

Commissioning Local Services for Local People: evaluating the potential of collaboration in the commissioning of local services for people with learning disabilities and complex needs currently living away from their home area

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Commissioners... need to manage the market they have created in order to sustain the capacity of local services to meet the needs of everyone with learning disabilities. This involves encouraging service providers to cooperate, underpinning service competence through training and service development and reshaping specialised challenging behaviour services to support effective local placements. There are not enough services that can provide skilled support in each local area and commissioners therefore have an important role in developing the new kinds of services that will be required.¹

Background to the North West London project

It is estimated that approximately one third of all people with learning disabilities eligible for publicly funded support in residential or nursing care homes live out of their home area and the proportion of people supported 'out of area' has been rising in recent years stimulated by the closure of long-stay hospitals. For many the 'out of area' is an anomalous designation, reflecting merely a continuing financial commitment for a persons support from an area of origin that ceased to be 'home' many years ago. Other people more likely to be placed out-of-area include those with challenging behaviour, autistic spectrum disorders (ASD), mental health needs, complex health needs, complex epilepsy and people at risk of offending.

A survey of all local authority commissioners conducted in 2002 mapped the scale of problem and explored the factors that either led to people being placed out of area and/or to such placements being maintained². The factors that emerged fell under six headings:

1) Quality of service

- Difficulties in monitoring quality of services some distance away
- Lack of control over cost of placement
- Lack of choice

¹Challenging behaviour: a unified approach. Clinical and service guidelines for supporting people with learning disabilities who are at risk of receiving abusive or restrictive practices', Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, College Report CR144, June 2007

² Pritchard, A & Roy, A (2006) 'Reversing the export of people with learning disabilities and complex health needs', British Journal of Learning Disabilities, 34, 88-93

2) Joint working

- Evidence of patchy joint interagency commissioning
- Poor coordination between mental health and learning disability services for commissioning and provision
- Lack of critical mass in individual commissioning areas
- Lack of clarity about funding responsibilities due to difficulties in interpreting guidance

3) Capacity

- Blocked inpatient beds due to lack of community placements
- Local services unresponsive to new crises leading to out of area placements often in the private sector
- Severe shortage of local forensic beds

4) Workforce issues

- Local service development limited by availability of skilled staff
- Gap between numbers of professionals required and numbers trained

5) Local issues

- Difficulties in completing resettlement
- Difficulties in disposing of surplus land and developing sites
- Difficulties in managing transitional costs (double running costs)

6) Transition

- Poor transition arrangements for children entering adult services
- Lack of information on population delaying planning
- Expensive individual placements
- Problems in providing local adult services for children in distant placements

A recent knowledge review of out of area placements carried out for SCIE noted a trend for setting up 'congregate' care services just for people with a particular support need, such as a challenging behaviour or autism. Potential consequences of this trend are an acceleration of out-of-area placements, institutional models of care, and poor quality services that are difficult to monitor. The review goes on to suggest that authorities should join together to set up services for people with specialist needs by developing the relevant expertise and skills locally³.

Commissioning services in London

The London Boroughs support a higher proportion of people with learning disabilities 'out of area' than other type of local authority. This is especially true for people whose behaviour challenges and who have forensic histories. A review of tertiary services in

³ Emerson, E. & Robertson, J. (2008) Commissioning person-centred, cost-effective, local support for people with learning disabilities (SCIE Knowledge Review 20)

Brent and Westminster in 2003 informed the development of the North West London project. This found a dearth of provision for people moving on from Assessment & Treatment and secure services because individual Boroughs lacked capacity to sustain a viable local service for people with very challenging behaviour. Existing support providers were ill-equipped to provide an appropriate service for this group and the capital cost of purchasing and adapting housing in London was prohibitive. As a consequence Boroughs in North West London were purchasing expensive private sector hospital placements outside of city: the cost of supporting the people included in the North West London project ranged from £137,000 to £320,000 per year despite the services they were using were inappropriate for meeting their needs.

