jit joint improvement team

May 2007

Improving Outcomes Guidelines 2007

Guidelines to support the use of evidence in commissioning services for individuals with learning disabilities

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May 2007

Part 1: Introduction

Commissioning: "The process of translating aspirations and need into timely and quality services". (CSCI 2006)

The purpose of these guidelines is to provide some practical guidance to people involved in commissioning services for people with learning disabilities. These guidelines have been produced following a conference on *Improving the Quality of Life for People with Learning Disabilities* held in November 2005, which was jointly organised by the Association of Directors of Social Work, the Joint Improvement Team and the Mental Welfare Commission (JIT 2006).

This was followed by four workshops around Scotland in March and April 2006, gathering practitioners' views on commissioning, at a strategic and at an individual level. The conference and the workshops looked at the question of "What works in learning disability services?" That is, what approaches have proven effectiveness in the planning, commissioning and provision of services for people with learning disabilities? The aims of the conference were:

(i) To provide some up-to-date evidence and information relevant to health and social care services, and
(ii) To begin to develop a framework to use this research based information.

These guidelines on commissioning should be considered in the context of recent policy developments in Scotland and, in particular, *Changing Lives: Report of the 21st Century Social Work Review* (Scottish Executive 2006) and *Delivering for Health* (Scottish Executive 2005).

Helping people with learning disabilities to live in their own homes or in other homely settings has been a major shift in policy and practice in the last ten years in Scotland. Commissioners from local authorities and from NHS services are responsible for planning and developing services from a range of different providers. They have the responsibility for organising good quality care, within budget and legislative constraints. Commissioners also have to develop professional relationships with numerous individuals and organisations involved in commissioning, from the statutory, voluntary and private sectors. These are very demanding roles.

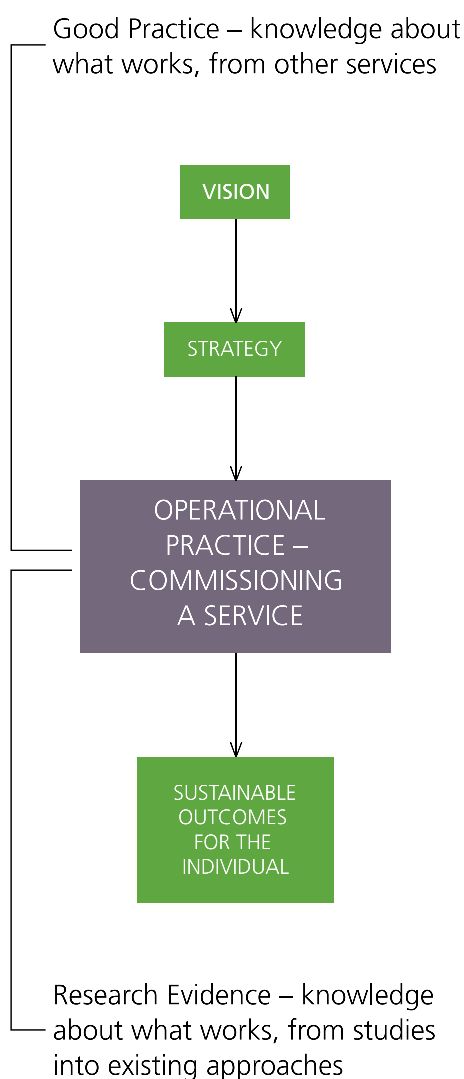
This guidance has been written to support the use of population based research and practice based evidence in commissioning and service provision. It is not intended to be a "how to commission" guide for commissioners, or a comprehensive resource; the value of local knowledge of commissioners cannot be underestimated. The research evidence, where it is available, should be taken into account at all stages when commissioning services (see Part 3 especially). The research presented at the conference in 2005 and the research links within these guidelines are intended as *starting* points to inform commissioning.

Commissioning is the process of specifying what services are required and then organising those services, including purchasing and contracting by statutory services (principally health, social work and education) through voluntary organisations or private sector providers. Although this is a complex process, the basic goal and steps involved are well understood: to get from the "vision" of the commissioners (or commissioning service) to the end product of *sustainable outcomes* for an individual with learning disabilities (see Figure 1).

[1] Adapted from Joint Improvement Team "A - Z Introductory Guide to Health and Social Care in Scotland Commissioning (including Joint Commissioning)"

You should read what follows in conjunction with the 7-step online pathway published on the JIT website **www.jitscotland.org.uk** (and the related resources), which is referred to in Part 3 of this document.

Figure 1 From Vision to Outcomes



There are a number of factors that determine how decisions are made in the commissioning process. These include knowledge about what works, gained either from experience of other services, or from research. Available funding and resources are almost always major factors in determining what services are eventually commissioned for an individual.

People who have learning disabilities have needs which are lifelong. Unless social work and health service commissioners agree a model for assessing these needs, and for commissioning appropriate services to meet them, there is a danger that the support people get will be inconsistent and fragmented. This is the challenge of "translating needs in a timely and qualify services." (CSCI 2006).

Background

Commissioning is not new. In 1990 the National Health Service (NHS) and Community Care Act required NHS authorities to assess the health needs of people with learning disabilities, commission services, and ensure that the services provided effectively met assessed needs within that health authority. Similarly, the Community Care Act in 1993 required Social Work departments to do the same for the social needs of people in their area. (HMSO 1991)

The White Paper "Caring for People" (1989) stated that local authorities would continue to play a valuable role in the provision of services, but that they should further develop an "enabling role". The White Paper set out proposals under which local authorities would increasingly become commissioners and purchasers of care services. Within this framework, "Caring for People" emphasised the importance of developing a "mixed economy of care", seeking out and purchasing

services from a range of providers in the voluntary and private sectors as well as the public sector. This concept of "the enabling authority" had also been central to the reforms of the NHS as set out in "Working for Patients" (1988). The "internal market" and competition became an important feature of NHS organisation, and was formalised through the establishment of NHS Trusts as legal entities by the NHS, and Community Care Act 1990. The separation of purchasing and providing functions became an important feature of health and social care. These policy changes required the development of more structured approaches to commissioning and the process of contracting.

Goh and Holland (1994) proposed a framework for commissioning services for people with learning disabilities in which different agencies (health, education, social services) are involved, but each takes the lead at different stages in a person's life. The aim of this framework was to avoid "fragmentation" of services, and to encourage integration and joint co-ordination of care.

Since devolution and the setting up of the Scottish Parliament, there has been a move away from "internal markets" within the NHS, as compulsory competitive tendering for local authorities has been replaced by the Best Value Regime (BVR). These new arrangements place a greater emphasis on *partnership* approaches, and while still emphasising value for money, provide more flexibility for commissioning arrangements.

The need for effective commissioning and contracting in health and social care and housing has been reinforced over the last 15 years by major resource changes including the transfer of DSS monies to local authorities to fund care homes (mostly private sector) from 1993, the development of community services (mostly voluntary sector) for hospital resettlement, and the establishment of housing support services through the Supporting People programme. In addition, health, social work and housing services have all been affected initially by the demands of compulsory competitive tendering (CCT). Throughout this there has been research to look at what constitutes *effective* commissioning[2].

The most recent developments have involved both an emphasis on the need to develop methods of joint commissioning by statutory bodies, and the setting up of support to help service users commission their own services, funded through direct payments and welfare benefits[3].

Key recent developments and issues

Services for people with learning disabilities need to be commissioned within the context of a range of national strategies and priorities and to reflect the terms of statutory requirements for local Community Plans, Children's Services Plans, Joint Community Care Plans, clinical strategies, and Partnership in Practice Agreements. Those plans will identify the needs of the local population, and set out commissioning proposals for meeting those needs that reflect best value service reviews of existing services and a drive for continuous improvement.

[2] Centre for Health Leadership Wales (2001)

[3] NatPaCT (2005), **http://www.scotland.gov.uk/Publications/2002/04/14662/4093** A Guide to Receiving Direct Payments in Scotland. Scottish Executive (2002)

Such commissioning strategies provide some of the key elements in Local Planning Agreements (LPAs) – reaching agreement on responsibilities and the level of funds each authority will allocate to the joint purchase of care. There is then a need for local commissioning to determine common service specifications, especially quality standards, conditions governing agreements or contracts with service providers and how much each will pay towards the specific services being purchased. The basic principles of seeking to provide choice, good quality care responsive to the preferences of service users and offering good value for money should be followed in any joint arrangements. There must also be a close working relationship with other agencies in their purchasing role, especially housing and education authorities, and with service providers.

Implications for Joint Working

Joint working has become a central theme to policy and practice of providing learning disability services. The challenges for joint working in relation to commissioning include how to:

- Place service users and carers at the centre of the commissioning process
- Use the work of regulatory bodies and benchmarking exercises to assess standards
- Develop commissioning as a key mechanism for improving the quality of care
- Work jointly with other agencies to improve sustainable outcomes for service users and carers
- Pay due attention to information, quality, equity and value for money issues
- Change the balance of care towards support at home and maximise independent living
- Promote service brokerage, self-directed care, and direct payments
- Secure good value through block procurement while supporting responsive and flexible individual services

In meeting these challenges Local Councils and NHS Boards will need to find a way of answering the following questions:

- What type and volume of services are required now and in the future?
- What quality and price of services are acceptable or desirable?
- How can current services be subject to continuous improvement plans?
- How are 'failing' services improved or decommissioned?
- What incentives are available to innovate and change in line with changing needs?
- Do key people who can comment on people's needs know how to feed this information into the commissioning process?

Evidence indicates that a range of agencies from the statutory, independent and voluntary sectors can work effectively together across organisational boundaries, but that the difficulties of doing so should not be underestimated. See, for example:
http://www.spkweb.org.uk/NR/rdonlyres/A7BF3C35-A788-4D1B-97DA-7BE28AB91FA1/10027/EvaluationPeopleReportBM.pdf

Definitions

This guidance is about *commissioning* services for people *with learning disabilities*, so it is important to be clear about definitions of both these terms.

