



Llywodraeth Cynulliad Cymru
Welsh Assembly Government



Learning Disability
Implementation
Advisory Group

**DRAFT PRACTICE GUIDANCE ON DEVELOPING
A COMMISSIONING STRATEGY FOR PEOPLE
WITH LEARNING DISABILITIES**

Contents

CHAPTER 1

A Guide to the Strategic Commissioning of Services for People with Learning Disabilities in Wales

- 1.1 Introduction
- 1.2 Key Principles underpinning commissioning
- 1.3 Commissioning Strategies
- 1.4 The People we serve – Who are people with learning disabilities
- 1.5 How many people are there with learning disabilities?
- 1.6 Outcomes – What are we trying to achieve?
- 1.7 Human Rights Act 1998
- 1.8 Self Directed Commissioning
- 1.9 Working Together: Working in partnership
- 1.10 Working with Providers

CHAPTER 2

Developing a commissioning strategy

- 2.1 Introduction
- 2.2 Clarifying Agency Roles
- 2.3 Key Questions
- 2.4 Project Plan
- 2.5 Skills for Commissioning
- 2.6 Addressing Key Issues in the Strategy

CHAPTER 3

The Commissioning Framework

3.1 What is commissioning

3.2 Levels of Commissioning

3.3 Strategic Commissioning Activities – The IPC Framework

(a) Analysis

(b) Planning

(c) Doing

(d) Reviewing

CHAPTER 4

4.1 What Analysis is needed

4.2 Purpose, Legislation and National Guidance

4.3 Needs Analysis

4.4 Market Analysis

4.5 Resource Analysis

4.6 Structuring the information to facilitate analysis

CHAPTER 5 Planning

5.1 Introduction

5.2 Gap Analysis

5.3 Prioritisation and Strategic Commissioning Intentions

5.4 Producing the Commissioning Strategy

5.5 Working with Providers

CHAPTER 6 Doing

6.1 Introduction

6.2 Managing Service Balance

6.3 European Union Requirements

6.4 Arrangements for Specifying Services

6.5 Processes for selecting service providers

6.6 Arrangements for Contracting

6.7 Ensuring Quality

CHAPTER 7 Reviewing

7.1 Introduction

7.2 Monitoring

7.3 Evaluation and Review

CHAPTER 8 Workforce Development

CHAPTER 9 Roles and Responsibilities

Appendix 1 Number of People with Learning Disabilities

Appendix 2 Information required for Needs, Market and Resource Analysis

Commissioning Framework

A Guide to the Strategic Commissioning of Services for People with Learning Disabilities in Wales

CHAPTER 1

1.1 Introduction

“Commissioning is at the very heart of providing effective social care for both children and adults. It is the process by which local authorities decide how to spend their money to get the best possible services for local people. It is about getting ahead of the game and anticipation future needs and expectations rather than just reacting to present demand.”

“Making Ends Meet” (Audit Commission).¹

Commissioning encompasses the entire cycle of assessing the needs of people in a local area, designing services and then securing them.

Commissioning then is a proactive exercise. It is about shaping the future pattern of services and involves making decisions about:

- The needs to be met by services now and in the future
- Outcomes to be achieved
- Who are we serving? Only people with substantial or critical needs? If so what will be the impact of unmet need?
- How well are people with profound or multiple disabilities being served?
- Types of services required to respond to need now and in the future
- What specialist services should be available?
- How do we engage service users and other important stakeholders in planning service development?
- What capacity and volume of services are required now and in the future?
- Location of services
- Quality of services required
- Who is most effective provider?
- Cost of services and value for money
- How are service gaps remedied?
- How are redundant / inefficient services improved or decommissioned?
- Contracting – most appropriate form
- Reviewing all the above
- Fit with corporate or partnership objectives

These are key activities and commissioning therefore requires leadership from senior managers and members and the active involvement of all stakeholders – service users, carers/ family, commissioners, commissioning partners, providers, etc. Success will depend on leaders senior managers / members lead professionals and other partners sharing a clear vision, being willing to bring their resources to bear collectively, and being able to demonstrate

¹ Making Ends Meet Audit Commission

consistent leadership of the process. Both elected members and senior managers have a clear role in monitoring the strategy once developed. Scrutiny committees and partnership forums will also clearly have a role to play.

These guidelines concern the commissioning of services for people with learning disabilities. The Mencap manifesto: 'Making rights a reality'², states that a learning disability is caused by the way the brain develops before a baby is born, during birth or because of a serious illness in early childhood. A learning disability is life long and usually has a significant impact on the person's life. It will also have a significant impact on the lives of their family. Given the lifelong needs of people with learning disabilities and their families effective commissioning is even more important to maximise their opportunities, share the caring responsibilities with carers when appropriate and protect them from harm.

Developing Sustainable Models of Service Delivery

The challenge for commissioners of services for people with learning disabilities and their families will be to develop models of service delivery which are sustainable. It involves the development of services which hopefully meet the needs and aspirations of people which in turn involves listening to people with learning disabilities.

This means investing in services which promote independence. It means, for example, trying to do everything possible to resolve problems of challenging behaviour at an early stage. This may avoid the individual being catapulted through a tariff of care eventually resulting in expensive out of county placements. Not only may such moves be against the wishes of the individual they may prove enormously costly. A local care package may be expensive at £60,000 pa but in comparison to a move to a medium secure unit at the cost of £120,000 or £150,000 plus pa it begins to look more attractive if it can address the needs of the individual. Similarly, the failure to provide communication aids may promote social exclusion and dependency at higher costs.

Commissioners need to think well ahead to develop sustainable models of services. Although commissioning strategies, for example, are usually developed to address a time frame of three to five years ahead; commissioners also need to try to look ahead 15 to 20 years. One example involves accommodation. If we reflect back to the closure of long stay hospitals some of the alternative accommodation initially developed was almost out of date as people moved in. Commissioners need to ask themselves if decisions about the next 3 to 5 years will help or hinder their successor's ability to meet the challenges in 15 years time.

² Mencap Manifesto: Making Rights a Reality

Benefits of effective commissioning

The benefits of effective commissioning include:

- Maintains focus on needs of service users and their carers, unclouded by the considerations of providers
- Sets framework for deploying resources to achieve objectives making best use of all sectors
- Encourages constructive dialogue between different stakeholders through transparent processes
- Building bridge between financial and service planning
- Aids the business planning of service providers by clarifying the medium term purchasing intentions of the commissioning authority.
- Encourages authorities to share intelligence and analysis to improve the range, quality and cost effectiveness of services within available resources, based on an understanding of whole systems of care.

Listening to service users

Commissioners need to listen, understand and anticipate the needs of their customers now and in the future and understand what constitutes best practice. Commissioners and providers have a fundamental duty to find out what people want and need from their services. Commissioners should look at services they commission for all service user groups and ask: are these the services I would want for my own family and friends or for myself? (see Relentless optimism).³

Knowledge of existing services

Commissioners need to know and understand the services presently available to people with learning disabilities and their families. In particular they need to understand:

- Who uses the services
- The outcomes for service users, their carers and for commissioners
- Their location
- Quality
- Cost
- The views of service users, carers, care managers and providers
- Gaps in availability or quality of service provision

Impact on market

Commissioners need to understand the impact they have on the market in terms of the services available. In areas, for example, dominated by in house social services provision there may be no alternative service provision. This limits the opportunities available for self funders. It reduces the opportunity for people or their family to top up their existing care package and it reduces opportunities for people to use their direct payments to purchase services off providers as opposed to directly employing carers themselves.

³ Relentless Optimism, Creative Commissioning for Personalised Care, Commission for Social Care Inspection 2006.

Commissioning Strategy

Commissioners need to develop a commissioning strategy which addresses what services are needed, how any gaps in availability or quality are addressed, and what are the priorities for development or change, over what timescale and with what resource requirements.

Commissioners need to monitor and review both the strategy as well as the performance of services. The commissioning strategy should operate within a performance management framework and as such should be the subject of performance evaluation reported to partners, management boards and scrutiny committees.

Rationale for Commissioning Strategy

Commissioning is not a precise science in terms of applying a precise formula to get the results required. It involves making judgements on the best information available. Commissioners need to be able to provide a rationale for the range of services available to people with learning disabilities. They need to be able to explain the rationale for the current and the future planned pattern of services to service users and their families, to providers, staff, taxpayers, inspectors, etc. It is important to remember that commissioners are responsible for decisions about the services commissioned not providers. Providers remain responsible for the quality of services provided.

Commissioners will need to be innovative in developing new services with all stakeholders with a range of providers to achieve the most effective balance of service provision. Service providers may be drawn from partner agencies, in house provision, private and Third sectors. The emergence of social and community enterprises will also have an important contribution to make.

Commissioning applies to all services whether purchased from the private and Third sector or directly provided by the local authority.

Guidelines

These guidelines are designed as a toolkit to help commissioners in local government and the NHS to work with stakeholders to develop their commissioning strategies.

These draft guidelines were produced as a result of discussions between the former Social Services Inspectorate for Wales (SSIW now part of the Care and Social Services Inspectorate for Wales) and the Learning Disability Implementation Advisory Group (LDIAG). In 2005, SSIW had commissioned some work on 'How to undertake a needs analysis' and on 'the information requirements for commissioning'. These documents are available on request. The rationale for this work was the need to generate thinking about the information required for commissioning and how we make more effective use of it.

Following discussions of these documents with the LDIAG it was decided to expand this work to develop guidelines to enable local authority and NHS commissioners to work with their partners and people with learning disabilities

and their families to develop commissioning strategies to shape the future pattern of services for people with learning disabilities in Wales. The reason for guidelines in relation to a specific client group – in this case people with learning disabilities – is to make the task of commissioning easier by breaking the task down into client groups. If it makes life easier, commissioners can break the task down further by developing commissioning strategies for particular service areas such as, for example, accommodation and support services for people with learning disabilities. Whilst this is possible it is probably better to start with some overview of the commissioning task in relation to people with learning disabilities to determine priorities. Service considerations are, of course, not mutually exclusive in that changes in one service are likely to impact on other services.

This will also have benefits in terms of performance management. The strategy will help to provide an overview of services for a range of stakeholders. Members should consider reviewing progress of the commissioning strategy at the appropriate scrutiny and partnership forums.

In 2004 SSIW commissioned the Institute of Public Care (IPC) at Oxford Brookes University to lead a series of regional seminars across Wales which provided a basic introduction on commissioning and how to develop commissioning strategies. These were well received and these guidelines follow the IPC's commissioning framework model together with other materials. These guidelines draw heavily on IPC materials developed in Wales in relation to Commissioning services for substance misuse and in England for the Care Services Improvement Partnership and South West Commissioning Strategy for Learning Disabilities.

Wherever possible these guidelines draw on existing work to avoid duplication of workload. It is recognised that we are not working on a 'green-field site' across Wales so far as the development of commissioning strategies are concerned. Some local authorities working with their partners have produced commissioning strategies or undertaken a considerable amount of work on the development of their 'Health, Social Care and Well-being strategies. Some local authorities have grouped together with partners in health to examine how they can work together to improve commissioning and service provision on a regional basis. The Social Services Improvement Agency (SSIA) can signpost this ongoing work. Hopefully these guidelines will help local partnerships to add value to their existing strategies.

In setting to the task of developing these guidelines it has become clear that other work is required. Work on developing and defining outcomes, for example, is being undertaken but is in its early stages. These guidelines are not therefore the finished article and we will need to work together to develop our knowledge and skills to plan improving services in the future.

Similarly, the personalisation agenda is gathering pace. Although the Welsh Assembly Government has no plans to introduce 'Individual Budgets' this does not mean that the personalisation agenda cannot be taken further forward. This will be a feature of an ongoing agenda. These guidelines

encompass reference to procurement because of the need to demonstrate its location within the commissioning cycle. Further guidelines on procurement will be available later this year through the Value Wales Procurement Route Planner.

