structures of delivery to entrench co-production, rather than simply ad hoc opportunities for collaboration."
- **SCIE research briefing 31**

Co-production

- **Co-production is:-**
- at its most basic about ‘action’, for example people (including professionals and people who use services) coming together and producing a service or an outcome
- about “broadening and deepening” public services so that they are no longer the preserve of professionals or commissioners, but a shared responsibility, both building and using a multi-faceted network of mutual support
- about delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change

Why did we form a partnership for co-production?

- Shared interest in personalisation
- User-led organisation and local authority
- Access to expertise
- Access to influence
- Building on good foundations
- Seeking a truly transformational approach
- ‘Together we’re better’

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Aims:

- Improving the life chances of disabled people: improve access to choice and control
- Make co-production upstream – vision
- Build a culture and reality of co-production
- Innovation

What do the partners bring?

- NCODP:
  - User led organisation
  - Expertise
  - Challenge
  - Access to disabled people and their voices
  - Resources to support the partnership
- NCC:
  - Statutory body
  - Budget for social care
  - Expertise
  - Access to decision makers
  - Resources to support the partnership

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What have we done?

- Target the transformation programme
  - Transformation Board
  - Project groups
  - Project managers development and advice
- Engaged independent living groups countywide
- Developed a shared vision for social care
- Seconded staff across the partners

Benefits

- Value for money
- Incorporation of expertise from the people who use services
- Health benefits and prevention.
- Practical skills.
- Builds Social capital, through
- Building supportive relationships and
- Increasing personal self-confidence and activity.

Challenges

- Cultural shift
- Getting beyond consultation/tokenism
- Top down and bottom up
- Resourcing
- Ensuring all user/citizen voices are included
- Being prepared for challenge

Benefits:

Some contributions from the people who use services may involve making the existing service work more effectively, such as providing information and advocacy to enable choice, whereas others may lead to more transformative models of co-production, such as user-led management or delivery of a service.**16** Some contributions may be generated by people who use services wanting to play a more active role – such as getting involved in the NHS Expert Patients programme or the Commission for Social Care Inspectorate Experts by Experience initiative – whereas others may be about greater responsibilities being placed on the people who use services.

Partnership and co-production with the Older People's Strategic Partnership

- Membership of local forum leads
- Membership of LA and NHS senior teams
- Other key partners
- Joint working groups
- Membership of project groups
- Joint visions, strategies and plans

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What does this mean for older people?

- **understanding and embracing personalisation?**
- **engaging with co-production?**
- **seeing it as opportunity not threat?**
- **potentially better more individualised provision?**
- **new alliances with other ULOs?**

QUESTIONS AND DISCUSSION