The standard definition of learning disabilities by Emerson et al (2001) is given here for commissioners who may not have a background in service for people with learning disabilities, learning or intellectual disabilities which includes:

> 'the presence of a significant intellectual impairment and deficits in social functioning or adaptive behaviour (basic everyday skills) which are present from childhood.'

The Scottish Executive Same as You? report in 2001 expands on this and defines learning disabilities as "a significant, life-long experience that has three facets:

1. A reduced ability to understand new or complex information or to learn new skills (in global rather than specific areas);
2. A reduced ability to cope independently;
3. Onset before adulthood, with a lasting effect on the individual's development."

Commissioning can be defined narrowly as the process by which directly provided NHS or local authority services and buildings are established, or externally provided resources are put in place using contracts and purchasing arrangements to specify, secure and monitor services. Commissioning guidelines have already been developed for older peoples' services. A wider definition looks at assessing and fulfilling aspirations and meeting needs. Audit Scotland's study, *Commissioning Community Care Services for Older People* (2004) identified the following elements of commissioning, which are equally relevant for learning disability services:

- Strategic planning and shaping of the local care market to meet the current and future individual needs
- Consulting with service users, carers and the public
- Involving people in planning how to meet their individual care needs
- Working in partnership with other agencies and providers where appropriate
- Providing responsive care management systems
- Managing limited resources and matching to local needs (which may involve setting clear eligibility criteria)
- Using best value mechanisms to improve the quality of care
- Using contracts and purchasing arrangements to specify, secure and monitor services
- Being accountable to local communities and users by providing information on services and performance

Contracts play a major role in ensuring that the right services are being delivered in the most appropriate way, and these can be used in a joint approach between commissioners and providers in driving up standards. See Commissioning Terms Glossary (Part 7 of this guidance) for some examples of commissioning and contracting models, e.g. block purchasing, spot purchasing.

Part 2

Quick Guide

The following headings are taken from NatPaCT (2005) a guide to commissioning mental health services. These are adapted and expanded in the context of commissioning in learning disability services to provide a "quick guide" to commissioning

The following 12 steps are suggested.

1. Learning from experience
2. Integrated planning with partners
3. Stocktake
4. Stakeholder involvement
5. Developing a strategy
6. Commissioning models
7. Agreeing the rules of engagement
8. Commissioning processes
9. Procurement
10. Delivery
11. Review
12. Governance

1. Learning from experience

Where services are already commissioned locally, do a general review, what has worked well and what needs to be changed. Include providers and services users in this review. Focus on outcomes. Gather as much good practice information as possible, from a range of sources. This may come from local, national and international examples of commissioning, and from research. Decide on what is likely to work best locally.

2. Integrated planning with partners

NHS, Social Work, Education and Housing have different priorities, and these sometimes conflict or compete. Agree commissioning models which can be used for partnership work (see number 6), and agree how stakeholders will be meaningfully involved (see number 4).

3. Stocktake

- Do a detailed audit and analysis on what you have.
- What services are available?
- Is there information on cost-benefit and cost-effectiveness analyses?
- Where are the recurring gaps in local services?
- What staff will need what training?
- What are minimum or required standards/ benchmarks to be met?
- Is there an up-to-date analysis of areas where need will be greatest?

4. Stakeholder involvement

Who are the stakeholders, what do they each want, how can they influence commissioning decisions, and how are they to be managed in the commissioning process?

5. Developing a strategy

From a joint "vision" of what commissioning should do for service users (number 2), develop a plan at strategic level. This should take account of *local* needs and meet these in the context of any *national* performance measures that need to be delivered.
Whilst the overall strategic plan may be complex, it should be possible to explain the main aims without using jargon. The three main elements will be:

– What services?
– What staffing?
– How financed?

6. Commissioning models

Once decisions have been made about what services will be provided (number 5) it is possible to look at available options for how these are commissioned. There is no single 'best' model for commissioning; the chosen (joint) strategy should use and combine models as necessary to meet needs. The most commonly recognised models of commissioning are: Block purchasing, spot purchasing, pre-placement agreements, service level agreements and grant aid (see Glossary, Part 6 of this guidance). See also Accounts Commission for Scotland (1997) and Wales Office of Research and Development in Health and Social Care (2002) for a summary of some research and Centre for Health Leadership Wales (2001) for the full report.

7. Agreeing the rules of engagement

Meetings, protocols and etiquette – there is no single, prescribed way of managing and providing administrative support during the commissioning process, and local organisations will operate differently. However, to avoid problems with co-ordination and communication it is important to agree at the earliest stage who will do what, when and how. A written agreement between local commissioners and any stakeholders involved may seem overly formal, but it is recommended.

8. Commissioning processes – *see JIT website online flowchart for individual commissioning*

1. Drawing up clear specifications, and tenders if necessary.
2. Agreeing the criteria for how providers "bids" will be judged
3. Agreeing which local provider(s) or preferred provider best meets need.
4. Identifying alternative and additional providers
5. Having some way of comparing the value and effectiveness of each of the services
6. Completing risk assessment

9. Procurement

The contracting, after decisions have been made about who will provide the services, or combination of services. This should include details of payments to be made, financial incentives and penalties if appropriate, how and when the contract will be reviewed, how the contract specifications can be changed if necessary. There may be jointly provided NHS and social work services, together with "external" providers.

10. Delivery

Making sure that what was planned is delivered. This is a combination of "project management" and contract monitoring, tailored to each commissioned service. For example, the group may consist of a senior operational manager from each contracted organisation and a Disabilities Services Manager. The size of the group should be proportional to the size of commissioned service. There should be a plan for managing risks and contingencies.

11. Review

On-going and periodic review of how well the service is delivering the agreed outcomes to the person with learning disability. This may include reviewing performance management, monitoring at an individual level meeting quality standards, and agreeing how recommendations for improvements are to be implemented.

12. Governance

Clinical governance, corporate governance, practice governance: all of these are about having systems in place to achieve the stated goals of commissioning, in a way that is safe, financially sound and realistic. Governance is a concept more familiar to the NHS in safeguarding high standards of clinical care, but partnerships are becoming more familiar with it and it is a framework increasingly used in commissioning. In 2006, Audit Scotland published a self-assessment tool aimed at supporting NHS boards and Community Health Partnerships (CHPs) develop and review the governance arrangements in CHPs (Audit Scotland 2006).

Key Questions: JIT Website Online Individual Commissioning Pathway

In the process of commissioning there are a number of *general* questions, which can be asked at several points in the process, as well as more *specific* key questions about how well an individual's needs and their aspirations are being met. These key questions can be used in several ways:

– as a form of self evaluation for commissioners, to check whether and how well each stage of the 7 step commissioning process is done
– as a guide to commissioners, to ensure that commissioning is done in a *systematic* way, and key elements of commissioning are not missed or neglected

In the Knowledge Bank on JIT's website – **www.jitscotland.org.uk** – you will find the online individual commissioning pathway that has been developed to help you work through the stages involved with commissioning services for individuals with learning disabilities.

Key questions are posed at each of the 7 steps within the online flowchart / toolkit. A sample of these only is given below, but you should read each of the 7 steps for full details. Links to relevant references for each of the 7 steps are also given in the JIT website tool. A number of starting points are provided to help you research appropriate evidence and good practice. These are backed up by a more detailed reference list.

In the process of commissioning there are a number of overarching questions, which can be repeated at several stages of the process, for example:

- What type and volume of services are required now and in the future?
- What quality and price of services are acceptable or desirable?
- How can current services be subject to continuous improvement plans?
- How are 'failing' services improved or decommissioned?
- What incentives are available to innovate and change in line with changing needs?
- What type and volume of services are required now and in the future?
- Is there information on cost-benefit and cost-effectiveness analyses?
- Where are the recurring gaps in local services?
- What staff will need what training?
- What are minimum or required standards/ benchmarks to be met?
- Is there an up-to-date analysis of areas where need will be greatest?

There are also key questions that are *specific* to a particular stage of the 7 step commissioning process. These questions variously ask about tasks (*if* a task has to be done, *how* it is to be done, or *who* will do it); information (Is it needed? Is it available? How can it be obtained? Who has access to it?); decisions (What needs to be decided? What evidence can be used to guide these decisions? Where can that evidence be found?)

A sample of these questions is given below, taken from the full website guide. This is intended to give you a flavour of the type of questions, before you work your way systematically through the full 7 steps in the online guide.

1. Initial/ongoing identification of need
What are likely housing needs for this person?
Is there a need for a housing commissioning process in parallel with a support services process for this person?
Is individual tenancy a possible model?
Will Care Commission registration be needed?

2. Identification of lead commissioner/care manager
Who has key roles and responsibilities, and what are these?
Does the project require a dedicated team, or only a co-ordinator?
Has finance been agreed, and are benefits being applied for?
Have requirements for revenue, capital and sources for equipping been identified?

3. Multidisciplinary assessment
Is a risk assessment needed, as part of the multidisciplinary assessment?
Who will do this?
How will carers be involved in the sharing of information and then in assessment?
Is carer assessment appropriate?
Has this been undertaken?

4(a) Development of specification
Is there a risk management strategy for individual and public safety?
Does the person have complex needs – challenging behaviour/ASD/forensic needs – and how will these be managed in the service(s) being commissioned?
How, specifically, will staff be trained and supported?

4(b) Development of care plan
What is the role of independent advocacy in supporting and speaking up for the person?
Are there agreed Quality of Life Indicators being used in the care plan?
How are family and carers and service users involved in the development of the care plan?

5. Commissioning a service
What are the essential, "non negotiables" in the service commissioned and what is the timescale for what else needs to be provided?
Is there a research and practice evidence base to support commissioning this type of service for this person?
Have cost/benefit analyses been done, to assess the impact of the new service?

6. Service in place
When will there be an early review of the care plan/ risk assessment management plan/case conferencing arrangements?
Who will provide support to family and carers of this person, and the person him/herself during and after the change to the new service(s)?
When will there be an early review of the service specification?