These guidelines also draw on the work undertaken in two workshops facilitated by IPC and commissioned by CSSIW held with commissioners and providers for services for people with learning disabilities. The purpose of the workshops was to work towards developing more effective relationships between commissioners and providers. Hopefully, this work can be further developed in the future.

This section will continue with descriptions of commissioning, commissioning strategies, and most important of all an introduction to the people they serve – people with learning disabilities and their families and carers.

Later sections will describe the IPC's commissioning framework and following sections will add some ideas about the more detailed information required at it stage to help shape the commissioning strategy. So, for example, the section on needs analysis will begin with some basic overall information but later sections will suggest some of the information required to examine future accommodation requirements, future employment requirements and so on.

Finally, as part of the implementation of 'Fulfilled Lives: Supportive Communities' the Welsh Assembly Government commissioned the Institute of Public Care to develop a 'Framework for Commissioning'. This is a generic framework which can be applied to commissioning services for any particular group. **This framework is statutory guidance and includes 12 standards which social services should measure their performance against.**

Hopefully, these guidelines take us a step further in providing more detailed considerations about services for people with learning disabilities.

1.2 KEY PRINCIPLES UNDERPINNING COMMISSIONING

It is important to be clear about how commissioning is expected to be undertaken across Wales. Commissioning should be a constructive activity which helps to foster good, long-term relationships with providers. It should help to ensure that service users and carers have an opportunity to influence services. The following principles should be adopted to guide those working to commission health and wellbeing services.⁴

1. Put the needs of service users first and ensure they are engaged in commissioning activities.
2. People who cannot speak for themselves have someone who knows them who can speak for them.
3. Give consideration to the needs of carers and ensure they are engaged in commissioning activities. Commissioners will have to

⁴ Drawn from 'South West Learning Disability Commissioning Guidance' Draft 2

manage any tensions where the interests of users and carers are in conflict.

4. Spend money wisely to secure effective and efficient services that are targeted to meet the needs of people with learning disabilities in Wales.
5. Look for opportunities to invest in community services, to promote independence and improve health and wellbeing, whenever possible.
6. Commission collaboratively with partner commissioning agencies.
7. Use open and transparent processes which are designed to build and maintain good long-term relationships with service providers.
8. Have a commissioning strategy which is based on population needs assessment, the best management information available, knowledge of the market, and the aims of national policy and guidance.
9. Develop services based on the priorities identified in the commissioning strategy.
10. Continuously evaluate services to improve the outcomes they achieve.
11. Comply with EU Procurement Regulations, and adhere to Local Authorities and NHS financial regulations.
12. Ensure that commissioners have the right skills and capacity to undertake the work.

These principles can be turned into a checklist of questions to measure performance. Are commissioners working together, for example? How is evaluation undertaken? Have commissioners build good long term relationships with providers? Do we have robust management information to analyse need to help us commission effectively? Have we defined outcomes?

1.3 COMMISSIONING STRATEGIES

A commissioning strategy or plan is:

‘A formal statement of plans for securing, specifying and monitoring services to meet people’s needs at a strategic level. It applies to services provided by the local authority, NHS, other public agencies and the private and voluntary sectors.’ IPC

A commissioning strategy is concerned primarily with effecting change in the overall configuration of services across a market to meet the needs of a whole population – in this case of people with learning disabilities. It is specifically developed by commissioning agencies rather than providers, and is a statement of commitment about the way in which they intend to purchase services in the future. An effective strategy helps to establish the credibility of the commissioner as an honest and effective broker in achieving the optimum range of services to meet the needs of a particular population.⁵

⁵ Keith Moultrie IPC ‘Developing a Commissioning Strategy in Public Care’ 2006 – Commissioning e-book.

Although commissioners should involve providers in the development of the strategy commissioners remain accountable for the range of services in place. Where there is a poor range of services in place any audit, review or inspection will immediately seek explanation from the commissioner and not the providers. Commissioners alongside inspectors will hold providers accountable for the quality of their services.

A strategy does not necessarily include details of budgets or planned contracts, as by its nature it needs to offer a long term, wide ranging overview of commissioning intentions rather than detailed plans for changes in prices or volume in contracts. However, if a strategy is to influence service plans and contracts, it should be complemented by detailed procurement plans which specify budgets and what services they will be used to fund, as well as details of immediate planned service improvement, dis-investment and decommissioning. The development of commissioning strategies will provide:

- Better matching of needs and services
- Ensure services are designed primarily to meet the needs of users and carers – rather than the interests of professionals or service providers
- Better balance between service tiers – improve the effectiveness of prevention and early intervention services, so that users will be better served, and demand for complex and expensive health and care services can be reduced.
- Better engagement with independent sector

Commissioning strategies are only useful if they lead directly to service change.

1.4 WHO ARE PEOPLE WITH A LEARNING DISABILITY?

If we are encouraging commissioners which should include social services, education and housing in local government as well as the NHS it is important that all parties share the same definition of who they are trying to serve. The term 'learning difficulties in education, for example, has a broader meaning.

The LDIAG helpfully describes what people with learning disabilities have in common.⁶ From birth or early childhood they will have had an impairment of intellectual function that significantly affects their development and leads to difficulties in understanding and using information, learning new skills and managing to live independently. They are, therefore, more likely to require support and services to lead an ordinary life.

The degree of these difficulties varies considerably from mild to severe and each individual is different and therefore the range of support required varies from minimal to extensive.

⁶ Proposed Statement on Policy and Practice for Adults with a Learning Disability: Learning Disability Implementation Advisory Group. January 2006

While some people with mild learning disabilities may have few significant problems, those with severe learning disabilities may have a variety of interconnecting needs that impact greatly on all aspects of their lives.

Common difficulties concern:

- Understanding and using information
- Making choices and decisions
- Learning and using symbolic forms of communication
- Getting around at home and in the community
- Dealing with social situations

Arising from such difficulties, people with learning disabilities often need help with ordinary activities of daily life, including:

- Where and how to live
- Work and leisure
- Relationships
- Staying fit and healthy

In addition, some people will have more complex needs that arise from additional problems, including:

- Physical impairments
- Sensory impairments
- Psychological difficulties
- Mental illness
- Neurological conditions (e.g. epilepsy, cerebral palsy)
- Behavioural difficulties which vary in severity and degree of social impact.

For some people, particularly those with a mild learning disability, it is not the degree of learning disability that determines their status as a service user, but the presence of some other significant factor, e.g. mental illness, offending behaviour or autism.

Some children assessed as having special educational needs by virtue of learning disabilities do not go on to be users of adult learning disability services.

1.5 HOW MANY PEOPLE ARE THERE WITH LEARNING DISABILITIES

Prevalence rates allied to local census information acts as a starting point for building up this picture. Prevalence rates vary from study to study, but combined wisdom suggests that 0.4% is a reliable rate for people with a severe learning disability (8). Studies have screened entire populations (as compared to people known to services) have provided much higher prevalence rates of approximately 6 per 1,000 for people with severe learning disabilities. If these rates were applied across Wales the figures for each local authority would be as described in table in Appendix 1 table 1.

These figures do not include people with a mild/moderate learning disability for which a rate of 2%-2.5% needs to be applied. Studies have screened entire populations (as compared to people known to services) have provided much higher prevalence rates of approximately 25-30 people with mild learning disabilities per 1,000 general population⁷.

The application of these prevalence rates to provide estimates of people with mild/moderate/ severe and profound learning disabilities are included appendix 1 table 2.

This latter group will include the majority of people with challenging behaviours and some who, whilst not receiving a service, may be vulnerable because of a future change in personal circumstances (e.g. if they are living with older parents – see below)

The LDIAG document noted that estimates at the beginning of the 1990s suggested the following age specific rates for severe learning disabilities:

- 3.5 – 4 people per 1,000 aged 25-44 years
- 2.0-2.5 people per 1,000 aged 45-64 years
- 1.0-1.5 people per 1,000 aged 65 years and over

The overall prevalence rate for people with severe learning disabilities was in the region of 360 -380 per 100,000 total population.

Applied to the population of Wales, such a rate would have suggested that there were about 10,830 people with severe learning disabilities living in Wales at that time.

The LDIAG notes that estimates suggest that there have been increases in the prevalence of people with severe learning disabilities since the beginning of the 1990s of between 15% and 25% in every 10 year age between 35 years and 64 years together with a doubling of the prevalence of people aged between 65 and 74 years and the beginnings of a significant very old population.

Prevalence rates allied to census information can therefore be used as a baseline to establish the size of the learning disability population in a given locality. The estimates will need to be tested against local knowledge from known cases and registers.

Other prevalence rates can also be useful. For example in respect of older carers (i.e. those aged 70+), it has been established that a rate of 53 per 100,000 populations applies (10). Treated with due caution, an alliance of prevalence and census data can provide an indicative figure for further study in a very important area. See appendix 2.

⁷ Learning Disabilities: The Fundamental Facts (Eric Emerson, Chris Hatton, David Felce, Glynis Murphy, Foundation for People with Learning Disabilities)

Census data on its own is also worth close scrutiny. For example, according to the 2001 census, the number of children in the 10-14 ages ranges in Wales is 195,000. This compares with figures of around 75,000 in the age band immediately above and below this range. Given the known trend of higher number of children with complex needs surviving well into adulthood, this sort of data is worth close scrutiny, as would the existence of any other clusters in other age bands.

The Mencap manifesto notes that the number of people with learning disability is expected to increase by 14% by 2021. This is because more small premature babies are surviving and because people with learning disabilities are living longer.

Appendix 1 also includes information on local authority disability registers in Wales.

1.6 Outcomes – What are we trying to achieve?

An outcome may be defined as the impact, effect or consequence of a service or policy. (Hazel Qureshi) Services are only useful if they have some effect on those who receive them.⁸ Although more complex to measure, outcomes help commissioners to understand the true value of services in terms of their impact.

Clearly all stakeholders need to have a common understanding of the agreed outcomes together with the rationale underpinning them.

A focus on outcomes has a number of benefits:

- It can make assessments more focused and allow for a better understanding of user and care priorities.
- Focus on important question – Is the service doing its users any good?
- Allow for more creative care planning with care plans being more specifically targeted to individual requirements
- Provide clearer guidance to for providers about the purpose of help/support offered and individual preferences.
- Enable feedback about the impact of services which could help in fine tuning care packages.
- It can help to focus providers on the purpose of the task, both at a personal level and that of individual workers. Overall outcomes can link into personal targets and appraisal systems, e.g. what are you doing to achieve the outcomes the agency is required to meet?
- Providers need to be able to demonstrate the effectiveness of their services, particularly if their costs are higher but they believe they are providing a better quality than other providers.
- Enables commissioners to target resources more effectively. Commissioners need to know that their money is well spent on services which are achieving impacts and to have sufficient information about the relative effectiveness of alternatives. Resource constraints impose

⁸ Andrew Nocon and Hazel Qureshi: 'Outcomes of Community Care for Users and Carers' OUP 1996.

a greater necessity to concentrate on services which are known to achieve agreed outcomes.

- Achieving outcomes can be both collectively and individually motivating.
- Commissioners and providers working together to arrive at a good set of measures can be a beneficial approach to both raising quality of the service and for enhancing working relationships.
- Promotes innovation by allowing freedom over methods.⁹

Being clear about desired outcomes is essential to service design and commissioning.

There are two layers of outcomes associated with specifications:

- General outcomes to be achieved for all users/ carers for whom the contract applies
- Specific outcomes that would be individually tailored to users/ carers.(see 8)

Commissioners need identify outcomes at both layers.

Unfortunately, most of the management information we have to date is dominated by activities, quantities and budgets or service inputs/ outputs. While this is useful we also need to give more consideration to capture information on the benefits to service users and carers.