The review took place within a wider context of radical changes to social care policy in the UK wherein health and social care commissioners were required to meet the needs of people who challenge within a framework that ensures⁴:

1. Individuals have services provided as far as possible in community rather than institutional settings
2. People are supported as near as possible to their homes and families
3. Development and expansion of the capacity of local services to understand and respond to challenging behaviour
4. Individuals are supported in conditions of no greater security than is justified by the danger they present to themselves and others
5. Services maximise rehabilitation and the individuals' chances of sustaining an independent living
6. The differing needs of people with challenging behaviour are reflected in highly individualised service planning and delivery
7. Local specialist services are provided which support good mainstream practice as well as directly serving people with the most challenging needs

These principles have more recently been reinforced in 'Mansell 2' which urges commissioners to 'stop using services which are too large to provide individualised support; serve people too far from their homes; and do not provide people with a good quality life in the home or as part of the local community, in favour of developing more individualised, local solutions which provide a good quality of life'⁵.

At the same time, emerging guidance suggested that specialist commissioning for such groups should be pan authority to optimise the cost-effectiveness of support where individual local authorities have responsibility for small numbers of people falling within

⁴ Commissioning service close to home: Note of clarification for commissioners and regulation and inspection authorities

⁵ 'Services for people with learning disabilities and challenging behaviour or mental health needs (Mansell 2)', Department of Health, 2007

these categories⁶. This kind of specialist commissioning had not been attempted before in the learning disability field and not in London, although a consortium of Boroughs in South West London have since been working collaboratively under the banner of “mutual marketing management”. Another example is to be found in the West Midlands where a Specialised Services Agency takes the lead in commissioning secure services by developing generic contracts on behalf of all commissioners in the West Midlands with providers offering secure services.

Collaborative commissioning in North West London

In 2004 joint commissioners representing eight local authority and PCTs discussed the feasibility of collaboratively commissioning a specialist service for North West London (covering Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster) for people with a range of complex needs, such as forensic histories, mental health problems and autistic spectrum disorders. A bid for £2.4m capital grant funding was submitted to the Strategic Health Authority to develop a local service for an initial group of between 8 and 12 people then placed in high cost out-of-borough secure or semi-secure accommodation. The commissioning group argued that the creation of a North West London “hub” would generate the critical mass necessary to stimulate support providers into developing the right expertise and a sustainable business model to bring back other people with complex needs currently residing out-of- borough as well as preventing resort to such placements in the future.

The proposed supported living service incorporated individual tenancies, individualised funding and individual support planning for each of the initial group of movers, ‘clustered’ in 2 host Boroughs. Some of the people would be on s117 leave or discharged from hospital on a Community Treatment Order (CTO). Commissioners would also put in place an infrastructure of specialist health and social care professionals and ensure pathways to mainstream mental health services. It was anticipated that the costs of running the new service would 20% lower than existing arrangements.

The journey, from securing capital funding for the project, through a public launch at a conference in 2007, to the first 4 people moving into specially designed self-contained flats in the Royal Borough of Kensington & Chelsea (the Kensington & Chelsea scheme), took five years to complete. Accommodation and support for up to 7 further people is still in development in West London (the Ealing Scheme). Along the way, the commissioning group have put in place detailed agreements about access to the project

⁶ National Procurement Strategy for Local Government 2003, Office of the Deputy Prime Minister, 2003; Sir Peter Gershon, Releasing Resources for the Frontline: Independent Review of Public Sector Efficiency, HM Treasury, 2004.

for participating Boroughs, the nature of their responsibilities as partners and the future governance of it. Person-centred plans have been drafted and individual service funds agreed for each of the people identified as project participants. A clinical support infrastructure has been developed and a service provider has been commissioned: London Cyrenians Housing and Yarrow Housing in partnership as CY Care have signed a 4 year framework agreement which allows Boroughs to call off support for individuals as it is needed.

This evaluation, commissioned by the Valuing People Support Team, attempts to identify the defining features of the collaboration required to make it happen and to highlight those aspects of the project that have worked well and those that have worked less well. Its findings are based upon observation of meetings and event over the past three years, analysis of project documents and interviews with the key players in planning and implementing the service. It focuses on five major elements to commissioning the North West London project: project management and leadership, securing accommodation, procuring a support service, developing a clinical infrastructure and the role of person-centred planning.

The complexity of collaboration

An inevitable complexity attends any project that spans eight Boroughs, each with its own partnership arrangements for health and social (and the attendant politics), governance structures and legal requirements. The journey for the North West London project has been marked by variable commitment across the Boroughs to pursuing the collaboration to its fullest extent by either hosting a service or purchasing places in those services. Reaching agreement amongst 16 public bodies (8 local authorities and 8 Primary Care Trusts) created considerable delay and occupied the time of project managers and lead commissioners at crucial times in the development of the service.