7. Evaluation and review
How are the health and well-being of this person being monitored?
Is there evidence of choice and control?
Economic well-being?
Is the Care Programme Approach appropriate?
Is a Community Treatment Order appropriate?

Finally . . .

Finally in this section it is worth asking, "How long does commissioning take?" While there is no definite answer to this question, other than "It will vary for each individual," evidence suggests that commissioners should establish a predicted timescale, to monitor the progress of commissioning. A timeline to set out how long each step of the commissioning process will take is a useful reference when there are delays or, indeed, when progress has been made more quickly than anticipated.

The timeline approach can also be used as a method of informing and involving users and carers in the process, and in the likely stages and outcomes; it provides a clear visual guide to how far the commissioning process has come, and what has still to be done.

There are various ways of setting out a timeline, and one example is given below, showing a "Gant chart" with the seven steps.

Commissioning - Key Questions: JIT Website Guide
(see full 7 individual stages on JIT website)

IDENTIFICATION OF NEED
IDENTIFICATION OF LEAD COMMISSIONER/ CARE MANAGER
MULTIDISCIPLINARY ASSESSMENT
DEVELOPMENT OF SERVICE SPECIFICATION
DEVELOPMENT OF CAREPLAN
COMMISSIONING SERVICE
SERVICE IN PLACE
EVALUATION/REVIEW

Timeline for Step 1-7 for Commissioning

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Step1	02/01/2006	09/01/2006	
Step2	16/02/2006	20/03/2006	
Step 3	30/03/2006	14/04/2006	
Step 4 (a) and (b)	21/04/2006	19/05/2006	
Step 5	19/05/2006	22/06/2006	
Step 6	09/06/2006	20/07/2006	
Step 7	20/07/2006	20/12/2006	

Existing Good Practice Examples

There is some useful and practical information available from commissioners and others who have been involved in a variety of commissioned services. Some samples are given below. Please see the full list of links by working your way through the 7 steps in the "Key Questions: Online Individual Commissioning Pathway" on JIT's website.

A sample of these web-based resources is given below, taken from the full website guide. This is intended to give you a flavour of the type of links, before you work your way systematically through the steps in the online flowchart.

Follow resources and links to the following:

See: http://www.jitscotland.org.uk/uploads/documents/Commissioning.pdf

Joint Improvement Team summary of the process of commissioning, including National Policy and Key Developments and links to other relevant websites.

See: http://www.integratedcarenetwork.gov.uk/index.cfm?pid=104&catalogueContentID=723

The Centre of Public Innovation, with the help of its partners, produces Commissioning News as part of the move to raise standards and knowledge around commissioning. It provides information, news and vital discussion points for commissioners and providers working in drugs, health, social care and criminal justice services.

See: http://www.refer.nhs.uk/ViewRecord.asp?ID=1394

A series of expert seminars, which reviewed what was known about good practice in commissioning learning disability services and discussed areas of particular importance: person centred planning, housing, day services, employment, quality assurance. These papers are also available on the Norah Fry Research Centre website.

See: http://www.idoxplc.com/iii/index.htm

IDOX, specialist information management company

See: www.natpact.nhs.uk/uploads/2005_Jan/MH_Print_Version.pdf

The Commissioning Friend for Mental Health Services: A Resource Guide for Health and Social Care Commissioners – Some lessons learned from commissioning health and social care services for people with mental health problems.

See: http://www.word.cymru.gov.uk/content/spotlight/spotlight100-w.pdf

A study to review evidence and expert opinion as a means of informing decisions about the commissioning of health and social care.

See: www.cat.csip.org.uk/_library/docs/GoodPracticeGuides/Catalystforchange2.pdf

Workbook to help local authorities and health organisations to improve commissioning of non-acute services for older people. Produced by the Department of Health Change Agent Team and Warwick Insight Ltd in collaboration with the Social Services Inspectorates in London and the South East, the London Older People's Services Commissioning Project and Department of Health policy branches.

See: http://www.bris.ac.uk/norahfry/

Developing housing and support options briefing papers: good practice in commissioning, Maurice Harker Housing and Support Partnership.
The White Paper said that the aim for housing was a choice of where and how you live, expanding choice including the full range of tenures and giving information about the options. It stressed the present uncertainties faced by families and the need for them to be able to plan.

See:http://www.integratedcarenetwork.gov.uk/_library%2FDemand_Forecasting_HSJ6thJuly06_NWalker.ppt

Powerpoint presentation about demand forecasting and strategic overview.

See: http://www.integratedcarenetwork.gov.uk/index.cfm?pid=125

Practice Based Commissioning (PBC) is a key initiative for the NHS in England and Wales designed to engage General Practitioners in the commissioning of health care and partnership based care with Local Authorities. The aim is that all practices will have sight of indicative budgets for their practice patient populations and use this along side their own knowledge of the practice population needs to advise PCTs on how and what to commission. This is a summary.

See: Community Leadership – Experiences of a Beacon Council

In 1998, Wiltshire made a corporate decision to establish a closer relationship with its local communities and to play a more dynamic role in their development. Community leadership is being increasingly recognised as a key feature of local government's role. The aim was to take an integrated approach to community development so that local people became co-owners of the issues and actions required to address them.

See: Engaging with Communities for PBC

Some guidance in involving local people in GP Practice based commissioning in England and Wales.

See: Practice Based Commissioning – Early Wins and Top Tips

Some tips on successes of GP Practice based commissioning.

Other useful websites:

The Care Commission
http://www.carecommission.com/

Quality Improvement Scotland (QIS)
www.nhshealthquality.org/

The Scottish Social Services Council
http://www.sssc.uk.com/

CCPS: Community Care Providers Scotland
http://www.ccpscotland.org/

UKHCA United Kingdom Home Care Association
http://www.ukhca.co.uk/

Scottish Care
http://www.scottishcare.org/

Part 5

Case Studies

The following Case Studies have all been written by different practitioners. Names have been changed to protect confidentiality, but all the cases are real. The Case Studies are *not* intended to be "Best Practice" examples; they are a cross section of practitioners' experience of commissioning, to illustrate the process and how complex it can be. There are some questions given at the end of each of the Case Studies to highlight learning points, both in terms of "how to" and "how not to," and practitioners have given their views honestly.

All practitioners were given the following remit:

Based on your experience of commissioning and/or providing services for people with learning disabilities please give an (anonymised) example of ONE of the following:

A service that is currently being provided effectively and efficiently to an individual, in a way that meets his/her needs very well. This service is responsive to changes in need and is financed and resourced in a way that makes it sustainable. You should include details of how this service was originally commissioned and any research or practice evidence base used in the setting up of the service, or is being used now.

OR

A service user for whom a service is currently being commissioned, or needs to be commissioned in the near future. This should be a person known to your service, who has needs that are not easily met by existing services. You should include details of any evidence base that may be used in the commissioning the service, i.e. what research or practice evidence will be used in planning the service in such a way that needs will be met and will continue to be met?

Your example (approx 400-500 words) should include information on:

- A brief description of the person
- The person's needs and how these were assessed
- The organisation(s) involved in commissioning and/or providing the service
- Any specific model of care commissioned or being planned
- The services needed for this person, or currently being provided for this person
- Specific sources of evidence information and/ or expertise used when services are being commissioned
- How the service is or will be evaluated for effectiveness and efficiency

The following eight Case Studies are presented:

1 – Jennifer
2 – Bill
3 – Julie
4 – A, B & C
5 – X
6 – Y
7 – Z
8 – Yvonne

Case Study 1 – Jennifer

Jennifer is a forty-year-old lady with profound learning disabilities, autistic spectrum disorder and scoliosis (causing problems with physical mobility). She has no verbal communication. She had been diagnosed with autism aged 4 and subsequently went into long term institutional care where she remained for more than 30 years. She lived mostly in a ward of around 28-30 people although at one point in the 1980's she had been moved into a bungalow in the hospital grounds only to be moved back to the ward when funding difficulties arose. The youngest of four children, her parents remained very close and loyal to her, making a round trip of around 80 miles each weekend to bring her home.

In 1999, we were approached by our local authority social work department, to ask if we would consider a joint venture. Three individuals living in long stay hospitals (three different sites and all from very large wards) had been identified for resettlement and needed to return to their local communities. We had, at that time, an under utilised supported accommodation unit (4 person shared house). It was agreed that building work could be carried out to convert this and an existing staff flat into a small group home for these named individuals (all three had been identified as having autism and profound learning disabilities) and the conversion started in November of that year. Costs for conversion would be met jointly by Local Authority, NHS Health Board and our own, voluntary sector organisation. As Jennifer had been identified as one of the named individuals, ahead of any building works being started, we were able to make contributions to the architect's plans which would help meet some of her physical needs, i.e. use of wheelchair – ramped access, wider entrance doors etc.

We first met Jennifer towards the end of that year. Her ward was scheduled for closure in March 2000 so we had a limited time in which to carry out our own assessment and begin to get to know her. During this time we were also living through the renovations (as we did not decant and were continuing to support other clients on the site). We went through a massive recruitment process increasing the team from 6 initially to 12, to meet the anticipated need. When I first met her, she was an angry, writhing bundle, lying on the ward floor and lashing out at anyone who passed by. She weighed approximately 5½ stones and was very malnourished and under weight.

Over the following months, we worked closely with the hospital authorities, ward staff and family and, of course, Jennifer herself to gather as much information and as clear a picture of her as we could possibly get and to learn her routines before introducing her to her new environment which although we did try to make moving home a gradual progression, it was hurried in the end when she moved in the day before her ward closure.

As individuals had been identified beforehand, the resource was ready and the staff recruited, there was time to identify their greatest needs and we worked closely with the local Professions Allied to Medicine (PAMs) team during staff induction period and for the first year; thereafter involvement tailed off naturally. Training involved such things as speech and language input, autism awareness, dietary needs, OT and physiotherapy input. During that first year, as the situation was monitored and reviewed, we realised that needs were greater than anticipated and we had to approach the local authority again and renegotiate the package. As a result, staffing now stands at 19 (although this team also supports an outreach service) and there is a 'dedicated' team just for the small group

home. We still have strong links with the PAMs team and use them as and when required but we are also closely linked into our local health centre and the generic services on offer there (i.e. podiatry, district nurses etc.).