Outcomes pose a number of challenges. The first concerns definition. One outcome which could be easily measured may be – the number of people with learning disabilities who have their own tenancy for their accommodation. This reflects the broad policy objective. Some would argue that this is not the outcome at all – the outcome being control of ones own living space. Nevertheless, tenancy or ownership could be used as proxies for outcomes.

Research, for example, has found a lack of consensus on the purpose of day care services which provide a range of activities, including:

- Arts and crafts
- Personal development
- Sports
- Education
- Work experience therapy external paid work
- Voluntary work
- Contract work.

The activities offered should not be arbitrary but should be geared to outcomes. Recreation and leisure among adults generally in society tend to be seen as diversions which derive their value from their contrast with other activities pursued in household, civic or vocational careers. Their purpose as a long term dominant lifestyle is open to question. Similarly, continuing

⁹ Drawn from 'A Guide to Fairer Contracting Part 2 Service Specifications. IPC on behalf of 'Care Services Improvement Partnership'

education and development without a clear end point is also open to question. To what does such education lead? When are students expected to graduate and what are they being equipped to do? The outcomes associated with an education or training service may be impaired if travelling time is excessive and diminishes time available for education and training.

Defining outcomes for more severely disabled people is also more challenging. Research has demonstrated that living in the community does not necessarily or even usually result in people with more severe disabilities being greatly involved in their own homes.¹⁰

People with more severe disabilities lead more segregated lives.

Active Support is designed to provide a bridge to participation in everyday activities for people who lack the skills to participate independent of assistance.

The prime focus of Active Support is creating the conditions that make homes places where people with severe learning difficulties can live as opposed to be accommodated.

In brief, Active Support is a way of training staff in small community residences to plan and monitor activities in consultation with or on behalf of residents with severe learning disabilities, as well as interact with them in a way that supports and encourages their participation in the activity.

Self determination is encouraged by emphasizing that staff should involve the people they support as much as possible in the construction of their activity plans and take account of the individual's activity preferences and aspirations.

Active Support has been demonstrated to be effective in improving participation of people with severe learning disabilities and can help to achieve positive outcomes.

The second major challenge posed by outcomes concerns measurement. It is difficult to transfer outcome measurement into useful management information in one go. There is also considerable room for improvement in our capacity to aggregate information from person centred and care management processes.

A lot of work has nevertheless already been undertaken on the development of outcomes by a range of commissioners and providers and these needs to be brought together and shared with the aim of achieving a more coherent view on how they can contribute more effectively to service development.

In the meantime there are several avenues open to identify outcomes.

¹⁰ Active Support: Planning Daily Activities and Support for People with Severe Mental Retardation; David Felce, Edwin Jones, and Kathy Lowe in S.Holman & P.M. Vietze, Person Centred Planning.

First, looking through policy documents one can identify the following desired broad policy objectives for people with learning disabilities. These are a starting point for developing outcomes.

The Welsh Mental Handicap Strategy was launched in 1983 to help develop community based support for individuals with a mental handicap. The strategy was based around three key principles:

- The right to an ordinary pattern of life within the community;
- The right to be treated as an individual; and
- The right to additional help and support in developing their maximum potential

The 1994 revised guidance had a number of clear objectives:

- Provision of a range of accommodation so that people with learning disabilities have as much freedom as anyone else to choose where they live and with whom they live and a level of support which enables them to continue to live in the community
- Help to obtain a real job for most adults and support to help them keep it – all adults who are able to work should have the opportunity of paid employment alongside other members of the community
- Help and support to become part of the community and to take part in leisure activities among other people
- Access to the same health care as others living in the community, with additional support to meet special health needs.

In its 'Statement on Policy and Practice for Adults with a Learning Disability' issued in 2007 the Welsh Assembly Government included the statement:

"All people with a learning disability are full citizens, equal in status and value to other citizens of the same age. They have the same rights to:

- Live healthy, productive and independent lives with appropriate and responsive treatment and support to develop to their maximum potential.
- Be individuals and decide everyday issues and life-defining matters for themselves joining in all decision-making which affects their lives, with appropriate and responsive advice and support where necessary
- Live their lives within their community, maintaining social and family ties and connections which are important to them
- Have the support of the communities of which they are a part and access to general and specialist services that are responsive to their individual needs, circumstances and preferences.

These policy statements reflect high order outcomes and can be turned into questions to evaluate the existing range of services as well as individual services. These include:

Place to live

- Do we give individuals the right to choose where they live and who they live with?

- Do individuals live in ordinary houses in ordinary neighbourhoods?
- Do we help individuals achieve security of tenure or provide sufficient support to them as homeowners?
- Do we help individuals obtain accommodation which allows them privacy and security for themselves and their possessions?

Sufficient income

- Do people have sufficient incomes to support independent living?

Work

- Do we provide enough support to help the individual to find a job and have access to education and training?

Community involvement

- Do we promote the involvement of the individual in community activities?
- Do children attend any organised clubs or leisure facilities

Health

- Do we promote access to health care?
- Are primary care services trained to help people with learning disability?

Carers

- Do we support families to care for people with learning disabilities?

Independent Living

- Do we promote independent living?
- Do we support people to make their own decisions?
- Do we listen to people with learning disabilities?
- How do we include them in decision making – planning and development of services?

Adult Protection

- Do we protect vulnerable people from abuse?

These questions all relate to positive outcomes. We could address outcomes from a more negative viewpoint. Does our current range of services leave people feeling isolated, lonely, insecure, and poor, with dependent lifestyles? It is important to remember that outcomes can be negative as well as positive.

Some suggested outcomes or proxy outcomes which are open to measurement:

Accommodation and Support

- Number of adults with a learning disability either owning their own home or who have their own tenancy agreement.
- Number of adults in residential or nursing home provision.
- Number of adults placed out of county

Employment & Occupation

- Number of people with learning disabilities aged 18 to 60 in paid employment – positive outcome
- Number of people with learning disabilities aged 18 to 60 in supported employment – positive outcome
- Number of people with learning disabilities aged 18 to 60 attending day services which have a defined skills development focus –Although this is an output with the skills acquired being the outcome it is still worth measuring.
- Number of people with no identified programme of daytime education or occupation

Health

- Number of people who have received an annual health check with no need for treatment identified.
- Number of people who have received an annual health check with treatment identified and provided
- Number of people who received annual dental check with no need for treatment identified
- Number of people who have received an annual dental check with treatment identified and provided
- Number of females who received regular cervical smear check with no need for treatment identified and provided.
- Number of females who received regular cervical smear check with need for treatment identified and identified and provided.

Challenging Behaviour

- % of people with learning disabilities with defined problems of challenging behaviour who are supported in their own home – positive outcome.
- % of people with learning disabilities with defined problems of challenging behaviour placed in residential care – perhaps an example of a negative outcome.
- Numbers of people identified as having challenging behaviour have seen a reduction in the severity and frequency of behaviour during the last year – positive outcome.
- Number of people with learning disabilities convicted of criminal offences – negative outcome.

Outcomes are not mutually exclusive. Some research indicates that some people living on their own with their own tenancy can become lonely and isolated. So we will need to develop a range of outcomes measures to evaluate the success of our commissioning strategy.

Measuring the impact of a service input does not always lend itself to easy measurement. They can only be evaluated and recorded as part of the review process or person centred planning system. To achieve outcome based

commissioning we need to achieve outcome based person centred planning or outcome based care management.

The development of outcomes goes hand in hand with the development of the Person Centred approach and unified assessment because the impact needs to be identified and recorded in order for the information to be aggregated to inform planning and commissioning. An individual may have made substantial progress in self care skills which can be broken down into outcomes – the individual is now independent in terms of personal hygiene, washing and dressing. If we want to capture information at this level of detail it needs to be recorded and available to aggregation. It may provide the evidence of good performance on the part of the service provider.

E.g. Self-care – maintenance, progress, deterioration

Monitoring outcomes and outputs.

The main means of ensuring that needs are being met / outcomes are being achieved, is by individual care management and review and contract compliance. Authorities need to have an effective system for aggregating the findings from reviews, contract compliance mechanisms, complaints, adult protection to develop a coherent understanding of the performance of a service provider as a whole. They also need to have effective communication with regulation and inspection.

It is important that all professionals understand how and to whom concerns should be reported. Such systems need to be developed where they do not exist. They protect both the service user and the provider. Providers also require early warning systems in addition to their quality assurance mechanisms should problems arise to address them promptly. Equally important, of course, we need to capture and record positive performance.

Another means of measuring outcomes will be through user satisfaction surveys. These are a familiar means of assessing the quality of service from the point of view of the service user. More specific questioning around particular aspects of service delivery can be valuable to explore. Indeed work with service users will help to define outcomes.

Future Work

Ideally, the Welsh Assembly Government, commissioners, providers and service users will need to work together to develop at least some common outcome measures that can be applied across Wales to enable some benchmarking to take place. In the meantime there needs to be a certain amount of tolerance as we develop outcomes without being fearful of making some inevitable mistakes along the way. Measuring whether or not the individual has a regular dental check is not an outcome. Whether or not the individual enjoys good dental health is an outcome. However, the monitoring of regular health checks at least enables us to ensure that everything possible has been done to ensure access to good dental care.

Further work, is therefore required on outcomes and outcome measurement. However, because we do not live in a perfect world with perfect information to support decision making this guidance makes suggestions only.

1.7 Human Rights

Commissioners and providers should also measure their actions and services against the Human Rights Act 1998. The Act provides a useful management tool to help you think through the complex judgements and decisions. Some of the rights that immediately spring to mind when thinking about services for people with learning disabilities include:

- Right to be free from torture, inhuman or degrading treatment.
- Right to respect for your private and family life and your home
- Right to peaceful enjoyment of your own possessions and property

Without going into detail on all the rights within the Act it would not be difficult to think of cases where these rights have been tested or breached. The simple example of moving an individual from one home to another may well breach several of the rights above.

Commissioners must take the Human Rights Act 1998 into account when making judgements.

Commissioners should also take into account Convention on the Rights of Persons with Disabilities (Disability Rights Convention). The UK government has indicated its intention to ratify by the end of 2008. (see Parker,"C"&"Clements,"L"[2008] E.H.R.L.R. ISSUE 4. !SWEET&MAXWELL LTD 2008")

1.8 Self Directed Commissioning

Direct Payments — Individual Budgets - Independent Living Trusts

Direct payments enable people to have cash instead of services and use it to meet their support needs. Direct payments can be used in a variety of ways, such as buying special equipment, spending time away from home, going to a gym, eating out, employing a personal assistant to help with everyday tasks and so on. Direct payments cannot currently be used to purchase permanent residential care, local authority provision or health care. They are a different way of fulfilling existing social services responsibilities by giving people the flexibility to find 'off the peg' solutions.

The Welsh Assembly Government's Direct Payments scheme, with associated local support schemes, provides individuals with the opportunity to better match their care and support arrangements to their particular circumstances. The purpose of direct payments is give recipients greater control over their own life, through being directly able to contract services which increase opportunities for independence, social inclusion and enhanced self esteem.

Care packages can, of course be split; one part, still being taken in the form of services directly provided or commissioned by the local authority and some

through Direct Payments. An individual may well wish to use direct payments for services to help with personal care but may still opt to use other services directly provided by the local authority to assist with daytime occupation. The challenge for providers is to ensure their services remain as attractive as possible.

The Welsh Assembly Government has commissioned a survey to look at the factors affecting the uptake of direct payments.¹¹ Certainly, the results of the survey would indicate that there need to be considerable work to improve the uptake of direct payments in many authorities in Wales. The survey makes several recommendations which all local authorities should study. Clearly, local authorities need to improve the information available to service users on direct payments and ensure that all staff are confident concerning the application of direct payments. Expectations of support services need to be clear and outcomes agreed.