However, one of the prime movers for the project on the commissioning group described how the size of the collaboration had proved decisive at key moments:

“It strengthened our original bid. But the practicalities of making it operational changed things. Getting sign up to agreements was difficult. What I would say is that at the point at which it didn’t look like it was going to happen, having eight Boroughs was helpful because it gave us options.”

The project has naturally resolved itself into two schemes each with a specialist focus so that people in the Kensington and Chelsea scheme are supported with their mental health problems and/or forensic histories, while people supported in the Ealing scheme will have more profound learning disabilities and may have autistic spectrum disorders. The day-to-day operational collaborations between Boroughs are therefore on a smaller

scale, although the larger partnership remains in place to guide the strategic direction of the project.

Project management & leadership

Throughout the project individual commissioners have provided leadership and direction, but everyone involved was agreed that dedicated project management should form a core component of the capital foundation. Project management was designed to achieve two key milestones: sign-up to agreements; and implementation of the service.

An experienced consultant took on the initial task of getting the project going, which required her to be proactive, initiating, cajoling, and leading the group. Essential tasks in this phase concerned the capital funding issues, framing the partnership agreements, coordination (holding the Boroughs together), action planning and delivery for the development of the clinical structure and day today support. Delivering these tasks demanded the sort of technical competence, tenacity, assertiveness, and organisational skills which commissioners acknowledged could not have been sourced from within the Boroughs.

A second consultant was engaged for the period leading up to implementation of the project plan. The style of project management required for this was more facilitative, developing and mentoring the leadership talents within the commissioner group. Implementation required the project manager to become enmeshed in the detail and taking a lead, working to the commissioner group, which began to assume a more strategic role.

This project management support was deemed invaluable by the commissioning group, but the length of the project placed a strain on the capital resources allocated to project management. Changes in personnel carrying out the project management role at key stages in the development of the project meant that continuity in the commissioning group was vital to maintain the momentum of the project. Leadership from individual commissioners was crucial to initiate and sustain activities: early research and bid development was led by two commissioners, while those representing the host Boroughs assumed leadership during the developmental phase of the project. Another commissioner led development of the enhanced clinical support infrastructure. There was general agreement that this input was vital: as one of the project managers noted: “when they are there, things happen, when they are not, they don’t!”

Accommodation

The prohibitive cost of property on the private market and the competition for social housing determined the speed with which both schemes could be developed. To the costs of purchasing property were added the considerable costs of adapting the

accommodation to meet the needs of the people who would be using it. This reflected the potential impact upon the immediate environment of people moving into ordinary housing, including wear and tear to properties, adaptations to minimize risks of harm (either self-inflicted or accidental) and disruption to neighbours. All of these factors contributed to the logic of a single building managed by a social care landlord (in this case the local authority). The successful launch of the Kensington and Chelsea scheme was therefore predicated on the availability of suitable a property owned by the Borough. Finding a suitable property, commissioning architects, seeking planning permission, engaging building contractors and structural engineers, fitting out and arranging tenancies took two years to complete. Sourcing, securing and developing accommodation for the second scheme has been similarly problematic. Two important consequences for the commissioning process flowed from the delays associated with finding suitable accommodation.

Firstly, it presented commissioners with the challenge of balancing the values of personalisation with the practicalities of a safe and secure service. A potential criticism of the North West London model is that the clustering of people with complex support needs favours single provider solutions while diluting the principles of personalised support. It can also isolate and segregate people from communities, while clinicians highlighted the potential dangers of placing people with challenging behaviours in close proximity to one another. Several commissioners acknowledged these concerns while countering with a robust defence of their strategy. As one put it:

“I’ve always said that the alternative is to leave people where they are, and that is not good enough. We’ve done that year on year on year. It’s not perfect but we have now got evidence that some people are able to live in the wider community, got their own front door and haven’t been recalled. It’s still early days.”

Another commissioner agreed:

“Some people said you’ve done it wrong by starting with the buildings. But we would never have been able to do it starting with the individuals. This was the only way we could have got it going. I suppose what I felt was that the buildings were only half of it and that having a competent provider and a competent clinical infrastructure was as important so that we could start working with other people. The next stage may be about taking learning and applying it to individual situations. Cyrenians and Yarrow say they do this all the time.”