For the first year Jennifer remained angry and quite destructive of her environment. Gradually, however, she came to trust her supporters and has become calm and settled. Through a specific planned programme of individualised care (with great guidance from the dietician and psychologist and great patience and resolve from the Team) her weight has risen to a healthy 7½ stones and she eats three healthy meals per day. She shows recognition of staff and is affectionate towards them. She enjoys activities and outings and takes great pride in looking and dressing well. She can make simple choices and carry out simple tasks such as putting laundry into a basket or watering the plants (much to the delight of her parents). Her parents no longer take her home for the weekend but are delighted to be able to visit her in her own home and go for outings elsewhere. She returns here happy and giggling and not as she did to the hospital angry and banging on the sides and windows of the car!

We are registered with the Scottish Commission for the Regulation of Care (Care Commission) as registered accommodation for adults with learning disabilities and they inspect us. The local authority has its own Contracts Monitoring Officer who inspects the service twice a year. We also have our own internal audit requirements to meet and there is a 'Carers' Group'. For the first two years, after commissioning, there were regular review meetings involving all interested parties – local authority, health board, families and our organisation.

For the individuals currently living here, this has been a hugely beneficial undertaking. Although restricted to renovating an existing building, we did have an opportunity to try to meet people's physical needs. Forward planning (with plenty of time allowed) enabled us to work with individuals in the hospital environment and get to know them before contemplating the 'real' move. There was sufficient time allowed for fairly comprehensive induction training, based on anticipated need, and working closely in partnership with other agencies gave us the opportunity to renegotiate the deal when needed.

Questions

1. What would have been the "ideal" timing for the building work and conversion?
2. At what point in this commissioning process would you recruit staff?
3. What can help to predict anticipated needs in the newly commissioned service?

Case Study 2 – Bill

Bill (not his real name) is a man in his late 30s with learning disabilities and autistic spectrum disorder. He lived with his family – mother and granny, who had mental health and physical disabilities respectively. They apparently managed without much attention from services until the situation broke down suddenly, necessitating Bill's admission to hospital.

There his specific difficulties were assessed by the multi disciplinary health team (Psychiatry, Nursing, Psychology, SALT, OT) leading to a diagnosis of learning disabilities and autistic spectrum disorder and detailing his specific needs.

As part of the hospital closure programme a residential service for adults with LD and ASD (two young adults within the community and two from hospital) was commissioned by the LA. This was jointly planned by means of a multi agency Steering Group including:
Health – Hospital staff, CLDT, (Psychiatry, Psychology, SALT, OT, Nursing), GP
Social Work – Care Management, LD Services Manager, Commissioning
Housing Association, Architect, Care Commission, Advocacy.

The preferred model for the commissioned service was an "ASD friendly," Social Care Provider. A Service Specification was drawn up from Assessments of Need and then agreed.

Providers (from LA Providers List) were invited to tender and a multi agency interview panel was used for the tendering process. Questions were asked not only about the proposed service model and finance, but also support for staff, understanding of learning disabilities, challenging behaviour and ASD.

Bill required his own flat adjoining the house for the three other people. He did not require 24 hour 1:1, but for staff to be available to motivate and support him in household tasks in the flat, for example, healthy eating, budgeting, time management, engaging in activities in community, facilitating appropriate interaction with family, anxiety and anger management.

In the commissioning process, best evidence information was sought about ASD friendly environments, e.g. textures, lighting, décor etc. Specific individual sensory needs were assessed and accommodated. Sound proofing, fixtures and fittings were discussed with the architect. (Sources of information used were the National Autistic Society, Internet and Scottish Consortium for Learning Disabilities literature searches, and local professional experience.)

The Steering Group set up at the beginning of the commissioning process continued until "snagging" issues were resolved. Some of these problems included heating, sound proofing, and garden work. The link with the Community Learning Disability Team was also maintained, and they provided useful training, and regular visits. Bill's care plan was reviewed using the Care Programme Approach (CPA).

In spite of this planning and contract monitoring this project was not without its difficulties. Fortunately these were identified by the above processes and remedied fairly quickly.

Currently this project has matured to the point that the Provider is carrying out further outreach work and there is discussion of Bill moving on to an outreach flat in the neighbourhood, in the process freeing up his placement for someone else in need of this level of support.

Questions

1. Who would you include on a multi agency interview panel in your area?
2. Where would you seek "best evidence information" for someone in Bill's situation who does *not* have the Autistic Spectrum Disorder?
3. The Steering Group set up at the beginning of the commissioning process continued until "snagging" issues were resolved. At what point in the commissioning process would you disband the Steering Group?

Case Study 3 – Julie

Julie is a young lady, nineteen years old. She lives at home with her mum, dad and fifteen-year-old sister. Julie, like many teenagers, enjoys spending time with her friends (away from mum and dad). She enjoys various social and sporting activities such as swimming, music, ten-pin bowling, computers, long walks and experimenting with make-up, fashion, shopping etc. She is a good-natured young lady with a good sense of humour who enjoys a joke and a laugh. Like most young ladies of this age, she also enjoys male company and attention. She enjoys having pets and currently owns a dog, cat, guinea pig and goldfish.

Julie has a profound learning disability and suffers from epilepsy and quadriplegia. She has no mobility apart from head movements and is unable to communicate verbally. Julie is, however, very skilled at expressing herself by using a variety of gestures and facial expressions. For example, she will close her eyes if she doesn't want to talk to you, or turn her head away to refuse something. If Julie stares intently at something, it normally means she is interested in it and she will laugh and smile to tell you she is enjoying herself. If she protrudes her tongue, she is telling you she is thirsty and if she points to her body Julie wants you to know she is uncomfortable with her spinal jacket and wants to be repositioned. Julie also has Partial Ornithine Transcarbamoylase Deficiency (Urea Cycle defect). This is a very rare medical condition that basically means that excess amino acids cannot be stored in the body. The nitrogen of these acids are normally converted by enzymatic processes to urea and safely excreted from the body. In Julie's case, this does not happen and ammonia levels in the blood are raised and toxic.

This medical condition requires very careful monitoring and specific medical interventions and protocols to be precisely followed. To keep Julie healthy and safe a high protein diet needs to be strictly followed. Food needs to be pureed and drinks require to be thickened. If she is sick an emergency protocol has to be responded to within 30 minutes but if she requires suction, this has to be undertaken immediately. Julie needs to be pump fed at night. She requires to be rolled rather than lifted, requires a hoist to be used to move her from one area to another and needs her position changed regularly. She utilises a standing frame and side-lyer and wears a spinal jacket. She has specific seating, positioning, eating, drinking, equipment, transport, manual handling, emergency care and communication needs. Julie needs to use a Gillingham tilt wheelchair and has a stoma that requires to be changed. She also has specific physiotherapy and speech and language therapy requirements.

Julie also has a variety of social, emotional and developmental needs linked to her personal interests such as spending time with friends, experiencing new activities, taking part in activities she enjoys and spending time away from her family and home. She loves going swimming for example or going for a facial. Careful and complex care planning is required to meet these needs in conjunction with Julie's health needs in such a way that she is able to take part in such activities within her local community, whilst keeping her healthy and safe and continuing to respond to any changing needs. Julie's needs were assessed initially by a Section 13 assessment, followed by a CCA1 initial assessment and screening tool, a CCA2 Community Care Assessment of needs including many specialist assessment referrals and laterally by a Person Centred Planning Team using Person Centred Planning approaches and tools.

In such an unusually complex case, many organisations worked together in providing/commissioning services and planning future care to meet Julie's assessed needs.

These included:

- Community Learning Disability Team (Social Work and Health)
- Resource Management
- Physiotherapy Service
- Home Care Services
- Day Care Services
- School
- Short Breaks Service
- General Practitioner
- Respite Services
- Neurology
- Metabolic Consultancy
- Speech and Language Therapy
- District Nursing
- LHCC Management
- Community Alarm
- Consultant Paediatrician
- Education Services
- Children's Services
- Paediatric Pharmacy
- Dietetics
- Orthopaedic Consultancy

Services currently being provided for Julie include 17 hours of Home Care per week, day care provision for 5 full days per week, a full-time 'F' grade nurse to support Julie in her day placement and community activities, regular physiotherapy and speech and language therapy input and the purchase of a variety of specialist OT equipment, mobility and sensory equipment. Building alterations were also undertaken to meet Julie's needs at the Day Care provision and a specialised mobility vehicle was purchased under a leasing agreement. Services were also secured to support the family consisting of 100 nights of respite provision per year for Julie, access to the Community Alarm service and access to the Short Breaks service as and when required.

Julie worked with a Future Needs Co-ordinator whilst at school to assess her needs, in line with the Disabled Person's Act 1986. They work in partnership with all agencies, the young person and their family to plan for the future and explore a variety of options for young people leaving school. The Future Needs Co-ordinators are employed by the Council Social Work and Health and are trained in Person Centred Planning to support young people and their families plan meaningfully for the future. Their appointments were a direct result of the recommendations in 'The Same As You?' National review of Learning Disability Services and the Person Centred Planning approaches and techniques were adopted as a result of comprehensive research undertaken and a comprehensive re-skilling the workforce initiative in the local Council, delivered by the National Development Team, the Foundation for People with Learning Disabilities and a major voluntary sector organisation.

A person-centred team worked with Julie and her family and all relevant agencies in planning and implementing a phased transition process. Teachers are actively involved in the transition, Social Work and Health staff are involved at an early stage and health care needs are given much greater consideration at an early point in the process. All relevant professionals work with the Person Centred Team to ensure a holistic approach to addressing the future needs of the person and their family. This allows relationships to develop prior to transition, a greater understanding of individuals' needs to develop and a sharing of information and expertise to take place in a more

seamless and co-ordinated manner. Resource and equipment requirements are identified at an early stage and agencies work together sharing and resourcing these.

