Written evidence submitted by United Response (CSR0039)

About United Response

United Response is a national charity which has over 40 years’ experience in providing skilled social care support to disabled people – predominantly adults with complex learning disabilities. We work under contract with local authorities across England and Wales and at any one time our 3600 staff are providing care and support to around 2000 vulnerable people.

United Response welcomes the opportunity to respond to the Health Committee’s inquiry into the impact of the Comprehensive Spending Review on health and social care, with a particular focus on learning disability. We have submitted a joint response as part of Learning Disability Voices which we are fully signed up to. We also thought it would be helpful to submit our own response to give a clear picture of the impact of the CSR on just one organisation.

The National Living Wage

The Chancellor’s budget in July 2015 announced a new National Living Wage to come into place from April 2016, beginning with a rate of £7.20 per hour as from 1 April 2016 and rising annually thereafter to a cited £9 per hour in 2020. Whilst we of course welcome this in terms of rewarding our staff, who do an incredibly skilled and vital job for little financial reward, it does also create a very significant funding gap which has the potential to be catastrophic not just for United Response but for the whole Learning Disability Sector. This is not just a voluntary sector issue; private providers are equally unable to meet these challenges and there is a significant risk of provider failure, broader market failure and ultimately put the life chances of the very vulnerable people whom we support at risk.

United Response has an annual operating budget of £76M for the financial year 2015/16. We are currently carrying out our budgeting round for 2016/17 and anticipate that the total budget will be £80M. We estimate that the amount of additional funding we will need to find to meet the minimum requirement of £7.20 for all staff over 25 in April 2016 is just under £0.5M. We further estimate that to meet the rate of £9 per hour in April 2020 would require a cumulative total of an additional £8M, based on our current workforce.

Our funding is derived almost exclusively through contracts with local authorities, with the vast majority being commissioned through Adult Social Care. We have little or no ability to influence the prices that they will pay us (based on an hourly rate) other than to decline to bid for or to withdraw our services. We also have little or no ability to raise funding by other means (leaving aside any moral or ethical judgements on doing so); there are scarcely any genuine “self-funders” in the sector as almost all people with a learning disability have had their diagnosis from birth, with no time to build up any funds of their own.

Since the 2010 Comprehensive Spending Review, we have driven down our prices by making efficiencies, stripping out layers of management, reducing terms and conditions for staff and stringent financial management. This process has seen us reducing our costs by over 23% over the period in real terms. There is simply no fat left to trim and we are faced with a huge and growing hole in our finances with the introduction of the National Living Wage, which increases over time as illustrated by the infographic attached to this submission.
The model of support we deliver is very people-intensive; many of the people we support have extremely complex needs (which in former eligibility criteria terms would have been expressed as “critical” or “substantial”) and many need at least 1:1 (if not 2:1) support 24 hours a day, seven days a week. As a result, our direct support staff costs represent a huge 77% of our total costs, despite the fact that frontline support workers are paid little more than the current National Minimum Wage (which is all we can afford to pay given the amount that we are paid by our commissioners).

Reducing hours of support is rarely an option; as per above, most of the people we support have extremely complex care needs and their lives would be put at serious risk if they are not supported. And, where it IS possible to reduce hours of support (see case study A below) this saving is passed directly back to the commissioning authority; it is not retained by us.

Post Winterbourne – Transforming Care

United Response has particular expertise in supporting people to move on from institutions, including Assessment and Treatment Units, in line with the NHS Transforming Care Agenda and the vision set out in the Green Paper “No Voice Unheard, No Right Ignored”; a vision which we fully support. We know that people with even the most complex needs can be supported successfully in the community, giving them not only vastly improved life chances but also representing a cost saving as compared to admission or retention in an ATU (typical cost £3500 per week). This work is at serious risk if sufficient funding is not available – from local authorities – for appropriate and skilled community support to be provided.

Two anonymised case studies are included below which demonstrate the complexity of the people we support and the skills which our staff need in order to support them effectively.

A’s story

A is a determined individual who knows what he wants from life. He is friendly and welcoming and enjoys both domestic endeavours – such as housework and cooking – as well as visiting the cinema and shops. He leads an active lifestyle and frequently goes bike riding, walking and dancing and values his family time with whom he recently celebrated his 40th birthday at a local pub. United Response became involved in supporting him in 2005 whilst he was still at a long stay hospital.