A second consequence arising from the delay in getting the Ealing scheme established has been a concentration of financial risk for those Boroughs placing people in the

Kensington and Chelsea scheme. The basic support model rests on a core staff of one waking and one sleeping available to provide back-up to whatever 1:1 support people have in their own flats. This is difficult while the 2nd scheme is not in place and the volume is not there. When there is a void at the Kensington & Chelsea scheme, the cost of the core support (£500-£600 per flat per week) has to be borne by the other flats. This was mitigated during the start up because it could be offset with SHA set-up monies, but more recently one Borough held a place for a few months before withdrawing its interest. The lead commissioner explained, “when we heard, it was quite a shock to the system. The costs of the void have been borne by K&C and Westminster because they support the other tenants living there. It hasn’t been awful, but if had gone on longer, it could have become awful.”

An important learning point to emerge from the Kensington & Chelsea scheme is that specialist accommodation can be over-designed. Many of the features incorporated into the design have proved unnecessary. One commissioner reflected:

“We listened too well to the advice we got from where they were living, which was for someone living in the NHS. Take ‘A’. We were told to lock away everything; she wasn’t to have a kettle, she wasn’t to have a knife, no sockets should be showing, her shower was inappropriate because there was a ligature risk and so on and so on.... So we spent a lot of money and we have locks everywhere. In fact, since she has been there we have opened everything up and she has access to whatever she wants and she is absolutely fine. I think we get into this safe and secure mode because we are dealing with people with complex needs.”

Managers from CY Care pointed out the irony of designing the building to take account of the risks highlighted by hospital personnel, only to find the new tenants arriving from hospital with a range of personal possessions that posed far greater threats to their safety. Nevertheless, the team leader suggested that getting the building right can be important for this clientele. For example, when one of the tenants gets agitated he tends to throw things around and stamp his feet - he has broken a floorboard doing this, while the soundproofing has proved inadequate, so that a trial tenancy in the basement flat ended because the person’s vocalizations could be heard at the top of the house.

The ‘a belt and braces’ approach towards getting the accommodation right needs to be understood in the context of Kensington & Chelsea as a vanguard for the wider aspiration of bringing a far larger cohort of people with complex needs back to live in North West London. The scheme was designed to reassure a range of audiences about the feasibility of supporting this group of people in the community. Having demonstrated the reality of people’s need for specialised housing, or lack of it, and the limitations of hospital-based assessments of such needs, is likely to make future developments less time-consuming. As experienced social housing providers, CY Care is

confident of being able to support more people coming through the project in individual tenancies in ordinary housing.

CY Care - forging a partnership

The commissioning group recognized that the project would require a highly specialised support service. Potential providers were invited to a conference in April 2007 to hear about the project and how it was intended to be commissioned. Following a pre-qualifying process, four bidders were invited to present a model for delivering a person-centred service with an individual service fund which they could use flexibly in scenarios involving people with needs similar to those due to move under the project.

CY Care is a partnership between two of London's leading social housing agencies. Yarrow Housing provides services to people with learning disabilities, ranging from those who need 24-hour support to those who only want one or two hours per week. It has experience of working with people moving from long-stay hospitals and employs 300 full-time staff across London. London Cyrenians Housing employs more than 200 staff and provides services across a number of Boroughs for people with different support needs, including men and women with forensic histories and complex needs and people with mental health problems. Both organisations have experience of developing and managing projects of groups of people with highly specialised care needs.

The initiative for the CY Care partnership came from the Chief Executives of the two organisations who recognised the project as an opportunity for a natural alliance based upon the experiences of their respective organisations to meet the requirements of the tender for single provider of support to people with a range of needs. Given the tight timescale for responding to the tender, and following a period of research, the two organisations opted for an informal partnership rather than constitute the service as a separate legal entity.

Leadership of the two supported living schemes falls out of the experience of the respective organisations: Cyrenians leads in Kensington & Chelsea where the focus is on supporting people with learning disabilities who have forensic histories and (in some instances) mental health problems; Yarrow will lead the Ealing scheme which will support people with more severe learning disabilities and autistic spectrum disorders. A service manager will be appointed to oversee both schemes, jointly supervised by managers from Cyrenians and Yarrow.