A multi-disciplinary, young persons planning group oversee the whole process. This group consists of Senior Managers representing a diverse range of services and disciplines, main stakeholders and parents. Their main objectives include designing and implementing transition programmes, establishing a system for longer term planning, securing resources and developing an integrated pathway allowing each agency to be clear of their responsibilities at varying points in the transition process.

The group work to the belief (researched by many theorists on collaborative and partnership working) that a team of people consisting of representatives from various agencies offer a range of expertise that creates the opportunity for more effectively integrated services and more efficient service delivery. This has resulted in less duplication of resources, maximisation of current resources, and wider access to varying resources and access to a wider variety of funding sources. This has made Julie's care package sustainable. Much of it was funded from within existing resources across various agencies, although some new funding was also secured which resourced a full-time, permanent staff member to work with Julie.
The planning group provide an active link between parents, service providers and planners, considerably relieving the stress families experience during the transition process.

The high level of collaboration between a diverse range of agencies has ensured protocols and procedures have been developed to support individuals' choices. It has resulted in a better use and allocation of resources and a more integrated service approach and more efficient, customer focused service delivery.

It is evaluated and monitored using person centred reviews and a comprehensive standards and monitoring tool based on the National Development Teams' Person Centred Planning Evaluation Toolkit which evaluates the service provided at individual, family, service and organisational levels, focusing on positive outcomes for the individual and their family.

The ideal would have been for the Person Centred Team to deliver an individualised service to Julie without accessing a building based resource e.g. the Day Service. However, this would not have been financially sustainable or practicable as the resources required to support Julie's health needs were not accessible within the local community.

Questions

1. Where would you seek "best evidence information" for someone with a rare medical condition such as Julie's?
2. At what point in the commissioning of services would you involve a Future Needs Co-ordinator, working in partnership with all agencies?
3. A multi-disciplinary, young persons planning group oversee the whole process in Julie's case. Locally, how is transition from school overseen in your area and what standards and monitoring tools are used?

Case Study 4 – A, B and C

Pen Picture

There are three young men (A, B and C) aged between 20-35 years who are currently In-patients in specialist forensic services. All are generally independent and respond positively to a structured environment. All three have offended in the past, but only two of the three have come through the Criminal Justice Service.

One person (A) presents as physically and verbally aggressive towards staff and peers, requiring control and restraint. He also has periods of mental ill health. The second person (B) requires high levels of support due to his sexually inappropriate and over friendly behaviour. He is a long-stay patient. The final individual (C) can be physically and verbally aggressive, is sexually opportunistic and has committed offences against children and adults.

Needs Assessment

A multi-disciplinary team with input from Psychiatry, Psychology, Forensic Nurse, Allied Health Professionals, and Care Management has carried out a range of needs assessments. The range of needs requiring management and support include mild and moderate learning disability, physical and verbal aggression, mental ill health, associated challenging behaviour, personal care, and other daily living tasks.

Proposed Model of Service

The proposed model of service is robust accommodation with 24/7 support, based on a previous service, which looked after individuals with similar needs who had been resettled from long-stay hospital. A voluntary sector care provider would provide the service, with secondments from in-patient services. This model is supported by the local Specialist Forensic Service, which has a good reputation, has published research internationally and has an extensive research base in the field of Forensic Learning Disabilities.

Commissioning Strategy

The Local Authority is taking the lead in the commissioning process. There is a set programme of tendering, expressions of interest, short listing, interviewing and selection. Representatives from the key agencies are involved and a dedicated group-interview exercise for families and individuals will be supported by the commissioning team and other staff. This will ensure that individuals and their families are meaningfully involved in the process. Visits to short-listed providers services will also be built into the process.

Support Services

There is a programme of work currently underway to develop the community infrastructure to ensure that appropriate levels of support are available to the three individuals and their service. These developments include:

- Ongoing attendance at Specialist Day Treatment Unit
- Seconded staff from Specialist In-patient Service
- Risk Management Policy Framework for Learning Disabilities
- Additional Community Forensic Nursing
- Additional Care Management

Evaluation

The project should go live in 2007 and it is anticipated that a similar exercise to previous resettlement would be carried out by Clinical Psychology Service to evaluate effectiveness and efficiency of services. Part of this study looks at involvement in the community, levels of contact with non-learning disabled people and levels of challenging behaviour. In addition, the service users will be involved in individual reviews through Care Management / Care Programme Approach arrangements. The service will be subject to Contract Compliance and reviewed through Local Authority Contracts and Commissioning Officers, including the multi-disciplinary team.

Questions

1. The local authority is taking the lead in commissioning services in this case study. Are there any advantages or disadvantages of different agencies taking the lead for commissioning services in your area?
2. In this complex case, involving three people, evaluating the effectiveness and efficiency of services is planned. How are effectiveness and efficiency evaluated in other cases that you are involved in?
3. The Care Programme Approach has been used in this case study. In which cases do you consider this approach (a) essential (b) desirable?

Case Study 5 – X

X is a 29-year-old male with a severe Learning Disability, Ataxic Cerebral Palsy, Epilepsy, and Challenging Behaviour. He lived with his family until he was 26 years old. As a child he attended a local Special Needs School for two years before transferring to Hospital School due to ongoing aggressive behaviour towards both fellow pupils and teachers. He attended hospital school until he was 19 years old.

On leaving school, difficulties were experienced in identifying a suitable day support system to meet both his needs and the safety of others. Extensive risk assessments – environment/personal care/behaviour management/aggression/communication were put in place and at age 20 he began to attend a local Day Service three days per week with two staff in place to meet his needs. Ongoing problems were experienced in developing and managing X's support. The Challenging Behaviour Team spent six months assessing X and working with the staff to support the service and make this more meaningful for X. Extending this service proved unfeasible, given the limits on activities acceptable to X and the continued pattern of spontaneous aggression.

Respite was also organised – with similar risk assessments – with the support of two staff for short breaks. Family also used ILF to fund care support at home on a daily basis.

Due to his mother's increasing health difficulties in 2002 it was agreed that X could no longer be sustained at home and alternatives were sought. Given his high needs and the unrelenting dilemma in managing the interface between safety/socialisation it was agreed that further assessment and treatment were required to attempt to develop a more stable pattern. At this point there was no availability with LD Health assessment/treatment provision local options were unable to sustain his support and a placement was identified outwith area (Joint Funded between Local Authority and Health).

X has now been there approximately three years and although his behaviour continues to challenge, much of the aggression can now be contained with clear intervention strategies, which allows him more personal freedom within agreed boundaries. He has now reached stage of being ready to move on to a more community setting where the strategies/staff support can be maintained. Joint planning/consideration of commissioning appropriate local options have been initiated.

Questions

1. Can you suggest changes to the commissioning process in this case study (a) while X was still in the hospital school? (b) after he left school? What additional assessment, support or procedures would you suggest to improve the final outcome?
2. How would you fully involve X's family in the commissioning process?
3. Who should oversee the commissioning of the new service, and what agencies should be involved in this?

Case Study 6 – Y

This is an example of a service user for whom a service needs to be commissioned in the near future. This is a person who has needs that are not easily met by existing services.

Description of the person (pen picture from Care Management)

Y is a 20-year-old man who has been diagnosed with severe learning disabilities, autism, severe challenging behaviour (including severe aggression towards people and property, faecal smearing, anal gouging and other self-harm) and epilepsy. He has no speech but can make pre-speech vocal sounds. He is prescribed six different daily medications plus PRN Haloperidol, Lorazepam and Chlorpromazine.

Quality of life

He is residing in a private hospital. He spends the majority of his day, every day, in his room. He is observed every 15 minutes by staff via a peephole. Those who know him believe he has no quality of life. This client prefers to be alone but requires a dedicated member of staff to carry out observations. Dependent on mood, he requires up to five members of staff to carry out personal care and when challenging behaviour is presented full restraint is used.

Needs (As assessed by Care Management)

To return to the local area he requires to have his own spacious accommodation, e.g., living, sleeping, bathing areas and free access to garden area. The accommodation requires to be quiet and calm. The accommodation needs to be highly robust in nature with appropriately robust/soft furnishings. Because of the variable level of staffing required (from 1-5), he requires to be located close to other similar accommodation so that staffing can be shared.

Local context

There are a small number of clients locally with similar needs to Y. The nature of their needs is such they require very specific support. If the correct support is available, these individuals may be enabled to live successfully in the community. If the correct support is not available the evidence shows spiralling challenging behaviour and other difficulties which have resulted in the breakdown of living situations, day services and deterioration in quality of life.

Increasingly large, expensive packages of support are being used to support a small number of people both within and out with the local area, in attempts to keep them and their surrounding community safe, while failing to meet their basic needs.

The NHS and the three Local Authorities are investigating the feasibility of commissioning an area wide facility that meets the needs of these individuals. Specific sources of evidence, information and expertise used to consider service to be commissioned.

A cross area (3 x Local Authority and NHS) group has been established. A clinical professional group are investigating examples of good practice and evidence based best practice in relation to supporting the specific needs of the small number of clients that have been identified and work is at the very early stages.

Questions

1. “Those who know him believe he has no quality of life.” How would you assess this person’s quality of life now, and when a new service has been commissioned? What sources would you use to find out how to do this?
2. “The feasibility of commissioning an area wide facility that meets the needs of these individuals” Can such facilities be justified and are they consistent with recommendations in the Same as You? How would you find evidence either to support or to argue against building such a facility?
3. “Examples of good practice and evidence based best practice in relation to supporting the specific needs of the small number of clients” How do you and your colleagues assess what is and what is not valid evidence based best practice?

Case Study 7 – Z

This is an example of a service user for whom a service is currently being commissioned, or needs to be commissioned in the near future.