All local authorities must ensure that care managers have a comprehensive understanding of 'direct payments'. This will give them more confidence to discuss the full range of options towards responding to service user's needs. It will be important to focus on the outcome which is not direct payments but the help the individual needs and how this should be provided to maximise their independence. Giving up attendance at a supported employment project, for example, may not be an attractive option in hindsight if the consequence is social isolation. Care managers need to look at service users lives through service users' eyes as far as possible to inform commissioning. We need to be sure we understand the aspirations and wishes of service users to help us begin to plan alternative service options.

Commissioners need to model future service provision with increasing use of direct payments. This will also take into account impact on current service provision.

Individual budgets are similar to direct payments in that they have the same principles of service user choice and control. However, an individual budget, unlike direct payments, does not have to be in the form of a cash payment. A single transparent sum is allocated to a person in their name and held on their behalf rather like a bank account. They can choose to take this money out either in the form of a direct payment in cash, as provision of services, or as a mixture of both. Resources from different agencies, not just social care monies, can be collated together and accessed from the one individual budget to give the individual a more joined-up package of support.

The Welsh Assembly Government will continue to monitor the implementation of the Individual Budgets' pilot schemes in England and will keep under review the opportunity for other forms of individual budgets in the light of evidence from these pilot schemes in England. In terms of empowering service users to

¹¹ A survey on the implementation of current Direct Payments Scheme in Wales: October 2007: Social Interface.

take control of purchasing their own services, the direct payments scheme will remain the mechanism to achieve this.

The Welsh Assembly Government has also commissioned guidance on the development of independent living trusts. This guidance has been completed in draft. The issue at present is that independent living trusts may require registration as domiciliary care agencies as the law presently stands which in many respects goes against the spirit of their development. One of the reasons for commissioning this work was to address the issues of capacity to consent. The parents of disabled children, for example, have capacity to consent and manage the care package. When the child reaches 18, however, he/she may lack the capacity to consent to direct payments. Does this mean they are no longer eligible for direct payments? This problem may now have been addressed by recent legislation (Health and Social Care Act 2008) the commencement of which will be determined by Welsh Ministers. This will allow direct payments to be made to third parties This would be subject to a condition that they are spent on purchasing services to meet a service user's assessed needs.

Independent Living Trusts may still have a contribution to make because they can address health as well as social care issues. The conclusion of this work requires further discussion and will also be influenced by the impact of forthcoming legislation.

Commissioners need to examine whether or not market conditions are conducive to self directed support and if not how they can influence them? See impact on the market CHAPTER 1.

Strategic commissioning will be required to ensure there are good quality, value for money services available for people who decline self-directed support, or for users who choose not to employ personal assistants.

In order to have funding available to make increasing numbers of direct payments, local authorities will need to develop financial flexibility to enable money to be withdrawn from unpopular services, so that it can be given to users who wish to commission their own support. Funds will need to be easily accessible and not tied up in long-term contracts with the independent sector, or by in-house provision. Existing in-house services and external services will need to be funded on the basis of clear, individual pricing mechanisms based on outcomes. This may be difficult as many local authorities have used long-term block contracts to manage the social care market and reduce transaction costs. Influencing the market (including in-house services), when they have less control over how the money is spent, will be a big challenge for local authorities. Commissioners will need to become strategic bridge builders, as they drop the role of large scale purchasers of blocks of service.

Further work needs to be undertaken in this area between commissioners and providers. Tyson¹², for example, notes that the local authority might make use

¹² Andrew Tyson, 'Commissioners and Providers Together' IN Control

of its purchasing power to buy blocks of service from providers more cheaply than could be bought on the open market by an individual. It can then sell services onto local people. Fitzpatrick¹³ has also referred to the possibility of managing block contracts in such a way that individuals maintain the choice and ability to transfer to direct payments or change support provider. Referring to 'Partners for Inclusion' which provides individually tailored support for 45 people in Renfrewshire and Ayrshire; Fitzpatrick notes that at the moment not all contracts are individualised. Where the only contractual arrangement possible is a block contract 'partners for inclusion' allocates it to an individual service fund.

Tyson also refers to the West Sussex Radical Redesign Commissioning Strategy which moves money over a three year period out of residential and nursing home budgets and into self directed support. As the money moves out of residential and nursing home care budget, the capacity and propensity of care managers to purchase the institutional care steadily reduces.

It would be disingenuous to assume that commissioners and providers have ignored the personalisation agenda. The commitment to Person Centred Planning is itself essential towards promoting the independence and control of service users. Work has been undertaken on working to outcomes. Commissioners and providers need to build on the work of developing customer-led services already in place.

Providers should explore:

- How they can individualise existing services
- The development of individual service funds so that they hold the personal budget on behalf of people who want and need them.
- the potential role as support brokers
- The changes required to promote development of services around individuals, e.g. staff recruitment, other HR policies, individual review processes, governance and accountability arrangements.
- Providers need to have an understanding of the costs of their service.
- Providers need to keep up to date on Direct Payments and any other individualised funding options that are developed.

One of the key innovations necessary to help local authorities develop self-directed support on a large scale is a resource allocation system – a system that enables a quick and easy assessment or self assessment of need and an indicative financial allocation, based on the current allocation of social care or other funding. In Control argue that the current system of social care is inherently wasteful, and that greater efficiency will be achieved through self-directed support – as demonstrated in the pilot sites - therefore, self-directed support offers a more sustainable future. This requires further exploration.

Local authority commissioners need to monitor the number of adults with learning disabilities in receipt of direct payments for both total packages of

¹³ Julia Fitzpatrick 'Dreaming for Real: The Development of Partners for Inclusion' Journal of Integrated Care Vol. 14, Feb. 2006.

care and split packages of care. Split packages of care may provide more encouragement for people with learning disabilities to take up direct payments. Once they gain more confidence they may feel they want to take more control of their care.

The Welsh Assembly Government will continue to work alongside commissioners and providers to explore how further progress can be made to improve the individual's control over their support.

1.9 WORKING TOGETHER: WORKING IN PARTNERSHIP

Joint Commissioning involves agencies pooling resources to implement a common strategy for providing services.

There are several powerful reasons why commissioners from the NHS and local authorities should get together and develop joint commissioning strategies for the development of services for people with learning disabilities. In some cases this may involve several local authorities and several Local Health Boards working together on a regional basis. These include:

- They share common customers – people do not live their lives within the administrative or organisational boundaries we create.
- Services should be organised around the service user
- Services are usually inter-dependent – decisions taken by one agency will often have a significant impact on its partner.
- Quality and cost effectiveness of services can be significantly improved when organisations work well together.

Local Commissioners need to decide how formal they wish their partnership agreements to be. The Health Act 1999 introduced Health Act Flexibilities. Guidance described these as:

- Lead commissioning
- Integrated provision
- Pooled budgets

This legislation is now reproduced as section 33 of the National Health Service (Wales) Act 2006 with effect from 1st March 2007. The 2006 Act consolidates certain enactments relating to the health service in Wales but makes no substantive change to existing law.

It will be important for partners to be clear with each other, with staff and with service users – what outcomes the partnership is designed to achieve.

The Welsh Assembly Government has produced separate and more detailed guidance on the use of these measures. In addition the Care and Social Services Inspectorate for Wales has also commissioned the development of templates for section 33 agreements as a practical tool to assist with their development. These have now been incorporated into the guidance. It is important to note that under this legislation the NHS can delegate a wide range of functions to the local authority and similarly the local authority can delegate a wide range of functions to the NHS. Delegating functions does not

mean handing over accountability. Whatever functions are delegated the local authority and the NHS retain their statutory responsibilities. So it is important that when using these measures partners have the appropriate mechanisms in place to ensure appropriate performance levels. There are limits as to what functions can be delegated. The NHS, for example, cannot delegate surgical procedures. These are described in more detail in the guidance on partnerships.

In terms of lead commissioning the NHS could, for example, delegate this function for commissioning services for people with learning disabilities to the local authority and provide appropriate funds to enable this to happen. This budget, however, is still separate to the Local authority's budget for services for people with learning disabilities and has to be accounted for separately. The money delegated by the NHS cannot be spent on anything other than NHS services.

Similarly, in terms of integrated service provision the NHS could delegate the management of NHS staff to the local authority to work perhaps in a joint team. But once again these staff could only undertake NHS activities. The same would apply if the local authority had delegated the management of social care staff to the NHS. They could be managed by the NHS manager but could only be allowed to undertake local authority or social care functions.

It is only when lead commissioning is combined with pooled budgets or integrated provision is combined with pooled budgets that greater flexibility over the use of resources is allowed – the line between the NHS and local authority becomes more flexible and less rigid.

Contributors to the pooled budget determine what the pooled budget can be used for. Partners may wish to limit the activities they wished to be addressed by the pooled budget such as, for example, joint assessment teams; or they could may wish to include the majority of services for people with a learning disability. Providing staff work to their competency level this may allow for a more flexible and innovative use of staff resources. It may also lead to more rewarding jobs.

Factors critical to success of partnerships include:

- Identify objectives at the outset – clear vision
- Outcomes identified
- Focus on service users
- Driven by strong values and principles
- Realistic joint aims and objectives
- Ownership by partners – rational for partnership accepted
- Set realistic timetable
- Invest in communication with service users and staff
- Costs, risks, rewards shared among partners
- Clear lines of accountability for the performance of the partnership
- Financial and other resources contributed by each partner have been identified.

- Robust procedures in place for monitoring performance
- Clarity re decision making and accountability
- Governance arrangements in place¹⁴

The use of these measures if implemented could have a number of advantages:

- More flexibility in the use of resources – money can be transferred across activities within the pool if commissioners felt this addressed needs more appropriately e.g. from acute settings to accommodation.
- More flexible use of staff resources
- Improved commissioning. Pooling budgets requires partners to estimate their financial contributions to the pool. This involves greater clarity and transparency over the use of resources.
- Avoids duplication
- Stronger governance arrangements. At present some joint working may be problematic where staff are working flexibly across boundaries without any formal agreement or delegation of functions.

It is recommended that the local authorities and the local health boards give active consideration to the using of these measures to services to people with learning disabilities. At the very least the local partners should do an option appraisal on application of these measures.

Previous legislation in the form of section 28A of the Health Act 1977 allowed for the NHS to transfer funds to the local authority if it was considered that such a transfer would lead to better health benefits for service users than would be the case if the NHS used the resources directly. This measure was used to close long stay institutions and invest in community services. This device was used to facilitate the implementation of the 'All Wales Strategy'. This transfer was designed to continue beyond the deaths of individuals previously living in the hospitals in order to help meet the costs of new generations of people entering services who historically would have been supported in the NHS long stay institutions.

It is recommended that local partnerships review any ongoing arrangements under this legislation with a view to transferring them to arrangements under section 33 of the National Health Service (Wales) Act 2006.

1.10 WORKING WITH PROVIDERS

Introduction

This material is largely drawn from commissioner and provider workshops facilitated by IPC. It is essential that commissioners, providers and service users work together effectively.

Government expectations of constructive relationships

¹⁴ See work of Bo Hudson on partnership working. Care Services Improvement Partnership.

The 'purchaser-provider split', and its role in shaping the market, is still very much evolving from its conception in the late '80's. The Griffiths Report and the NHS and Community Care Act 1990 provided clear messages that this split would require active intervention from commissioners to ensure a responsive independent market.

Promoting Partnership in Care (2003) made explicit the need for commissioners to work with providers to:

- Achieve a strategic, inclusive, and consistent approach to capacity planning
- Achieve early, on-going involvement between the independent sector, health and social care providers in the planning, delivery, monitoring and review of local services
- Realise positive outcomes
- Promote trust
- Be open and transparent

The emphasis was on localities deciding on their own arrangements for delivering these goals but with productive, mature relationships between all stakeholders as the aim.