The evaluation highlighted the benefits of this approach. The most obvious benefit is that it pulls together the relevant skills and experiences to meet the highly specialised needs of a relatively small group of people and does so in an efficient and effective way. It filled a gap in the local health and social care economy, one that had previously been filled by purchasing services outside of London. The arrangement meant that the commissioning group in North West London could shape the development of the new service through known and trusted providers and clinicians, care managers and families could feel confident in the competence of them to provide a safe and secure service.

The partnership also produces economies of scale. Set-up costs were mitigated by the availability of skilled and experienced staff, especially managers used to managing similar projects; for example, Cyrenians have seconded an experienced team leader to work at the Kensington & Chelsea scheme during implementation phase. The team manager defines her role as making sure that both the support staff and the person being supported are clear about why they are here. She is there to guide and advise about how to deal with people. It is important that she is involved in their lives (“hands-on”), but is careful that she does not undermine staff.

The ready availability of training from the respective organisations can fill gaps in the knowledge of the staff teams at either scheme and the use of bank staff and locums has provided flexibility and security in the day-to-day management of the Kensington & Chelsea scheme. However, the issue of terms and conditions of employment had to be resolved since pay scales differed significantly between the two sectors within which the organisations generally operate. So, while staff at the Kensington & Chelsea scheme are employed by London Cyrenians and those working at the Ealing scheme will be employed by Yarrow, all will work to a newly created set of terms and conditions, and be governed by policies and procedure cherry-picked from the best of those belonging to both organisations.

There are also potential economies to be made in the unit costs of the service as the volume of business grows and overheads are shared more widely. The assessment on finances for the CY Care proposal was on a 'doughnut' model of a core staff team and a selection of services to be drawn on for each individual. However, the model was based on the assumption of a single provider managing 2 schemes and supporting a minimum of 10 people. Commissioners have drawn upon the flexibility and experienced management contained within the CY Care partnership to address the gap between the model and reality caused by the delays to the Ealing scheme.

Managers and staff of CY Care have also had to work flexibly to meet the actual, as opposed to assessed, needs of people who have moved into the scheme. As the team leader explained:

“My expectation was that we would have people who provided more challenges but it has not been like that. They were erring on the side of caution, so that we were expecting to have to provide 2:1 support for people to go out, but two of the tenants have 1:1 and the other one can go out on his own”.

Commissioners and clinical support staff have monitored the development of the partnership and in particular the marrying of subtly different languages and cultures. A senior practitioner noted,

“It’s been interesting to see the team coming together from mental health and learning disability backgrounds. They used very different languages - in mental health they talk about patients and focus on safety and values. There are definite benefits. Mental health staff are much better at challenging norms, saying this behaviour is unacceptable. You need people from separate backgrounds, not people with experience of both backgrounds because you are dealing with two components (LD & mental health) in the same person.”

Meetings and visits have provided the clinical team with an insight into the factors that make the support service effective. They contributed three observations to the evaluation. Firstly, the specialist experience of the organisation, its managers and support staff gave clinicians confidence that their input would be respected and understood. Secondly, they were impressed by the energy of frontline staff and the general culture of 'getting on and doing it'. Thirdly, they commended the provider for planning proactively with individuals to think about a future beyond the current situation.

Clinical support

The development of robust clinical support arrangements was a major concern for the commissioning group. Planning this support began in earnest in early 2007 and many clinicians from across the Boroughs first heard about the proposed project at the conference held in Ealing in April of that year. A group of lead clinicians from the eight Boroughs was convened as a sub-group of the commissioning group and began developing protocols for assessing and working with the project participants. The sub-group devised a common risk assessment tool which informed the transition plan for each of the people identified for participation in the project.

The issue of risk was a major factor especially in the initial stages of clinicians' involvement in the project. Particular risks were around that potential for people moving to the Kensington & Chelsea scheme to either offend, or self harm or place themselves in vulnerable situations. In preparation, the clinical team received a briefing from the Royal College of Psychiatrists about CTOs and used the Green Light Toolkit to develop protocols for people with a dual diagnosis of learning disabilities and mental health problems. However, accessing mainstream mental health services for this group was not straightforward.