The client, Z, is male, in his late twenties, currently living in a large residential setting for people with learning disabilities. He has lived in residential settings from early childhood and this will be the first opportunity for him to experience living in a “non-congregate” setting.

The person has been diagnosed with severe learning disabilities, a concurrent mental health problem and presents with severely challenging behaviour, which manifests as physical aggression towards others and self. These behaviours occur on a frequent basis. The individual’s current community participation extends to walking in the grounds of the residential setting accompanied by one staff member and participating in car trips during which he does not leave the car.

The service that is to be commissioned for the individual is a single tenancy with 24-hour staff support including waking night staff. There will be two staff members to support the individual through the day with one member of staff awake at night. The tenancy will be in close proximity to other supported accommodation from where additional support will be available if required. The provision of community-based accommodation has been shown to bring about benefits in adaptive functioning, choice making and objective quality of life measures.

The support team will be provided by an independent voluntary sector or private organisation that is still to be identified through a tender process. It is anticipated that the staff team from this organisation will receive significant training in working with people with challenging behaviour, including the use of emergency management techniques. It has been shown that the provision of training and support systems for staff teams is a variable that may reduce the risk of readmission to an in-patient setting.

In addition to the individual’s dedicated staff team, additional support will be made available from specialist learning disability health services. This will include personnel with experience in the assessment and treatment of severely challenging behaviour that will provide support as required. There are plans to be able to provide an intensive support service to allow for additional resources to be allocated to support individuals within their current placement in times of crisis.

Transfer for Z to his new residence is due to take place in late 2006 and it is hoped that all the necessary supports will be in place by this time.

Questions

1. "The provision of community-based accommodation has been shown to bring about benefits in adaptive functioning, choice making and objective quality of life measures." How or where would you find evidence to support this statement?
2. The use of emergency management techniques is proposed as part of this commissioning package. What training and safeguards would you include if you were commissioning a similar service locally?
3. In this case study additional support will be available from other nearby supported accommodation. What would you consider to be the advantages and disadvantages of this "core and cluster" model?

Case Study 8 – Yvonne

The following is an example of a service that is currently being provided, from a Provider perspective.

Yvonne is 45 years of age. Her service was originally commissioned in 2002. She had been in institutional care from her late teenage years until her service was commissioned, at which point she was living in one of the long-stay learning disability hospitals, which was scheduled for closure that year.

Yvonne is a bright, lively and active person. She finds it difficult to wait for things she knows will be happening. She enjoys being out and about, but can find new situations and places difficult, and may need extra support initially. Yvonne asks for a lot of time, attention and consistency from the people who support her, and this works best for them and Yvonne over shorter periods of time during the day. One of the team sleeps over in Yvonne's flat at night to be there in case of any unplanned need or medical emergency.

Records indicated that Yvonne has a non-specific learning disability, epilepsy (rectal diazepam prescribed), and Type II diabetes. Onset of the latter condition in her late teens appeared to start enduring 'food-focused' behaviour, which coupled with difficulty in securing appropriate day care, led to the breakdown of her family situation. Active family contact continued throughout her period in institutional care and is part of her current support in the community.

Organisations involved in commissioning the service were:

- Council Social Work Department – Hospital Discharge Team and Headquarters staff
- Local housing provider
- Hospital-based healthcare personnel
- Community-based health care personnel
- Family members
- Yvonne
- Support provider – local housing association

Specific Model of Service

The support provider was asked to provide an individual support service to Yvonne in a top floor two bedroomed flat, which had already been identified by the social work department and a local housing provider. The flat is close to the town centre and is part of a development built by a mainstream housing association which has limited previous history of providing accommodation for adults with learning disabilities who have additional support needs.
The accommodation was adapted by provision of

(a) a lock on the kitchen door – to prevent food related incidents and diminish risk by unsupervised use of electrical appliances, and
(b) a main door alarm sounder to alert worker's to unplanned departures.

The support provider was advised that Yvonne would require 1-1 support at all times throughout waking hours (7.00 am-11.00 pm), with a worker to provide sleepover cover at night for any unplanned support needs which might arise. Given the level of supervision and support required with personal care and other interventions, an all female team was specified. The commissioners explained to the support provider that family involvement was critical to the success of the service as the family was very sceptical that a move from the security of institutional care was in Yvonne's best interests.

The commissioners noted time constraints at the outset which provided for a 4-month period from initial specification agreement to commencement of service provision. Some of these time constraints related to family concerns at previous delays and uncertainties, and others to hospital contraction plans. The commissioners made available an Essential Lifestyles Plan which had been devised with involvement of everyone who knew Yvonne well at that point. The plan was helpful in shaping the initial service proposal, but it was more helpful in shaping delivery of support to speak directly to contributors including health care professionals, Yvonne, and her family.

As referred to earlier, it was anticipated that when the service was established, responding consistently to Yvonne's support needs would require shorter shift patterns (than in hospital) for workers to enable them to remain fresh and appropriately focused on her support. This was because there would not be a facility to 'rotate' support with other workers as was the case in hospital to provide more natural breaks.

Services currently provided
Comprehensive lifestyle support in home and community included – support with all finances including payment of bills, most personal care, health monitoring, and support with medication including insulin for diabetes and midazolam with regard to epilepsy. Also needed was practical support to maintain household and tenancy, to ensure personal safety and security, meal planning, shopping and meal preparation, social support in the community and to maintain contact with family members. Finally, it was important to fulfil and review aspirations identified in Essential Lifestyles Plan.

Specific Sources of Evidence used
Nurses and Nursing Assistants – Oral evidence, observation of practice, shadowing, working jointly in hospital setting. This enabled team members to acquire confidence and experience in role prior to formal commencement of service in Yvonne's own home.

Speech and Language Therapist – Written guidance based on professional assessment augmented by oral evidence gathered by service manager. Direct contribution to induction training for worker team in relation to understanding Yvonne's communication and enhancing own communication with Yvonne.

Clinical Psychologist – Written reports offering assessment and suggested strategies in relation to diversion from food-focused activities and behaviour. Practical suggestions in relation to activities which would involve Yvonne with other people, and maintain her attention span as effectively as possible. Direct contribution to induction training for the worker team. Direct service provision after commencement of service.

Psychiatric Services – General oversight and agreement of discharge planning and ongoing out-patient monitoring when service commenced in the community.

Dietician – Specific input to team training in relation to diet, healthy eating, and diabetic condition.

Physiotherapy - Initial assessment material, input to team training. Ongoing access to 'rebound therapy' since discharge from hospital.

Social Worker/Care Manager – Yvonne's care manager was a qualified nurse who had previously worked with her in the hospital setting and knew her well. She had prepared the Community Care Assessment. The providers' manager had access to written material and oral evidence from her with regard to Yvonne's support needs and day-to-day lifestyle.

Family Members – Considerable anxiety about Yvonne's move to the community, compounded by a lack of trust of the motives of the Health Board and the Social Work Department to secure support which would ensure Yvonne's safety and comfort, and their own peace of mind. These anxieties had to be given credence, and enabled the provider to establish its credentials and a trusting relationship with Yvonne's family which continues to date.

Essential Lifestyle Plan – original document was extended and updated during Yvonne's staff team's induction by the provider's local manager, but provided an invaluable source of information for direct use, and/or functioned as a 'source document' for elements requiring further investigation.

Providers' own resources – The local manager who was to be responsible for this service was simultaneously involved in the commissioning of services by the same provider for a further six individuals. The provider was able to offer temporary support to the local manager from another experienced manager who had set up similar services in the past.

Service Evaluation

There was no formal service evaluation agreed at the outset beyond a standard 'Contract Compliance' document applied by the local authority. The service has been reviewed since its inception by means of the Care Management Review mechanism. The provider offers individual supervision to Yvonne's worker team, regular team meetings and other meetings to discuss support delivery. The provider has limited internal Quality Assurance measures (currently under review) involving worker and service user 'satisfaction' questionnaires.

Subjective indicators of service provided

1. Care Managers have been satisfied with the level, quality and consistency of service offered by the provider.
2. Psychologist withdrew specific input during first six months as she felt her input was no longer required in support of the service user/team.
3. Family members have consistently stated their feelings of satisfaction with the service offered to Yvonne.
4. Management of diabetes and injection is now the province of the service user with the support of her team (over last 18 months). This previously relied on district nursing support which was constraining of time and lifestyle.
5. Rectal diazepam discontinued as preferred treatment for epilepsy and replaced by midazolam (oral medication).

6. Some reduction in food-focused behaviour.
7. Infrequent need for use of door lock on kitchen.
8. Main door alarm unused.
9. Service user appears happy with her lifestyle, and the developments which have been possible over time – own car, other opportunities, and short holidays. Speech and use of language has shown some development in terms of age-appropriate speech. Control of medication in relation to diabetes. Apparently greater sense of self, and ownership/investment in home/surroundings.
10. Low staff turnover within worker team – 1 of the 5 original part-time team members (1 full-time + 4 part-time) left for a full-time post after approximately one year. Generally consistent high level of commitment to Yvonne and to each other despite some difficulties within team.

Questions

1. The housing association in this case study had limited previous history of providing accommodation for adults with learning disabilities who have additional support needs. At what specific stage in the commissioning process would you first involve the housing association, what would be their involvement, and when would it end?
2. Use was made of Yvonne's Essential Lifestyles Plan in this case study. What role would this record play in any services that you would commission? What information would be included in the Essential Lifestyles Plan, and what information would be withheld, or kept in other records?
3. Check the list of "Subjective indicators of service provided" given at the end of this case study. Try to draw up a similar list, which could be used to supplement any formal "objective" quality indicators used with a service commissioned for a service user in your area.

Commissioning Terms Glossary – What do you mean?

Clarification of terms
It is important to be as specific as possible when using terms in the commissioning of services. The following grid (Figure 2) is given as an example of how easy it can be to construct meaningful sounding terms which mean very little, if not precisely defined!