Since then, Design for Life (2005) and Fulfilled Lives: Supportive Communities; A Strategy for Social Services in Wales (2007) have moved the agenda forward with explicit and implicit expectations that mature relationships with providers and purchaser are key to successful commissioning.

"Most social care is provided by the private sector. Their contribution is central to driving up standards and they must be key partners in achieving our agenda for change" (Social Care Institute for Excellence 2005 Developing Social Care: the past, the present and the future).

Local Authorities need to secure ongoing quality service for their whole population and providers need to rely on individuals making a consumer choice of their services, rather than on business security based on LA block contracts. Both have to work together to understand current and future demand, to be able to forecast this and create the market conditions to enable a diverse set of choices for the customer while avoiding market instability.

Commissioners can support providers by communicating available data on current and future need in order to identify what services might need to be developed and make risk more calculable.

To deliver these changing national requirements the Office for Government Commerce suggests that commissioners need to know their markets via activities such as market intelligence, market dialogue, and market shaping¹⁵.

¹⁵ Office of Government Commerce. (2003). *Increasing competition and improving long term capacity in the Government Market-Place*. Office of Government Commerce

Market Intelligence – is the accessibility of local, regional, and national market information regarding market activity; current and potential suppliers and future opportunities to inform strategic planning on both the supply and demand sides, as well as market research for individual transactions.

Market Dialogue – refers specifically to the quality and frequency of interactions between stakeholders on the supply and demand sides, in interpreting and discussing data, to better inform individual transactions and the medium and long term development of supply markets for local government services.

Market Shaping – refers to collaborative action by public sector organisations and the supply market, as a whole, to develop markets in ways that support the delivery of key policy objectives at both local and national level.

Commissioners should put themselves into the shoes of the supplier and determine how they might view their contract from the provider's point of view. By understanding the benefits or challenges the contract brings to the provider the commissioner can work out the kind of relationship they expect to have

Strategic Engagement

If providers and commissioners can engage with each other early, at a strategic level, the care sector would be stronger for it. Providers, if involved at the beginning of a commissioning strategy, can give unique insights into demand, for example from their detailed knowledge of service user need, and also invaluable information regarding supply. Providers have the incentive to know their market otherwise they go out of business, and commissioners can benefit from this knowledge.

Early involvement with providers in developing a commissioning strategy then improves relationships further on in the commissioning and procurement process as this dialogue can:

- Develop respect for each others knowledge and skill bases.
- Provide clarity of vision and direction.
- Recognise capacity issues of providers and lead to shared responses to meet these gaps.
- Recognise specific areas of joint ownership such as risk sharing and incentives
- Raise morale and direction.
- Cast the planning net wider (diversity of providers i.e. small business enterprises, voluntary organisation etc.) and further (longer term planning) thus real potential for responsive and innovative service development.
- Effectively invest and create value for money for Local Authorities and providers.

OVERALL BEHAVIOURS AND ATTITUDES

Constructive relationships can be promoted by these processes and actions on the part of commissioners and providers. However, these activities will not of themselves solve the difficulties. There are some generic behaviours, attitudes, and ways of working that need to underpin them. A genuine commitment, by all stakeholders, has to be made towards positive and mature behaviours¹⁶, such as:

- ❖ Openness – dealing with differences and difficulties in a non-defensive or non-adversarial way.
- ❖ On-going self reflection and assessment.
- ❖ Confidence in ones own skills and organisations to contribute to solutions.
- ❖ Knowledge of appropriate boundaries (i.e. confidentiality issues and discretion) yet also knowledge of where and how you can be flexible.
- ❖ Desire and commitment to seek realistic alternatives and sustainable solutions.
- ❖ Shared ownership of outcomes.
- ❖ Willingness to invest time and effort.
- ❖ Willingness to invest emotional and creative energy.
- ❖ Willingness to be proactive.
- ❖ Acceptance that individually we are all responsible for change management.

In 2007 the Welsh Assembly Government worked with the Care Services Improvement Partnership in England to commission the Institute of Public Care to run a series of workshops involving commissioners and providers of services for older people designed to examine how relationships could be improved. This exercise was repeated in Wales concerning services for people with Learning Disabilities in 2008. A checklist of constructive behaviours has been developed. For ease of reference, the checklist is organised around the IPC commissioning and purchasing framework activities of Analyse, Plan, Do, Review as set out in Figure 1 and included in the appropriate sections of the guidelines.

¹⁶ Crampton, J. and Ricketts, S. (2007). *A Catalyst for Change II: Tackling the long ascent of improving commissioning*. Care Services Improvement Partnership

Figure 1 The IPC Commissioning Framework



CHAPTER 2

DEVELOPING A COMMISSIONING STRATEGY

2.1 Introduction

Each local authority and their new LHB should develop and implement a joint commissioning strategy, which clarifies the changes in the overall configuration of services required to meet the needs of people with learning disabilities in an area.

Work on a commissioning strategy will not be undertaken in a vacuum and it is important to recognise previous commitments together with local and national strategic objectives that have already been agreed. Agencies will need to plan how the commissioning strategy will fit with other plans affecting people with a learning disability. It is important, therefore, to outline existing plans across both organisations and how they relate to one another e.g. draw an outline diagram showing the key plans for both agencies and the links between them.

2.2 Clarifying Agency Roles (See Developing a Commissioning Strategy in Public Care by Keith Moultrie – Care Services Improvement Partnership)

The roles of different agencies and the rules of their engagement need to be specified right from the start to ensure that the project does deliver what is required. In most situations this means having different, clearly specified roles for commissioning agencies, provider agencies and other stakeholders. Each group has a hugely important role in the development of the strategy, but these roles are not necessarily the same. Broadly speaking the roles can be characterised as:

- Commissioners are the agencies with the budgets and responsibilities for making and implementing strategic service development decisions on behalf of service users. Commissioners need to lead the project, and to ensure that the work of the project is sufficiently detailed and accurate to be able to guide final plans. They also have the key responsibility for ensuring that the work is fair, decent, and as open as possible, and for balancing the interests of existing and potential stakeholders.
- Providers are the agencies with services which can be purchased by the commissioners to meet the needs of service users. They – both existing providers and potential future providers – can contribute their specialist knowledge and experience, and in so doing, can add quality to the analysis of needs, services and gaps. Providers can also play an extremely important role in testing the feasibility of a gap analysis and service development proposals.

- Many service user or carers groups play an invaluable role in providing their own specialist knowledge and experience of services to add depth and quality to the analysis, and as such are important sources of reference. More enterprising commissioners will engage with users and carers' representatives as partners in decision making on strategies and purchasing decisions.

2.3 Key Questions

Commissioning strategies vary considerably in their purpose and in their relation to other documents, and hence in what they include. Agencies will need to decide the boundaries for their strategy and what elements it will contain. It is necessary to decide at the outset what sort of strategy you want to produce, namely, what elements will be joint and what separate, how comprehensive do you want it to be, what basic ingredients you would like it to include and the limits of your strategy. This will then guide those producing the strategy. The following questions will need to be addressed at an early stage:

1. Whose strategy is it, and what type of document will it be?
E.g. short statement of strategic intent or a detailed analysis and Plan?
2. Who is the audience(s) for the written strategy?
3. What are the boundaries of the population or definition to be used?
e.g. geographical area, client group, age range.
4. What are the services to be included?
E.g. health, education, social care, housing
5. What is the timeframe of the strategy? E.g. 5 years
6. When does the strategy need to be completed by?
7. What existing partnerships or forums are there for multi-agency planning / commissioning?
8. Is there an agreed definition or understanding of commissioning between partner agencies?
9. Are there any agreed or published outcomes, values and priorities of the partner agencies?
10. What research/best practice and guidance/legislation do you know About and where might further resources be found?
11. What population/ demographic data is currently available and /or what arrangements need put in place to produce a population needs analysis?
12. What relevant or recent consultations or feedback exists?

13. What existing service mapping data is available and/or what arrangements need put in place to produce an analysis of the level and costs of the existing service provision?
14. How will you review the quality of current service provision? (e.g. CSSIW inspection reports, contract monitoring, feedback from care managers, complaints, customer satisfaction surveys, etc.)
15. How will you identify and test major gaps in service provision, quality stakeholders?
16. Who will lead the development of the strategy?
17. Who will gather the data?
18. Who will steer and advise?
19. Who will write the strategy?
20. Who will need to agree the strategy?

2.4. Project Plan

It is vital that the development of any commissioning strategy is led by a senior manager at Head of Service level. This does not mean that the Head of Service does all the work but they are in the best position to ensure that all those who are required to make a contribution whether from finance, human resources, operational management, commissioning, etc, do so. In the past strategic plans or commissioning strategies have all too often been left to third tier officers.

A key element of developing an effective commissioning strategy is designing the arrangements to be used, including a clear project and communication plan right from the start. A project management approach may be helpful here.

The first stage of which is project preparation or set-up stage, which usually includes agreeing:

- The scope of joint working between commissioning agencies.
- Clearly specified roles for stakeholders.
- The process and project plan for the activities, including resources and timescales.
- The focus of the strategy – ensuring that key priorities are addressed.
- A clear communication and engagement plan.
- Monitoring and evaluation arrangements.

To ensure the strategy development process is seen to be fair and balanced and that all stakeholders in the final strategy have an appropriate input, it is worth considering the following different roles:

1. A project sponsor to 'own' and back the project.
2. A project steering group to oversee the production and continuous review/development of the commissioning strategy. The following remit is suggested:
 - Establish a project team with the task of producing the commissioning strategy and ensure that they have sufficient resources available during the course of the project to complete the activities.
 - Agree commissioning priorities for the client group.
 - Recommendation the commissioning strategy and future spending decisions.
 - Monitor the implementation of the commissioning strategy.
 - Oversee contracting arrangements for learning disability services.
 - Report to a joint commissioning or other partnership board.
3. A project team (task and finish group) to undertake the necessary work on strategy development, analysis, procurement, implementation and monitoring is required. A project team could include operational and support staff who would:
 - Write a project and communication plan outlining the activities to be undertaken and timetable to work to, and then agree it with the steering group prior to commencement.
 - Co-ordinate consultation and engagement of appropriate stakeholders.
 - Co-ordinate and/or undertake the research and development activities agreed in the project plan.
 - Quality assure the work at each stage of the process, including feedback on draft materials.
 - Monitor progress on the development of the strategy.
 - Produce draft and final reports/strategies.
4. Project reference groups of provider agencies and other stakeholders, who would be responsible for testing, challenging and adding quality to the analysis.

Building a commissioning strategy from scratch can be a resource-intensive activity. The time and energy required is substantial. Going through all of the stages in the example project plan can rarely be done in less than six months, and will usually require the active input of a significant number of commissioners, providers, service users and carers, and other stakeholders. Of course, some of the background work required by a commissioning strategy may have been done previously (for example, population needs assessment).

2.5 Skills for Commissioning

The project team will need access to some combination of the following skills and experience:

- Project management
- Change management
- Policy analysis
- Demography
- Data collection and information analysis
- Financial Data
- Qualitative research
- Working with service users and carers
- Interviewing, questionnaire design and analysis
- Presentation, workshop management and facilitation
- Report writing

All those involved in the process need appropriate training. This is not a matter that can be left to those in a contracts unit. It is a core competence for senior staff, as well as for councillors and non-executives.

2.6 ADDRESSING KEY ISSUES IN THE STRATEGY¹⁷

It is helpful to be very clear about the focus of the strategy at the start to ensure that resources are not wasted on exploring minor or insignificant issues. The project team can then develop the priorities, rationale and evidence, and gain consensus on the implications of the priorities.