There were two major issues of contention. The first related to eligibility and the question of whether mental health services should be offering a service to the people moving into Borough under the scheme. Secondly, the proposal to move people with forensic histories into a community setting prompted the response from a mental health colleague, 'are you crazy?', while a commissioner confirmed that the mental health team had been "horrified" by the idea. It is worth adding a contextual note to this episode. Clinicians from both learning disability and mental health services became involved in the North West London project at a relatively late stage in its development. Some learning disabilities clinicians admitted to a deal of resentment at not being involved earlier and wondered if their mental health colleagues might have been more receptive had more preparatory work been done with them.

Relationships between the two teams have improved immeasurably since, but the initial dialogue had some unfortunate consequences. A senior practitioner recalled,

“We had some forensic assessments that were arranged by our commissioners that were just awful. They said that people lacked insight – well, that is hardly surprising for someone with a cognitive impairment, but that does not mean that they are particularly dangerous or more dangerous. But we had reports saying things like, ‘this person should never access the community for the rest of their life!’ Bearing in mind this was written in 2009, that’s quite frightening... That person is likely to be in secure accommodation for a very long time because of that assessment. He is now in step-down. All of our clinicians think this person is right for the project, but we dare not go against this assessment (we would be stupid if we did).”

The clinical support team noted that a Green Light protocol was not well developed in Kensington & Chelsea when the project started, but opening the scheme meant that it had to be put in place and this had led to some positive outcomes. Instead of having one protocol for a number of people, bespoke protocols were written for each person. Despite the problems encountered along the way, after 6 months negotiation the team had good pathways for those people (and others with a dual diagnosis) in place. One of the commissioners commented on the central role of the Green Light worker in this process and the potential lessons for others seeking to replicate the project elsewhere:

“He was a particularly talented man. If I was talking to someone who was going to set it up tomorrow, I would say that person needs to have really good negotiation and diplomatic skills. We found that the police highly cooperative, we found the local A&E highly cooperative; the mental health trust was not. It may be different elsewhere, but generally people in mainstream mental health services don’t really get people with learning disabilities. Besides the battles with the psychiatrists, the community response team said that they do not work with people with learning disabilities. We had to challenge that with the DDA. It was a very nasty negotiation and eventually we built bridges over a long period. Fortunately we have never needed them.”

The infrastructure for clinical support was designed to give the service provider confidence although the anticipated demand for clinician’s time at the scheme far exceeded the input that was actually required. As one commissioner acknowledged “to be honest, the impact upon the clinical team has been nowhere near as great as we were expecting.” Generally a psychiatrist will visit once a week and a psychologist twice a week, rather than daily as anticipated, and have not been called upon for emergency support. Speech and Language Therapists, whose input was predicted to be much greater, also visit once a week. Instead, health personnel have acted like consultants,

helping frontline staff manage the risks proactively: “there is a genuine dialogue, genuine negotiation and that is down to the people involved; that is how they work.”

The issue of confidence has worked both ways. The competence demonstrated by CY Care has given the clinical team confidence that things will the scheme will succeed. One clinician described how this worked in practice: “the support there is negotiated; based on clinical judgment and expertise, balanced with the day-to-day experience of CY”. The team leader confirmed that care planning with individuals proceeded on this basis and she appreciated the willingness of clinicians to listen and respect the views of frontline staff in arriving at their judgments.

Formal weekly meetings between representatives of CY Care and the clinical team were said to demonstrate their respective commitment to the project, while at a practical level it builds relationships with staff, provides a safe space for the service provider to raise issues with them, and keeps clinicians informed about people’s lives. Clinicians also commented on the proximity of the scheme to the team’s base which means that they often see the project participants in the street. This helped give them a real sense of them having presence in the community.

Person-centred planning

Another major capital cost of the project was a 5 day programme of training for Person Centred Planning (PCP) coordinators across the 8 Boroughs. A sub-group of the commissioning group was also convened to guide the production of PCPs for each of the people projected to move under the project. The evaluation found that for the people used to institutional care, PCP represented the first opportunity to articulate lifestyle choices and to engage in the process of choice and decision-making. However, the general consensus from people closely involved with the project is that while PCP produced a wealth of useful information about the lifestyles that people desired, it was less influential than had been anticipated in guiding the overall project.

There were a number of reasons for this. Coordinators were starting from different positions and PCP meant different things in different Boroughs where interest in and commitment to it varied. Junior members of staff given the task felt disempowered in the relation to commissioners, care managers and clinicians. Some felt that being person-centred about planning change would take a long-time but there was pressure from commissioners to get things moving. Staff turnover and the withdrawal of nominations to the project slowed progress.