Instructions:
Combine one word from column 1 with one word from column 2 and one from column 3 to make meaningful sounding terms. For example, "positive, transition analysis." Can you say what this combination of terms actually means in practice?

The terms may all be acceptable to those involved in commissioning, but they may mean very different things to different practitioners, or they may mean nothing at all!

It is essential that all of the partners involved have an agreed understanding of the terms used when commissioning services. This will help avoid misunderstandings and confusion in what can be a complex process.

Figure 2 Commissioning Terms Generator

Column 1	Column 2	Column 3
strategic	developmental	approach
individual	communicative	capacity
multi-faceted	best value	placement
quality	multidisciplinary	review
lifelong	research-based	governance
principled	person centred	policy
positive	commissioned	advocacy
systematic	programmed	overview
holistic	functional	criteria
evidence based	improvement	practices
alternative	transition	analysis
assiduous	care-focused	cycle
health	based	procurement

What follows is a selection of terms **(in bold)** that may be used in commissioning, with some definitions. You may wish to add new terms and local variations.

Advocacy/Advocacy organisations
Representing and supporting the interests of the person with learning disabilities by negotiation with social work, health and other stakeholders during commissioning and afterwards. Ideally, this should be advocacy which is organisationally and financially independent of the managed services. Empowering the person to express choices and preferences in where they live and how. See the Scottish Executive's Guide to Advocacy for Commissioners, http://www.scotland.gov.uk/library3/health/iagc-00.asp, the Scottish Independent Advocacy Alliance http://www.siaa.org.uk/ and Advocacy Resource Exchange for UK sources of information http://www.advocacyresource.net/
A more recent update, reviewing developments since The Same as You? can be found at:
http://www.scotland.gov.uk/Publications/2006/04/13144910/0

Assessment
Methods of measuring and understanding the needs of an individual so that an appropriate care plan can be commissioned. There are many different kinds of assessments, e.g. contact, overview, single-shared, multi-disciplinary or specialist, and different levels of assessment – simple, comprehensive, complex.

The choice of assessment(s) to be used can depend on how much support the person will need, and the professional involved.

Different "tools" for assessment are used. The Scottish Executive Health Department published guidance on the single shared assessment:
http://www.scottishexecutive.gov.uk/Publications/2005/02/19542/39297/Q/Zoom/80

www.show.scot.nhs.uk/sehd/publications/DC20011129CCD8single.pdf

A "fast track" assessment usually reflects an urgent need for a service to be commissioned. (Sometimes referred to as "Friday afternoon commissioning.)" This type of assessment will not be comprehensive.

Benchmarking
The process by which comparisons are made between or amongst services; as a means of setting of minimum or required standards to be met.

Best Value Review
Scottish Executive value and quality procedure for checking how well services are using the funding they have been allocated.

Block purchasing
The payment of an annual fee for access to a defined range of services. This type of commissioning is not initially related to individual users, or individual needs and the numbers will be estimates. The model has the advantage of *guaranteeing* that services will be available and guaranteeing funding for the provider, although it may 'lock up' resources in the short/medium term.

Bridging Finance
Funding from Scottish Executive to pay for the setting up of community services and infrastructure during the closure of long stay learning disability hospitals. The money helps to pay for the high cost of running a hospital while setting up new services at the same time.

Capital Funding
Money used to develop "fixed" aspects of a commissioned service, for example purchasing/building new premises.

Care Management/ Community Care Management
Managing, co-ordinating and reviewing services for the person with learning disabilities in a way that provides for continuity of care and accountability to both the person receiving the care and the organisation managing it. Usually follows a cycle of assessment of needs, care planning, monitoring care and review.

Care Manager
Practitioner, usually from health or social work services, who undertakes all or most, of the tasks of care management. This person may hold a budget, depending on local arrangements.

Care Planning
The process of negotiating the most appropriate ways of meeting assessed needs involving the organisation doing the assessment, the service user and other relevant organisations. The process often focuses on what resources are available and how they can be incorporated into an individual care plan.

Carer
A person who is not employed to provide the care in question by anybody in the commissioning negotiations. Normally, this will be a person who is looking after a person with learning disabilities in the home, where the dependence relationship 'exceeds that implicit in normally dependent relationships' between family members. *(Social Services Inspectorate 1991)*

The carer is typically a relative, involved in practical activity, where the person is unable to carry out those activities for themselves.

Client Group/Community Care Client Group
A classification applied to a person according to the type and extent of support needed. Sometimes a needs analysis will have been done to predict resources that will be needed for a particular group, e.g. adults with profound and multiple disabilities in a particular health authority area. A person with learning disabilities may fall into more than one client group classification, e.g. people with mental health problems and learning disabilities, or people with autistic spectrum disorder and learning disabilities.

Commissioning [Individual]
"The process of translating aspirations and need into timely and quality services." (CSCI 2006) Organising services for a person with learning disabilities.
The process by which local authorities and health authorities assess the needs of an individual, identify and secure the resources they need, and then devise a plan for achieving the desired, sustainable outcomes for that person through contracts/service agreements contracting with a variety of organisations. (The terms "contracting" and "purchasing" or "procurement" are used in the context of commissioning but these are *part* of overall process of commissioning.)

Commissioning [Strategic]
The strategic activity of assessing the current and predicted needs of the learning disabled population in an area served by a health authority or social work department. Reviewing current services and developing a strategy to make best use of available resources to meet need. May be a specific health needs assessment, or a wider ranging predictive assessment of future needs, for example housing, community support, transport, advocacy, specialist staff. See also presentation on "Demand forecasting" at:
http://www.integratedcarenetwork.gov.uk/_library/Demand_Forecasting_HSJ6thJuly06_NWalker.ppt

Commissioning Cycle
The stages of commissioning which organisations can undertake individually or jointly. Commissioning is often represented as a linear process, but it should be cyclical, as activity should be planned, contracted, monitored then revised to feedback decisions made and revisions to the plan. (See flowchart on Stages of Commissioning and Commissioning Cycle also).

Community Care Planning
The process whereby local authorities, health services and sometimes other organisations. e.g. housing or independent advocacy work together to plan future services and priorities for user groups. See for example
http://www.scotland.gov.uk/cru/resfinds/drf26-00.htm
www.scotland.gov.uk/library/swsg/index-f/c161.htm

Contract Management
The process for ensuring that service providers being paid for by a local authority or health authority sticks to the terms of the contract. Under the terms of contract management regulations and the competitive tendering process, there may be mechanisms in place to govern how the contract is to be awarded and which suppliers of services are on a "preferred providers" list or deemed to be best value. Local authorities or joint health/social work services may have a detailed contract management framework.

Cost Benefit Analysis
Compares the costs of different services with the benefits or outcomes of that service. Different types of services may aim to achieve the *different* outcomes, however, and direct comparisons may not be appropriate.

Cost Effectiveness Analysis
Compares the costs of different services that aim to achieve the same or similar outcomes. Direct comparisons can be made, provided clear criteria for the analysis are specified.

Co-terminosity
Where two or more organisations share geographical boundaries so that they are providing services to the same population, for example Fife, Western Isles, Shetland each have one NHS service and one local authority covering the whole area, whereas Lothian, Lanarkshire and Ayrshire each have one health authority, but a number of different local authorities.

Cross Authority
Matters relating to a service that cross local authority or health authority boundaries, including assessing need and supply for services, strategic planning, funding, monitoring, reviewing and decision-making, for example Greater Glasgow has one NHS authority covering the area, but a number of different local authorities.

Day Care
Managed care and meaningful activities provided during office hours usually, outside the person's home setting. Traditionally provided in day centres/adult resource centres, but increasingly services are making use of leisure and recreation facilities in the community, and supported employment schemes.

Directly Managed Unit
NHS service providers which are directly managed by Boards, for example forensic units, health care houses.

Discharge Plan
An example of a commissioned service. Multi-disciplinary plans for a person leaving long stay hospital. Includes details of how the person's needs (medical, nursing, therapy, social work and housing) will be met by the organisations involved.

Domicilliary Care
Managed care provided in the person's home, or place of residence. Can be social and/or health care provided to someone living alone or with a carer.

Floating Support
A support service that is specifically linked to an individual rather than to specific premises or sites. This may be day services support in the community, for example, for a person not based at an adult resource centre. Home Support or Visiting Support or Outreach Work are all examples of floating support that might be commissioned.

Governance
In the context of commissioning this usually refers to the ways in which NHS organisations are responsible for the management, finance, quality and performance of all of their services and staff. See also specific recommendations about governance for services to people with learning disabilities at:
http://www.phis.org.uk/pdf.pl?file=pdf/LDSummary.pdf

Grant aid
Voluntary sector services are increasingly funded by means of contracts or service level agreements, although the agreements may span a number of years. Many councils now use grant aid only for lower cost services. Councils find it useful in supporting the continuing functioning of voluntary organisations.

Health Care/Health Care Commissioning
Activities performed for a person by a health care provider/professional with the intention of directly or indirectly improving or maintaining the health of that person. Health care is usually medical and nursing care which is provided by NHS is free at the point of access.

However the differences between health care and social care are not clear cut in some cases, e.g. for someone who needs support with bathing, what is a "health care" bath and what is a "social care" bath?

In the context of commissioning, the distinction between health care and social care has major implications for funding and the differences are the subject of much debate between health boards and social work, particularly.

Health care commissioning is the total expenditure of an NHS board under NHS Service Agreements, including all expenditure on patient care and related services.

Housing Association
Not for profit organisations who provide, build and/or manage housing accommodation, for example Key Housing, Ark Housing. "Registered Housing Associations" are registered with Scottish Homes. Housing Associations often play a crucial role in the commissioning process, and should be involved in discussions as early as possible. See also the Scottish Executive website on "Supporting People," which has updates on housing support services.
http://www.scotland.gov.uk/Topics/Housing/Housing/supportpeople/

Independent Sector
Services to people with learning disabilities that are not health authorities or local authorities. This includes voluntary, not for profit, and private profit making organisations. It also includes housing associations.