Introducing 'hypotheses' at an early stage of strategy development can help to focus on priorities. Hypotheses can be defined as 'assumptions to be used for the basis of investigation' and they can be used to enable stakeholders to identify key issues that they believe have to be explored in the development of the strategy. This also helps to ensure that key assumptions about services, however controversial, are brought out into the open from the start, and that all stakeholders have an opportunity to influence the key areas to be explored in the strategy. The hypotheses can also inform the details of the methodology to be used in the development of the strategy, without pre-judging the final findings.

A selection of 8 -10 key strategic service hypotheses is probably sufficient. Examples of hypotheses include:

- 'An expansion in the number of new service users using individual budgets and direct payments may mean that we need to reduce our provision of day care placements by 30 over the next 3 years.'
- An expansion in the number of people gaining access to employment or supported employment may mean we need to reduce our provision of day care placements by 30 over the next three years.

¹⁷ Drawn from South West Learning Disability Commissioning Guidance Draft 2.

- ‘Investing in extra care housing will allow us to reduce the number of residential and nursing beds we purchase.’
- ‘We are going to need to increase the volume of supported living provision by 10% and specialist residential placements for people with dementia by 5% over the next 5 years if we are to keep pace with needs.’
- ‘Increasing the level of adult placements offered may enable us to reduce the number of residential and nursing care admissions for people with learning disabilities, and improve the independence of service users.’
- ‘Over half of the users of our day care services do not need them, and there are more effective and cost-effective ways of providing community support for them and their carers.’
- ‘If we invest in assistive technology, it may reduce hospital, residential and nursing care admissions by enabling early support for individuals at high risk of entry into hospital or long term care, and improve the independence of service users and their carers.’

Once they have been agreed, the steering group then needs to ensure that the hypotheses are fully investigated during the course of the analysis activities, and accepted or refuted on the basis of the evidence gathered. Where accepted, they can then rightfully play an important role in defining service direction, and can be turned into implementation plans.

There may already be pressure points in services to inform the hypothesis.

CHAPTER 3

THE COMMISSIONING FRAMEWORK

3.1 WHAT IS COMMISSIONING?

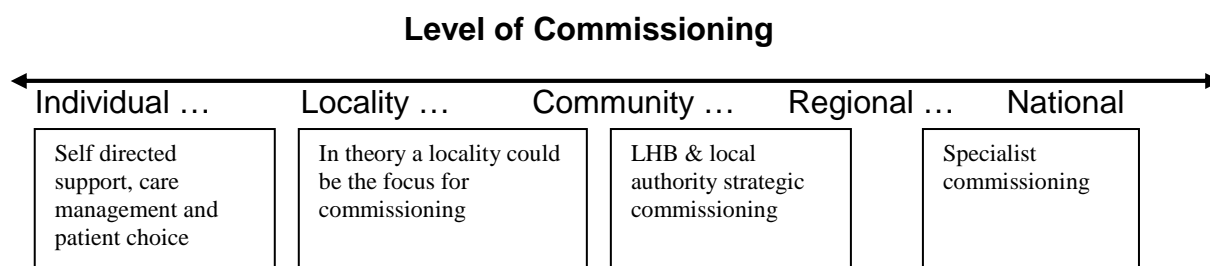
Commissioning is a broad concept and there are many definitions.¹⁸

Most definitions of commissioning paint a picture of a cycle of activities at a strategic level - concerned with whole groups of people - including:

- assessing the needs of a population;
- setting priorities and developing commissioning strategies to meet those needs in line with local and national targets;
- securing services from providers to meet those needs and targets;
- monitoring and evaluating outcomes; and
- the above combined with an explicit requirement to consult and involve a range of stakeholders, patients/service users and carers in the process.

3.2 Levels of Commissioning

There is a continuum of commissioning activity that runs across the health and wellbeing system as illustrated in the diagram below. There is not a single 'ideal' location for commissioning all services.



Individual level – commissioning at this level may be done by the individual, a family carer, an independent broker, a care manager or a combination of these. The planned expansion of self-directed support via direct payments will require fundamental changes to the present system of assessment and care management and will impact on the strategic commissioning role.

Locality level – commissioning responsibilities and activities could be focused on a locality level. In an authority like Powys, for example, account needs to be taken of the needs of people with learning disabilities living near the Wrexham or Gwynedd borders in the North as well as those living near Swansea in the South.

Community level – traditionally LHBs and local authorities have determined how to make the best use of available resources on the basis of population needs assessments and evaluating existing services, past performance and notable practice elsewhere. However, the role of strategic commissioning will

¹⁸ South West Commissioning Guidance Learning Disabilities Draft 2.

need to change to reflect the increasing importance of individual and locality commissioning as well as the responsibility to develop the market for the whole community by leading and coordinating the activities of different agencies.

Regional/sub-regional level – the more specialist the service and the lower its volume, the higher the level at which it is most appropriately commissioned. Some complex and acute needs will often be most effectively met when local authorities, LHBs work together. Local partnerships involving LHBs and local authority would do well, for example, to share information on out of county placements with other local partnerships. They will probably find that many of them are purchasing from the same provider but negotiating their contracts as individual commissioners. Some regional approach to commissioning may secure the same service at a better price by combining purchasing power. Partnerships could also share a common approach to quality assurance providing better protection to service users. Work at this level on commissioning services for people with learning disabilities is already well underway in some parts of Wales.

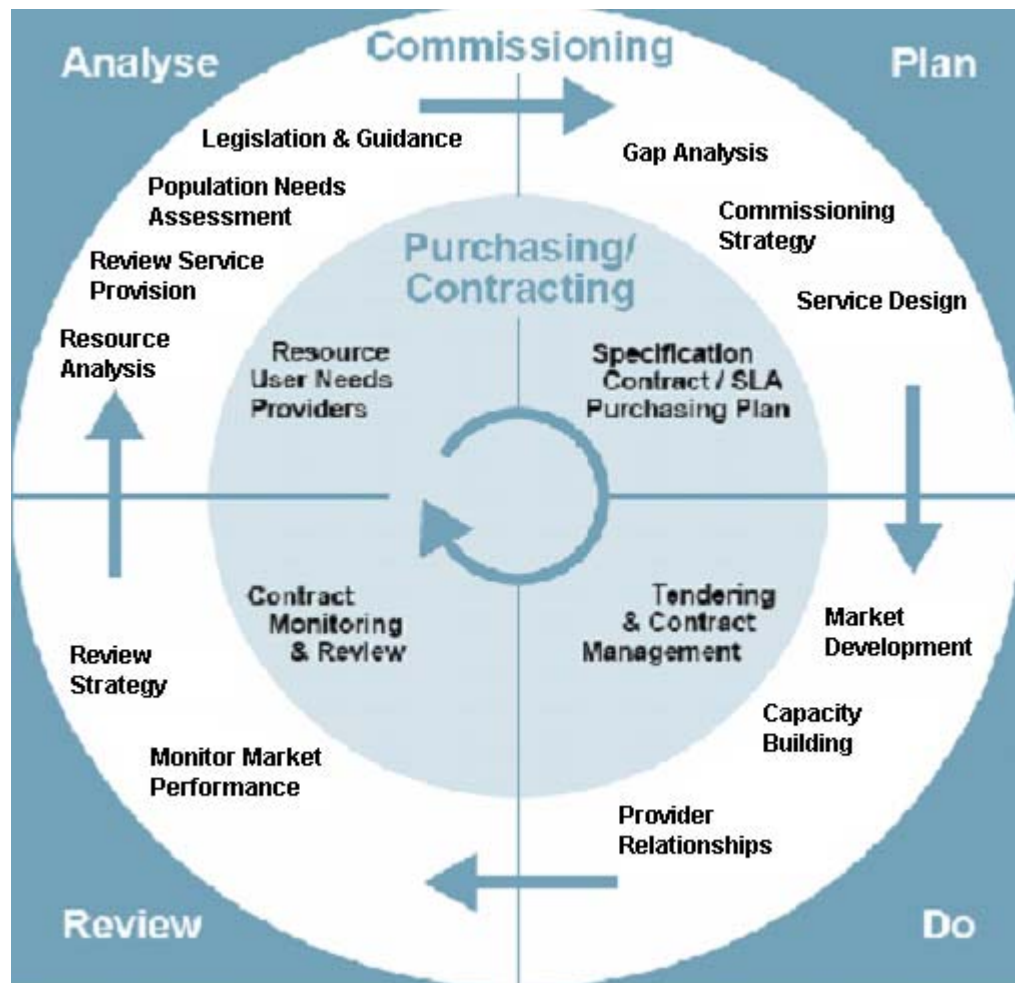
3.4 Strategic Commissioning Activities

A common view of the activities involved in commissioning is helpful. The IPC approach sees effective strategic commissioning in terms of a cycle of activities with commissioning strategies driving purchasing arrangements, and systems to ensure strategies are implemented and monitored to assess and evaluate progress.

A summary of the activities involved in the strategic commissioning process and the relationship between commissioning and procurement is included in the diagrammatic representation of a best practice commissioning framework from IPC below.

The key principles of the framework are that:

- All of the four elements of the cycle (analyse, plan, do and review) are sequential and of equal importance, i.e. commissioners and contractors should spend equal time, energy and attention on the four elements.
- A written joint commissioning strategy per client group (or as appropriate) should be developed, which focuses on that client group's needs across agencies.
- The commissioning cycle (the outer circle in the diagram) should drive the purchasing and contracting activities (the inner circle). However, the contracting experience must inform the ongoing development of commissioning.
- The commissioning process should be equitable and transparent, and open to influence from all stakeholders via an on-going dialogue with patients/service users and providers.



The activities involved in the **commissioning cycle** (the outer circle) can be grouped into the four elements of analyse, plan, do and review, and outlined as follows.

(a) Analysis - understanding the values and purpose of the agencies involved, the needs they must address, and the environment in which they operate. This element of the commissioning cycle involves activities such as:

- Clarifying the priorities through reviewing legislation, national guidance and local strategies and policy statements.
- Undertaking population needs assessment.
- Mapping and reviewing existing and potential services across agencies to understand provider strengths and weaknesses, and identify opportunities for improvement or change in providers.
- Identifying resources needed and risks involved in implementing change and/or continuing with the status quo.

(b) Planning - identifying the gaps between what is needed and what is available, and planning how these gaps will be addressed. This element of the commissioning cycle involves activities such as:

- Undertaking a gap analysis to review the whole system and identify what is needed in the future.
- Designing services to meet needs.
- Writing a joint commissioning strategy (or prospectus) which identifies clear service development priorities and specific targets for their achievement.

(c) Doing - ensuring that the services needed are delivered as planned, in ways which efficiently and effectively deliver the priorities and targets set out in the commissioning strategy. This element of the commissioning cycle involves activities such as:

- Supply management and capacity building to ensure a good mix of service providers, offering consumers an element of choice in how their needs are met.
- Developing good communications and effective relationships with existing and potential providers.
- Purchasing and contracting of services and de-commissioning services that do not meet the needs of the population group.

(d) Reviewing - monitoring the impact of services and analysing the extent to which they have achieved the purpose intended. This element of the commissioning cycle involves activities such as:

- Pulling together information from individual contracts or service level agreements.
- Developing systems to bring together relevant data on finance, activity and outcomes.
- Analysing any changes in population need and reviewing the overall impact of services to identify revisions needed to the strategic priorities and targets.

The procurement or purchasing cycle (the inner circle) follows the same pattern of analyse, plan, do and review and consists of similar activities, but at a different level i.e. contracting for a service, but could encompass the care management or referral function of securing a service for an individual.

Activities in the purchasing cycle include:

- Confirming the resources available for the contract.
- Analysing the strengths and weaknesses of providers, and the direction set in the commissioning strategy.
- Developing service specifications and deciding on contract type and terms.
- Making a spot purchase to implement the care plan.
- Day-to-day care and contract management and communication with providers.
- Tendering for services and letting of contracts or Service Level Agreements.
- Monitoring and reviewing contracts.