A moved to a unit of a long-stay learning disability hospital in the North East of England in 1984. As a strong-willed person, he often became frustrated by being denied the choices he wanted in life and he often exhibited challenging behaviour which ranged from self-harm to threatening actions against other people. This often led to him being physically restrained and staying on the ward for most of the day.

United Response began our involvement with A when he was thirty five years old. We looked to overcome the issue of a lack of intensive support by planning a supported living
scheme for him around his local area but this was soon abandoned due to health and safety concerns.

We then developed a United Response staff team in the hospital and staff members worked alongside the hospital staff. The number of United Response staff was increased over time and, over the period of a few months, the original complement of two staff members was increased to four and continued until full capacity was reached and Adam had twelve people who worked full shifts around him.

Over the course of this transition of support staff, A was also moved to an upstairs ward where he had his own bathroom, sitting room, office and a shared bathroom. When United Response eventually got the go-ahead to provide full support to A in the hospital, the staff then found themselves in a position to seek to help A with his challenging behaviour.

The result was dramatic. Gradually, as we got more involved every day, A’s challenging behaviour ebbed away. He didn’t receive a full restraint during the last four months and his behaviour improved so much we only used body restraint to calm him down.

After five months we asked the local authority if A could have a vehicle solely for him whilst he was in hospital so that he could go out every day. Then, seeing that A responded well to being given his own choices, we asked him what he wanted from his life. He expressed a desire to move to new accommodation on his own and, plans were put in place to relocate A to a single-person supported living service. A told us that he wanted to live on his own in a rural setting. He also wanted more specific facets such as having what he called ‘a bubble bath’ and to be near to a chip shop. We enlisted the help of a local housing association who helped us find his ideal house. In the end, we managed everything but the chip shop!

A was able to move into a large, rural house which he had chosen for himself. He now has a vastly improved level of personal choice and has been involved in deciding everything from the location of his new house to the colour of the walls.

When he moved in, A was given 2:1 residential support and 3:1 support in the community due to his history of challenging behaviour but, such is the progress he made, this level is gradually being reduced. NB that as packages of support reduce, the saving is passed back to the local authority, it is not retained by us.

B’s story

B is in his 40s and began being supported by United Response in 2008, after spending most of his life in a long-stay hospital. He is on the autistic spectrum, has learning disabilities, is deaf and has other sensory impairments. B’s pen profile was very negative - stating that he caused damage to himself, other people and property. It referred to instances where he had bitten off someone’s toe, attacked people and smashed through a window. He was subjected to PRN on a regular basis throughout his years there and had clearly been labelled as a violent and difficult individual – essentially, a lost cause.

His previous care workers, who were transferred with John to our team, described him as “poisonous”. To add to this reputation B had been described as “the most dangerous man in the area”.

Our service manager worked closely with our practice development team to put in place positive behaviour support and good active support plans and approaches in order for his support team to work with B properly. These included looking for and changing
environmental and communication triggers and also engaging B in meaningful activities and relationships

The approaches put in place ensures that B has consistent support which provides a structure to his life so that he is engaged and knows when and what will happen throughout his day. They also include spotting risky situations which might trigger B’s anxieties with proactive approaches to minimise these but also reactive ones for when something happens.

One example is when B is out walking, he is inclined to pick up and eat cigarette ends he sees on the ground. Over time we have supported B with strongly flavoured snacks (chocolate covered coffee beans, liquorish sticks and extra strong mints). By offering him one in these situations he is less interested in picking up the used cigarettes. These distraction techniques are all part of a range of positive behaviour support approaches.

B is now fully engaged with his life which includes taking part in arts and crafts, pottery, gardening, swimming, bowling, cookery and visits to a sensory room and the only incident of "aggression" in recent years was when he once moved someone out of his way. And his support team now are affectionate, understanding and empathetic whenever they talk about B.

Funding the National Living Wage

We believe that the package put forward to fund the cost of the National Living Wage is woefully inadequate in addressing the huge cost pressures on the sector. It must be borne in mind that the sector was already facing massive pressures as a result of many years' cumulative underfunding so the introduction of the National Living Wage comes as the final straw.