Individual Joint Commissioning
The commissioning of a range of services for an individual through the care management system and based on a comprehensive joint needs assessment process. For example during closure of long stay hospitals in Scotland a number of joint health/local authority partnerships were formed and joint needs assessments were done. http://www.scotland.gov.uk/Publications/2004/01/18742/31614

Individual Needs Assessment
The process of defining needs and determining eligibility for financial and resource support against stated criteria, e.g. profound and complex disabilities, continuing care. A process involving the individual, his or her carers and other relevant organisations. Sometimes called "micro level" needs assessment. For an example see:
http://www.scotland.gov.uk/Publications/2003/03/16940/21290

Joint Commissioning
When two or more commissioning organisations act together to co-ordinate (but not necessarily to pay for) a service or services for an individual. The organisations take joint responsibility for translating the agreed plan into action. Joint commissioning should achieve better, more sustainable outcomes for an individual and carers than one organisation acting alone. For example health, social work, education and housing in various combinations.

Joint Provision
This differs from joint commissioning, but can result from it. A service is jointly provided and paid for by more than one organisation. Joint provision for children, e.g. where health and education services have a pooled budget for an individual, is more common than joint funding of placements between health and social work for adults. The local pooling of health and social services budgets centred around individuals tests the effectiveness of local teamworking.

The Community Health Partnerships in Scotland will be the main mechanism through which future joint provision will be achieved. Joint provision is not the only outcome from joint commissioning.

Joint Purchasing
Turning shared strategy into shared action. (Also known as" putting your money where your mouth is.") Two or more organisations buying a service for an individual, having agreed the need. A good, but relatively rare example of "joined up" services. Sometimes used interchangeably with joint commissioning, but more specific. The role of joint purchasing is recognised in recent Scottish Executive guidance to practitioner's in care management (Scottish Executive 2006) "It is recognised that agencies will be dividing responsibilities for the purchasing and providing of services in different ways, over variable timescales. To overcome these difficulties, there is considerable merit in agencies pooling their resources and developing joint purchasing arrangements for users for whom there is a shared responsibility."

Joint Investment Plans
A national or a local summary of the resources being spent on services for people with learning disabilities identifying what changes or developments are needed and how these will come about and be funded.

Local Health Strategy
A 10-year plan drawn up by health boards or Community Health Partnerships, setting out the health services and health targets for the local population. This may have implications for what will, or will not be funded in the commissioning of future services.

Locality Planning
The process of looking at need of people with learning disabilities on a locality basis. Locality planning, undertaken on a joint basis, may lead to locality based commissioning. Locality planning forms the basis of joint approaches between social work and health in some areas, saving duplication of contact for people and their families. See, for example recent recommendations for locality planning in day services http://www.scotland.gov.uk/Publications/2006/04/24103440/6

Mixed Economy of Care
In the context of commissioning, this means planning and funding a package of care that may involve a combination of private and voluntary organisations, social work, health and housing associations.

Monitoring
Contract monitoring and monitoring the safety and well-being of the service users are separate processes. Specific quality indicators or agreed measures should be used for each.

Needs Mapping/Needs Analysis
The identification of future needs and required support services, to assist in planning specific and area wide services. See also Community Care Planning.

Nursing Home Care
Care provided for a person in a registered nursing home. Most nursing homes in Scotland are privately run. Since 1998, there has been a fall in the number of people with learning disabilities living in residential care homes, while the number of people with learning disabilities living in nursing homes has increased.
http://www.scottishexecutive.gov.uk/Publications/2003/12/18693/31067

There is concern that some of the estimated 900-1000 people with learning disabilities in nursing homes are inappropriately placed.

Operational Planning
The process of establishing local contracting arrangements, developing robust approaches to quality assurance, supporting providers, agreeing some generic or learning disability specific service specifications.

Partnership Agreements
Health Authorities and Local Authorities working closely together in providing joint services for people with learning disabilities. Partnerships in Practice documents for each health authority give details of plans, and Community Health Partnerships (CHP) link clinical and social care teams, and work in partnership with local authorities, the voluntary sector and other stakeholders. There is more active involvement of the public, patients and carers. The CHP Regulations is the base within which the CHP guidance is based and this came into effect on 1st October 2004.
http://www.show.scot.nhs.uk/sehd/chp/guidance.htm

Person Centred Planning
Strategies that are used to find out how people want to live, who and what is most important to them and what it will take to get the lives and support that they want. Can be used as a starting point for commissioning services for an individual. For an overview of how person centred planning can be used in Scotland see for example, Sanderson, H.; Kennedy, J.; Ritchie, P. and Goodwin, G. (1998) *People, plans and possibilities: exploring person centred planning.* Edinburgh: Scottish Human Services. For a more recent review of the advantages and barriers of promoting person-centred care at the front line see www.jrf.org.uk/bookshop/eBooks/9781859354520.pdf

Practice Guidance/Good Practice Guidance
For commissioning purposes there are a number of good practice documents, giving recommendations from research and experience on how to best design and develop services for people with learning disabilities. (See Part 3 Key Questions: JIT Website Guide also) Good practice guidance is often as a result of changes in legislation and in policy. Some examples follow:
Commissioning Housing Support Services
http://www.scotland.gov.uk/Topics/Housing/Housing/supportpeople/CCP
Research into practice
http://www.scotland.gov.uk/Resource/Doc/113949/0027745.pdf
The review of Scottish services for people with learning disabilities in 200 produced 29 recommendations for good practice and improving services (Same as You?):
http://www.scotland.gov.uk/ldsr/docs/tsay-11.asp

Pre-placement agreements
Establish an option to purchase a pre-defined service at a set price. The option is usually established as part of strategic commissioning, but is exercised at the operational (individual) level. A number of councils use the term 'call-on/call-off agreement'. The model helps co-ordinate strategic and operational requirements.

Primary Care
Health care provided to people with and without learning disabilities through health centres, GPs, accident and emergency etc. First point of contact with the health services.

Procurement
The process by which services for people with learning disabilities are purchased. This must conform to The Public Contracts (Scotland) Regulations (2006) for Public Procurement.
www.scotland.gov.uk/Resource/Doc/1069/0017034.pdf
It is often the case that price is the most important factor in this process.

Provider Organisation/ Providers
The organisation that has been contracted to provide residential and/or day/community related support services.

Purchasing
The commissioning activity buying services to meet needs either at a macro/client group level or at a micro/ individual level. (See entries for Block purchasing and Spot purchasing also.

Quality Assurance
The process by which provider organisations set up or demonstrate reliable systems which demonstrate to commissioners that they are monitoring and seeking to improve the quality of their services. An example of a draft checklist for quality assurance in English services is given at http://www.bris.ac.uk/Depts/NorahFry/Strategy/framework.pdf

Residential Care
Care delivered in managed accommodation designed for more than one person, usually. Personal care or support, excluding medical or nursing care, provided for people who do not or cannot live in their own home.

Respite Care
Respite services for the person with learning disabilities and/or their carers. May be short or longer term and may offer the respite in a variety of settings; family, residential, leisure, holiday. Respite care is sometimes included in a package of care commissioned, as a means of supporting carers. See, for example the National Care Standards on respite care for adults at http://www.scotland.gov.uk/library3/social/ncssbrc-00.asp

Revenue Funding
Money used to pay for the running costs of a commissioned service for an individual. For example staff costs associated with providing housing support. For a literature review of housing and support options, see The View from Arthur's Seat:
http://www.scotland.gov.uk/cru/kd01/view-01.htm

Service level agreements
Specify in detail (e.g. amount, value, quality, access) the minimum acceptable service to be provided. Mainly used for in-house or voluntary sector provision. The model helps emphasise service quantity or quality, rather than availability.

Service Specification
A set of minimum requirements relating to a service to be supplied. This may be determined by a combination of existing local contract specifications and the assessed need of the person for whom a service is being commissioned.

Social Care
See "Health Care" also. Social care and health care are primarily differentiated by the tasks involved, but these differences are not clear-cut in some cases. For example, a person with learning disabilities is well supported at home by both parents. The person is doubly incontinent, has swallowing difficulties, has no speech and requires an overhead hoist. Does this person require health care or social care? Would the answer be the same if the person was not well supported by parents? If the person was a child? If the person was an older adult?

Social care professionals working with people with learning disabilities are in the process of being regulated by the Scottish Social Services Council, with a target date of 2009/10. Health care professionals using their professional qualification for a social care role will continue to register with their existing health care regulator (Nursing and Midwifery Council for nurses; the Health Professions Council for allied health professionals) Health care professionals who work in other social care roles may have the choice of registering with the Scottish Social Services Council, depending on their work setting.

See:
http://www.scotland.gov.uk/consultations/health/rohc-00.asp
Regulation of Health Care Support Staff and Social Care Support Staff in Scotland.

Spot purchasing
Buying/commissioning of a specific type and amount of care for a named individual. It secures an immediately available, more tailored service, but may also have a higher unit cost than block purchasing.

Stakeholders
The people who have an interest in commissioning; both those organising the commissioned service and those who will receive the service. This can include various professionals involved in planning and delivery, parents, other carers, service users, other supporters, and those who may have objections or could block the process.

Supply Analysis
The process by which information on current service provision is recorded/captured, for example by Joint PIAF at the Scottish Executive.

Strategic Planning
The process of single service or joint service strategic assessment of needs in the population of people with learning disabilities. Process of identifying what services and resources exist, and what is needed. Developing commissioning plans, including policies, which take account of these.

Supported Living
This is a way of delivering services which ensures that the service is designed around what people need and want. It places great significance on people's rights and on being a tenant or owning their own home, being involved in deciding who supports them and how they are supported. Since the early 1980s there has been a steady growth in the number of people with learning disabilities supported in ordinary housing settings, using a variety of support arrangements.

Voluntary Sector
Not-for-profit organisations which provide advisory, or hands-on services, for example ENABLE, Sense Scotland. (Housing associations are not usually included in this classification, but this varies in some definitions.)

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