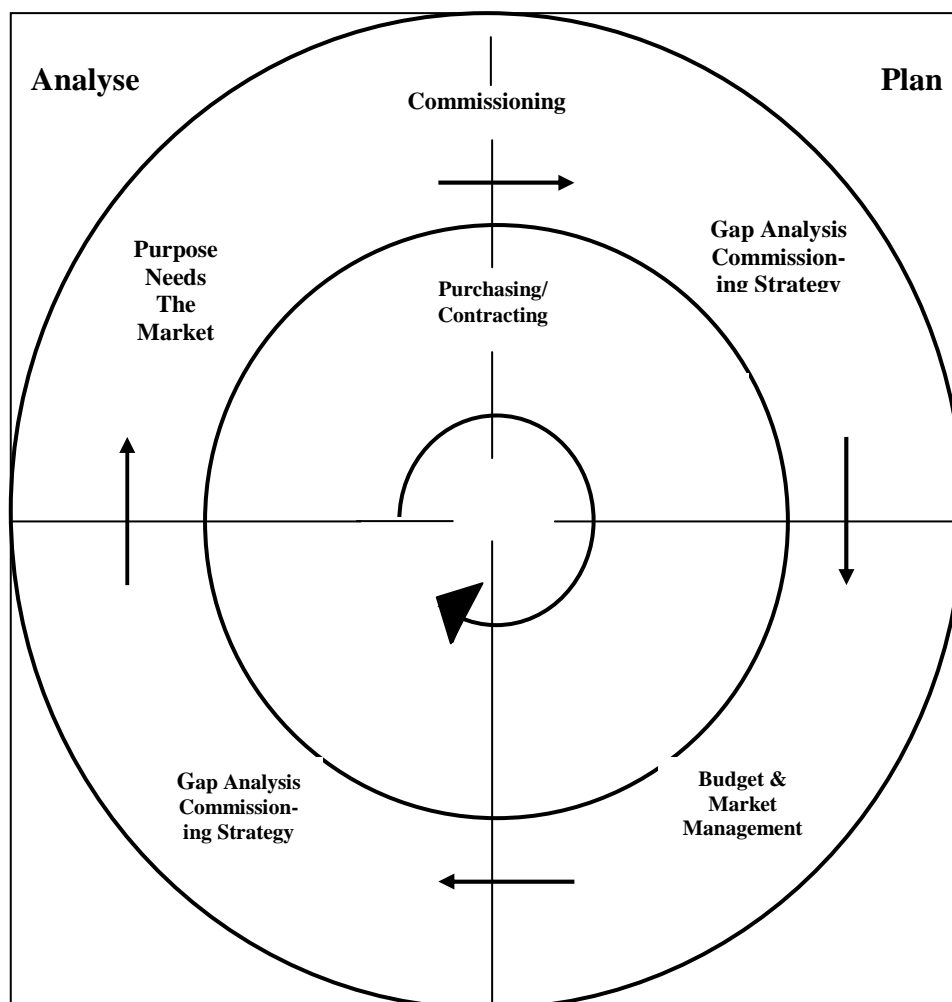
Further guidance on the procurement cycle is available on the Value Wales Route Planner: www.buy4wales.co.uk/prp

This commissioning framework can be applied to developing commissioning strategies for any client group such as, for example, older people, people with a mental illness and so on. The framework has already been applied to services for substance misuse. The following CHAPTERs fill out the framework in more detail. These are then supplemented by more details about the application of information for commissioning.

CHAPTER 4

The Analysis Stage

THE ANALYSIS STAGE – GATHERING INTELLIGENCE



4.1 What Analysis is needed?

The analysis stage of the commissioning cycle involves the following activities, which will help you to establish the basis for your commissioning strategy:

- Clarifying the purpose and the strategic aims of the Commissioners, taking account of All-Wales and local priorities.
- Undertaking population needs analysis.
- Undertaking a market analysis, mapping existing and potential services, including contracting arrangements and the quality of services.
- Analysing the resource base for the commissioning strategy.

These activities are considered in turn below.

Once the preparation activities are complete, the project team will need to carry out or organise the investigation of: national guidance and best practice; population needs assessment; current and future services and costs. For all these activities the hypotheses can be useful as a starting point in identifying what information needs to be collected, and can help focus research on key issues within what could be a very wide field.

4.2 Purpose, Legislation and National Guidance

National research studies and best practice guidance on services can provide ideas about new ways of working. Later confusion and disagreement can also be avoided by ensuring that there are clear statements about key relevant legislation and national guidance pertaining to the commissioning agencies' abilities to act for the population – for example what services each is legally entitled to commission or provide, how they are allowed to be contracted, or what national targets are set for service delivery. The product from this stage should be an accurate analysis of joint and individual agency's responsibilities for people with learning disability. It should neither be a list of recent local and national publications nor vast tracts of national legislation or guidance cut and pasted together. Instead, the analysis should attempt to answer the following questions:

- What are the keys themes from national guidance and legislation?
- Can we identify new trends, technologies or treatments likely to impact on patterns of need, demand and costs?
- What does national research say about effective services for this client group and what examples of best practice sites and case studies are available?

4.3 Needs Assessment

A foundation of every commissioning strategy is an understanding of the current and future health and wellbeing needs of the local population.

The needs analysis stage of the commissioning cycle is concerned with ensuring that commissioning intentions are informed by an understanding of need in relation to the availability and quality of service provision.

As part of the project management process decisions need to be taken in identifying who is going to undertake the needs analysis involving data gathering, consultation, interviews, analysis of case examples, etc. Depending on local circumstances, it is worth considering appointing a project manager with analytical skills backed up by a small representative group (i.e. representing the stakeholders who can connect with their own networks. Depending on the precise nature of the needs analysis to be undertaken, it may well be an option to co-opt people with particular expertise (public health, pediatrics, housing research,

employment research, experts in working with people with complex needs etc.) Who is co-opted will depend on the range and depth of the analysis undertaken.

A fully comprehensive need analysis would cover each of the activities described below:

- Demographic analysis including public health analysis
- Findings from service users and carers' research and consultations
- Person Centred planning
- Consultation with providers

It is likely that some of this information has already been collected for Health Social Care and Well being Strategies.

An analysis of needs is important because:

- It can improve services for people with learning disabilities. The aim of the needs analysis is to identify patterns of need and thereby service changes which will improve the lives of people with learning disabilities
- It can help to make best use of money, services and people who can help. Needs analysis helps to prioritize the changes required to improve people's lives, and how best to target both existing and new resources.
- It can encourage an evidence based approach to analyzing need, including wider determinants such as housing, employment and education.
- It can advocate for vulnerable groups and encourages wider community involvement. By adopting an inclusive approach to needs analysis by building on consultation, interviews and case sampling, the results of the analysis are likely to gain greater ownership within the population of interest and the wider community.
- It can help to clarify some of the complexity surrounding need and provision. At its simplest, need and provision sometimes get confused. Hence the statement "he/she needs regular, meaningful activity during the day" (diagnostic need) sometimes gets translated into "he/she needs day care/ an ATC (prescriptive need) or similar. The starting point is diagnostic need and not prescriptive need. Otherwise historic patterns of service replicate themselves.

4.3.1 Demographic Analysis (see appendix 1)

The purpose of undertaking a demographic analysis is to estimate the level and location of need of people with learning disabilities across the population. The following types of data are needed:

- Population disaggregated by age, gender, ethnicity, location and mobility patterns

- Natural prevalence rates for learning disability disaggregated by age, gender, ethnicity and location

In order to establish the baseline estimate of the level and location of need, prevalence rates derived from research can be applied to population data. By comparing the prevalence of people in need of services, with numbers and types of service users actually known to be receiving services, it is possible to estimate some degree of unmet need,

Prevalence data can give a broad picture of numbers in particular categories of needs (e.g. numbers of people with severe learning disabilities, numbers of older carers, numbers of children in different age bands). See Appendix 1.

The population needs assessment will need to look at the overall needs of people with learning disabilities, not just existing service users, as well as likely future changes in demand. Demographic and epidemiological data relating to people with learning disabilities need to be analyzed to help predict likely needs. For example:

- Population projections and social care demand prevalence by age group, gender, ethnicity and location etc to identify potential future population need.
- Census and prevalence information complemented by information about the people who actually use services, their needs and demands.
- Patterns of demand compared over time, to consider trends, and benchmarked to consider whether there are major differences between geographical areas.

In 2005 SSIW commissioned work on 'How to undertake a needs analysis for commissioning services for people with learning disabilities'. In addition the CSSIW also commissioned work on defining the information required for commissioning services for people with learning disabilities. Full copies of these reports are available.

In developing a commissioning strategy for adults with learning disabilities commissioners need to understand future demand in terms of children with learning disabilities already known. No one in adult services should suddenly be surprised to find a half a dozen cases of people with complex needs requiring expensive care packages being transferred from children's services when they have been known to the authority for years.

Another way of beginning to think about needs analysis is to start with relevant evidence based on national/ UK studies which identify specific trends in need and then to test those out locally to:

- See whether they are relevant
- See whether any are real priorities
- Find out whether there are others

Such a list would include the following:

- Increased numbers of children surviving into adulthood with complex needs
- Increased numbers of children with challenging behaviours
- Critical need to ensure transition to adult service is handled well.
- Greater awareness of specific health problems amongst learning disability population
- General issue about under access to generic health/dental services
- Increasing longevity of people with learning disabilities and related health and support problems (e.g. early onset dementia)
- Number of older carers who cannot remain in a caring role (this will include caring for some people with a learning disability who are not currently in receipt of services)

4.3.2 Findings from User and Carer Research & Consultation

An important element in assessing need is to consider the relevant needs identified directly by those people who have used services and their family and carers. At this point in the commissioning cycle it may be helpful to consider existing national or local user and carer research or findings from recent local consultations with service users and carers.

The audit commission has provided useful guidance on community consultation. General guidance on involving people with learning disabilities and their families in the planning process are available from the Department of Health and the Community Care Development Centre. More specific guidance is also available on such issues as involving people with learning disabilities in meetings and developing successful materials for people with learning disabilities. Local authorities also have responsibility for consulting with users of housing and support services.

A key component of a consultation strategy will be to provide self advocates and their relatives with accessible information on the range of housing and support options that they may wish to consider. Information designed for self advocates has been produced by the Foundation for People with Learning Disabilities, BILD. Information for relatives has been produced by, among others the Foundation for People with Learning Disabilities, Mencap and Housing Options. This can be adapted for local use. It is important that such information is available to all carers, including carers from minority ethnic communities, carers who themselves may have learning disabilities and carers who themselves may have learning disabilities and carers who have difficulty reading written information.

Commissioners may also find it profitable to commission a detailed study of a sample of cases to reveal a more refined analysis of particular need areas.

Users and carers will need to contribute their views both about needs and also current services as part of the market analysis below. These need not be conducted as separate exercises.

4.3.3 Findings from Person Centred Planning

The views of users and carers should always be accessible through Person Centred Planning. One longstanding weakness of planning in health and social services has been a failure to aggregate information from individual plans and use it effectively for planning service development.

Commissioning will become more effective if we learn to bring together more effectively, the information from support plans, care plans and reviews. This will contribute to commissioning being based on what people are saying they want and need.

Care managers will also have an important contribution to make given their day to day experiences of assessment, care planning and review. Mechanisms need to be in place to capture their contribution.

4.3.4 Consultation with Service Providers

Service providers are able to draw on their day to day contact with service users and their carers, as well as their practical knowledge of what works well, to inform the needs analysis stage of the commissioning cycle. The perspective of managers and practitioners from provider agencies are a valuable element, and can be collected by:

- Meetings with individual service providers
- Service provider forums
- Focus groups
- Questionnaires.