Some coordinators lacked confidence that lifestyles choices could be achieved or that the people being supported lacked faith in the process because they had been let down so often in the past. This was the biggest regret around the man who was scheduled to

move but didn't following the psychiatric assessment – the coordinator for him felt “we had led him up the garden path.”

Above all, there was a lack of clarity about the status of PCPs, how they fitted with clinically-led transition planning and the care planning approach of CY Care. From the perspective of CY Care person-centred planning for this group of people was “idealistic” and had to be set within the context of individual behaviour plans. However, there was also an acknowledgement that PCP had been limited by being worked out in a hospital environment.

“At this stage we are still getting to know them. All these plans were made in a hospital environment and a major issue for these people is that coming into the community can be an overwhelming experience. They need to take small steps, like (A) getting beyond the first session of a computer course.”

There was also evidence of good practice in PCP. This was marked by creativity and adaptability and this required coordinators who were both confident and willing to try new approaches to building a relationship with the person at the centre of the plan. For ‘Ms A’ the PCP process seemed babyish, so the coordinator had to find a way to make it meaningful and engaging for her:

“She was able to articulate more but was quick to change her mind as well. The time it took to move actually helped because she had been in that area for some time, so it was hard for her to think beyond that, to remember what it was like before that place. We did a DVD of the area – the market, the shops, the facilities, the bank, the things she said would like to do during the day, everything that she would like to try. That was quite fun. But when she saw it, she said ‘you’ve left out the pubs?’ So we hadn’t got everything right! It made it more real when she came over for a visit. It was step by step process, getting a flavour of what the area is like... We also added in some things that she hadn’t asked for because she has been in that place for a long time so there were choices she wouldn’t even know about.”

The conclusions to be drawn from the project are that PCP is an ongoing process and one that is heavily contextual. It cannot be used to full effect until people begin accessing the facilities, activities and relationships that will inform their decision-making. Staff responsible for facilitating PCP felt that their work lacked influence within the project and the priorities afforded to accommodation, specialist support and the clinical infrastructure mitigated against PCP playing a more prominent role in shaping the ultimate service design.

The outcomes of collaborative commissioning

Commissioners were unanimous in stating two principal objectives for the project; objectives that flowed from the expectations that are placed upon them by managers and politicians from their employing Boroughs. These were to demonstrate good outcomes for people supported in the project and to produce cost savings. To these may be added two key benefits of working in partnership; the sharing of risk and building specialist capacity.

Good outcomes for people. The principal objective for all the commissioners was about achieving better outcomes for a marginalised group of people. The commissioners principal aim, of getting people out of long-stay hospital accommodation, is complemented by their desire to prevent readmission for those people moving under the project and avert admission of people with similar needs in the future. One commissioner noted that it was something,

“They have got sorted in mental health services, but in LD services we have been slower at doing this. “They are high risk people, but they were assessed as people who could live in the community with the right level of support and lo and behold they can live in the community with the right level of support quite well. So the formula might have taken a few years to get to, actually works.”

Cost savings. Because the project has not yet been fully implemented, it is not possible to assess the degree to which the anticipated cost savings of 20% have been achieved. However, commissioners from The Royal Borough of Kensington and Chelsea and Westminster indicated the potential savings that were already accruing.

“In Assessment & Treatment services they are very quick to raise staffing levels and charge us for the pleasure of that, and we have people who can cost us anywhere between £350k to £400k depending on staffing levels, how many staff they have in situ, plus the need to access the community: “oh, we always need 2:1”. Whereas in this package – although £204k is an awful lot of money and there is no getting away from it – the staffing is built in to be able to do all of that. So accessing the community or needing extra staff is there; there is no hidden agenda, there are no additional costs. For one person, we reduced the staffing level at night so that we can increase staffing levels during the day so that they can access the community more... which means they will be more settled at night anyway.”

Sharing risk. The host Boroughs’ showed a willingness to take on the risks associated with the project, especially around the ‘ordinary residence’ rule. While this is addressed by a clause in the partnership agreement, which states that the placing Borough retains responsibility for funding an individual in one of the schemes, this could be subject to legal challenge and in reality it relies on the spirit of partnership fostered by

collaboration. Partners to the Kensington and Chelsea scheme felt confident that having people placed locally meant that things were less likely to go wrong and that any problems could be sorted out more easily. Moreover, the risks were balanced by the opportunity for the host Boroughs to have priority in selecting people for places in the scheme.