The King's Fund has described the Government’s estimation of £2bn to be raised from the council tax levy as based on "completely implausible assumptions", as it depends on all 152 councils in England applying the levy. It is also not reflective of need; we know that urban areas, particularly in the north of England have seen the biggest cuts in funding since 2010 and hence have the greatest gap to fill – yet given the property prices in these areas, have the least ability to raise the funds needed.

We believe that to enable this there needs to be a proper and genuine joined up approach to health and social care budgeting to enable resources to be properly targeted (e.g. in support of the Transforming Care agenda) and managed at a level that rises above individual budget responsibility and setting. This has never yet been achieved; even programmes that set out to do this such as the Better Care Fund, have in reality seen all funds being allocated to the NHS rather than social care. So, the assumption that the additional 1.5bn from the Better Care Fund will help alleviate the social care funding crisis leaves us extremely concerned.

The issue is also exacerbated by the question mark over the status of "sleep-ins" as working time. At present, when staff members sleep overnight at a service to provide emergency cover if necessary, this cost is paid at a flat rate of £35-£40 a night, in accordance with the relevant primary legislation.

However, due to recent case law (not government policy), these sleep-in shifts could now be considered working time, and fall within the scope of the NLW, increasing costs yet further. This would also have the unintended consequence of incentivising providers to employ “waking night” (on shift) staff rather than “sleep-ins” which, where not needed, is deeply disruptive and intrusive to the people being supported and runs contrary to our primary aims of increasing people’s independence.
What needs to happen?

We believe that central government needs to:

- Make extra funding – that is ring fenced to social care – available to local authorities as a matter of urgency. We would be interested to explore what has happened to the £6bn that has been freed up as a result of delaying the full implementation of the Care Act (following the Dilnot Commission’s funding recommendations) to an as yet undetermined date and the extent to which this could be used to plug the gap.
- Legislate to compel local authority contracts to contain provision to fund legally imposed wage increases (NLW and previously NMW) which providers have no choice but to implement.
- Legislate to make it clear that “sleep ins” are not working time and should continue to be paid at a flat rate.

Conclusions

Without proper funding to cover our costs, we and the other providers in our sector are forced to consider withdrawing from existing contracts (an option we are actively pursuing at present) and to refuse to bid for new work. These leaves the most vulnerable people in our society at risk of receiving either no support, or the wrong and more costly support, in the shape of admission to hospital to ATUs.

We would be happy to provide further written or oral evidence to the Committee, and we look forward to working with you to ensure a future funding environment that sustains the right kind of care for vulnerable individuals.

22 January 2016
ANNEX: LD VOICES COST CALCULATIONS

We have examined in detail the 70% of our budget that goes towards wages in the context of the introduction of the National Living Wage (NLW). The table below shows the planned increase in the year-by-year, rising to £9 an hour by 2020 (we have assumed an incremental increase year on year from its introduction in April 2016).

We have also examined the role of sleep-ins and the NLW. This change doubles the average cost of a shift from around £35-40 to £75-80.

<table>
<thead>
<tr>
<th>GOVERNMENT POLICY - NLW</th>
<th>LD SECTOR - NLW</th>
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<tbody>
<tr>
<td>Rate</td>
<td>NLW Rate Increase Year on Year</td>
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<td>NMW - Oct-14</td>
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<td>NMW - Oct-15</td>
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<td>NLW-Apr-20</td>
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To build our LD cost inflation scenarios, we have taken the total budget of the LD sector in 2014-15 coming from LAs and used the annual increase in sector costs figures outlined above. We have modelled two scenarios for the LD sector:

1. LD Sector costs with sleep-ins paid at NLW rates
2. LD Sector costs with sleep-ins paid at flat rates

The table below shows our resulting LD Sector budget scenarios for 2016-2020:

<table>
<thead>
<tr>
<th>(£, millions, p.a.)</th>
<th>Scenario 1 (Sleep-Ins NLW)</th>
<th>Scenario 2 (Sleep-Ins flat rate)</th>
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<tbody>
<tr>
<td>2015</td>
<td>£ 4,977.00</td>
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<td>2016</td>
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<td>2019</td>
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<td>2020</td>
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<td>Total additional requirement 2016-2020</td>
<td>£ 4,377.58</td>
<td>£ 3,538.59</td>
</tr>
</tbody>
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REFERENCES

1 Mrs J Whittlestone v BJP Home Support Limited UKEAT/0128/13/BA and Esparon v Slavikova UKEAT/0127/12/DA