Building capacity. The Kensington & Chelsea scheme provides some important learning about the legacy of this type of project. Reflecting on the lengthy gestation period and the time and resources devoted to the project, one commissioner suggested that what they had been investing in “is the confidence and belief that you can do it – there is an accelerator at work which means that in the next 5 years we could do so much more.” This confidence and belief rested on the mutually supportive tripartite relationship between the commissioners, the clinical support team and the service provider. Representative from each of these parties mentioned the development of trust as the most important ingredient to sustaining their working relationship.

From a commissioning perspective it is important for “managers to tell me if something is wrong. I say, I am not here to criticize; I understand that stuff happens. They need to be able to say we cocked it up and we need to be able to say that we didn’t provide you with the right support. It takes time but we got there.” Building capacity was therefore about creating a culture rather than developing skills and expertise. Asked to define what had fostered the culture, the various parties consulted during the evaluation suggested that it relied on having colleagues who:

- Have good interpersonal skills
- Are ‘up for the challenge’
- Are forward thinking
- Are open to doing things differently
- Strive to improve
- Believe that long-stay hospital provision is not an option
- Show determination to make it happen.

Conclusions

The evidence base for successful collaborative commissioning like the North West London project is small and tends to concentrate on the barriers to making it work. The findings of the evaluation have some resonance in a London Centre of Excellence report⁷ which identified a number of barriers to the successful development of shared services: lengthy and costly negotiations; high procurements costs; high capital cost of set-up; problems caused by the incompatibility of legacy systems; and lack of commissioning knowledge and experience. Problems were also experienced because of

⁷ OPM (2006) London Centre of Excellence – Shared Services (Final Report)

political concerns about risk and uncertainty, absence of trust within partnerships and cultural barriers.

The real success of the North West London project is to be found in the ways that it has addressed and overcome many of these barriers. Early evidence also suggests promising progress against the about the challenges thrown up by the SCIE Knowledge Review and the Mansell Report which called for greater pan-authority cooperation to deal with needs of some very vulnerable groups of people with learning disabilities.

Some areas of the project remain under-developed. Governance structures have not been fully implemented to drive future strategy and the detail of quality assurance measures and outcomes monitoring is still being worked through. The voices of families have not been prominent in directing services although this may change with the development of the Ealing scheme. These will provide greater detail about the difference that such projects can make to the lives of people with very high and particular support needs.

However, there are emerging lessons for commissioners seeking to emulate the North West London project.

- The size of collaboration is important. The eight-Borough arrangement in North West London reflects the relatively small size of these authorities and served a purpose of providing political and economic clout to the project at key points in the journey. Partnership and access agreements helped to clarify the respective roles and expectation of the partners to the collaboration but proved difficult to negotiate across so many agencies
- The smaller operational collaborations for the Kensington & Chelsea and Ealing schemes probably reflect a more effective model for implementing a specialist service.
- Project management and leadership time and resources are vital during the developmental phases of such a project. The tasks and roles associated with this will vary, but the primary concern should be to generate and sustain momentum through to completion.
- Early identification of, and engagement with, key partners such as the police and community mental health services is crucial to establishing understanding about the specific needs of the people being supported and for getting commitment to the project. Powerful interests can delay or disrupt progress where this is not done.
- There needs to be clarity from commissioners about the priorities within the development of such projects. It was understandable that in North West London

a premium should be placed upon getting the accommodation right, and this may be less of an issue elsewhere, but this served to distract energy away from other aspects of the project especially during the early stages of development.

- Encouraging partnership and collaboration between service providers can boost local capacity to provide good individualised services for people with complex needs. There are indications that economies can also be achieved through a partnership approach.
- A good enhanced clinical support infrastructure gives confidence to everyone concerned. Early work to develop skills, protocols and tools to support transition planning is recommended. Particular attention will need to be paid to protocols for accessing mainstream services or where local agencies, such as the police, may need to be involved.
- Planning with individuals must be a dynamic, creative and ongoing process. Wherever possible futures planning needs to take place in the environment in which choices and decisions will be made.
- Risk-taking is crucial to such projects. Many of the risk factors that were pondered in great detail during the implementation of the Kensington & Chelsea scheme were only clarified and resolved once the service became operational.