Commissioners need to develop a framework for working with providers. The following are likely to further develop constructive relationships:

1. Local joint protocols on good practice in relationships – agreements might include frequency of meetings, attendance, agendas; fee setting timescales and processes.
2. Clarity about levels of engagement, to avoid inappropriate expectations and frustration, examples include:
 - Communication: activities involved in providing information.
 - Consultation: activities involved in securing ideas, suggestions, and feedback.
 - Negotiation: activities involved in securing agreement to commissioning decisions.
 - Participation: activities involved in working together to make commissioning decisions.

- Specific meetings between commissioners and providers agenda for 'blue sky' thinking to avoid constant reversion to the nitty-gritty of contract and price.
- Provider forums actively engaging and informing smaller organisations of what is going on, e.g., publishing minutes of meetings.
- Providers developing within their own organisation, or sector, specific representatives to engage with commissioners at a strategic level.
- Specific commissioner representatives with the role of liaison with providers.
- Provider contributions to Local Service Boards in Wales.

4.4 Market Analysis

In this element of the analysis stage of the commissioning cycle you are trying to get an overall picture of the current range and quality of services available to service users in your area. To do this a combination of four activities is useful:

- Mapping existing services for people with learning disabilities
- Mapping existing contract arrangements
- Analysing the quality of services
- Consulting with service users, families and carers.

4.4.1 Mapping existing services

Mapping existing services is an important element of strategic planning and you need to build up a picture, for example, of:

- Availability and location of current services across providers in both the statutory and independent sectors.
- Where are they located?.
- Accessibility of services – are there barriers to service access because of factors such as geographical location, opening times, building design or stigma attached to attendance
- Balance between public, private and voluntary services, and the range and scope of the different providers in the market.
- Range of services provided by each individual provider.
- What are the volumes of activity and cost of these services.
- How many people use what services, for how long and for what cost?
- How do similar services for similar clients compare in terms of demand, activity, costs and outcomes?
- Workforce – are there enough, sufficiently skilled staff available?

Ways of collecting this information include: gathering information via questionnaires; reviewing annual reports of service providers; holding meetings with groups of providers; and conducting interviews with individual

service managers. A number of these activities can be carried out in conjunction with the needs analysis activities described in above.

Market analysis can help commissioners understand provider intentions in terms of growth or disinvestment. Constructive engagement with service providers will help to determine current and future provider's interest in developing services in the area. It can also provide valuable insight into what is available for those using their own resources to buy services and where public sector support might strengthen or augment the agreement.

The approach to commissioning needs to consider how best to build robust and enduring relationships with service providers, but with sufficient flexibility to close or change services that are not delivering results. Annual funding anxieties do not promote the sort of investment in the workforce, or the quality and flexibility needed.

Providers need information on which to base investment decisions or funding cases.

Performance, activity and utilisation data about current services can be invaluable in helping understand whether services are well aligned with the needs of the population; the quality of services is good enough; services present good value for money; and if there are significant risks of service failure.

4.4.2 Mapping Existing Contract Arrangements

You also need to review existing contract arrangements, to help you to build up a picture of the capacity for change and development in services. You need to analyse existing contracts considering the following:

- What are the range and types of contracts in place?
- How long have these contracts been in place?
- How much spot purchasing is done?
- Are contracts - service, volume or outcome driven?
- What is the balance between the independent and statutory sector?

In addition to reviewing the contracts themselves, it is useful to get additional perspectives on their effectiveness by, for example:

- Interviewing providers to explore the extent to which they consider service demand actually reflects contracts.
- Interviewing contract managers to explore the extent to which they consider activity actually reflects contracts.

4.4.3 Analysing the Quality of Services

It is important that commissioners analyse the quality and effectiveness of the services that are provided to ensure that they are actually addressing the detailed needs of the service users and carers. Analysing service quality is

therefore a key element at this stage of the commissioning cycle, and it is important to ensure a degree of objectivity in your analysis. It is not always possible or advisable to analyse the quality of all aspects of services at one time – you will need to identify priorities. You may, for example, decide to concentrate on one of the following:

- Acceptability of services – do they meet user’s and carer’s requirements/are they satisfied with these services?
- Equity – is there any unwarranted exclusion of people to services as a result of policy or practice on, for example, race, gender or language?
- Efficiency – are there significant waiting times for services?
- Effectiveness – what are the outcomes of treatment or care?
- Appropriateness – what is the degree of alignment between the assessed needs of service users and the services actually provided?
- Coordination – do services provide effectively co-ordinated packages of care?

There are different approaches which can be used to undertake an analysis of service quality, the choice of which will depend on the aspects of the service you decide to focus on. The approach might include a combination of the following activities:

- Reviewing previous inspections of local services.
- Undertaking an audit of a relevant sample of cases and care plans to compare service user’s experiences with good practice standards.
- Reviewing the effectiveness of services provided in a selection of cases by interviewing the service user, carers and professionals involved.
- Analysing services delivered against the policy requirements.
- Reviewing compliments, complaints and serious incident reports.

Consultation with Service Users, Families and Carers

Engaging with service users, families and carers in reviewing services is one of the most valuable activities at this stage of commissioning but it can also be the most challenging. The purpose of consultation is to draw on the experience of users and carers and their views about the impact that the services they have received has had on their lives. It may be helpful to consider the following approaches to consultation with service users and their families:

- Joining regular meetings of existing networks / user support groups.
- Written consultation / questionnaires.
- One-to one or small group structured interviews, possibly undertaken by agency staff or service users.
- In-depth user-profile interviews.

- Running specific focus groups.

In certain circumstances methods for consultation with service users and carers will require medical ethics approval, and this may need to be checked with the Local Health Board.

4.5 Resources Analysis

In addition to the activities described above, at this stage you also need to consider the existing and potential resources available for services for people with a learning disability. To do this you need access to:

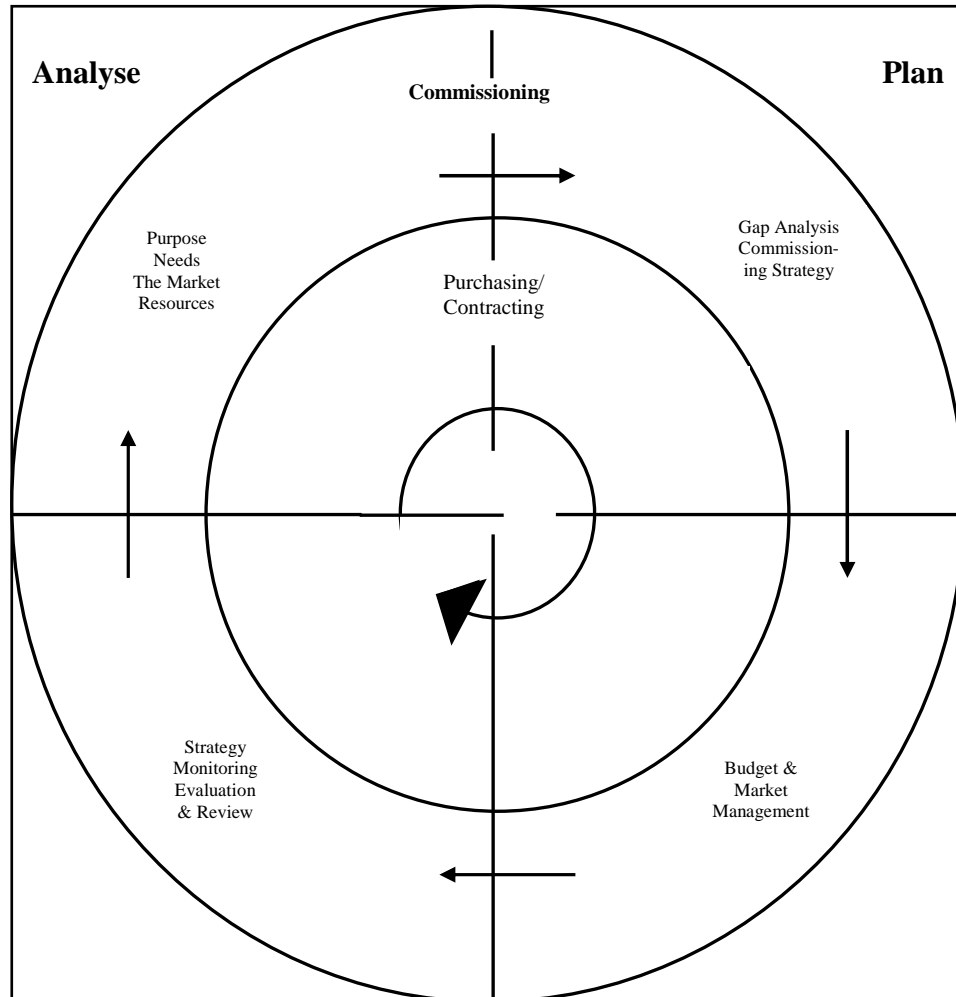
- The current and potential future budgets available for services for people with learning disabilities.
- A breakdown of how budgets are allocated.
- An analysis of how budgets are committed, and where they may be flexible in the future.
- A breakdown between capital and revenue spend.
- Information about the distribution of resources between different sectors, client groups and across the tiers of service provision.
- An analysis of the allocation of resources mapped against strategic priorities.
- Information about the existence of available resources in complimentary strategic initiatives such as, for example, Supporting People, the NHS Estates Strategy, or the investment plans of national voluntary sector organisations.
- Details of the balance between core and grant funding including an analysis of the risks attached to reliance on short-term funding.
- The availability of matched funding schemes and what internal resources would need to be made available.
- The future capital needs for learning disability service developments.
- Areas where future savings or investment might be made

4.6 Structuring the Information to facilitate analysis

In order to be useful and useable, information will need to be collected in ways which are consistent and sustainable. In order for that to happen, broad needs categories or domains need to be agreed, as a first step in the process. These may include accommodation and support, daytime occupation and employment, health, etc, Information to support the analysis is included in more detail in **Appendix 2**. These examples of information should be used flexibly. They may be adapted locally depending on the configuration of services. Some commissioners may have better examples which can be shared with others.

CHAPTER 5

THE PLANNING STAGE – DEVELOPING THE COMMISSIONING STRATEGY



5.1 INTRODUCTION

You should now have all the information that you need to develop your commissioning strategy using the information obtained from your needs, market and resource analysis. You should be in a position to develop a strategy document, by undertaking the following activities:

- Gap Analysis.
- Strategic Commissioning Intentions.
- Producing the Commissioning Strategy.

These activities are considered in the sections below.

5.2 GAP ANALYSIS

You need to carry out a gap analysis involving the following activities to establish gaps between identified needs (obtained from your needs analysis) and existing provision (obtained from your market analysis).

- Review the data you have collected in your needs analysis stage about the nature, extent and location of service need.
- Review the data you have collected in your market analysis about the extent to which services currently meet those needs and are likely to meet them in the future.
- Reflect on the sections on outcomes to stimulate questions.
- Review quality and consultation data about what sorts of services are most effective and efficient, and whether these types of services are currently being delivered.
- Complete a list of identified gaps across the tiers of service provision and across the client groups. In doing this you should consider:

Are there any gaps in particular types of services?

Is there an absence of service within a particular community?

Are some services weak or of poor quality?

Are some services in inappropriate locations or inaccessible?

Is there an over-provision of particular services?

Is there an over-provision of services within particular communities?

Is the funding for particular services sustainable?

Having identified the gaps in service provision you may wish to assess the risk that these service gaps pose to the achievement of national and local objectives that were identified in the first stage of the commissioning cycle.

A gap analysis template is a very helpful way of drawing together the information gathered in the previous stages. An example gap analysis template that could be used as the basis for consultation is shown below. The template can be gradually populated from left to right, with the rationale for the proposed service developments completed with the evidence gathered during the analysis activities, and the commissioning implications developed from the consultation activities. In this way the thinking behind commissioning objectives can be shared with stakeholders as it is developed.

Gap Analysis Template

Strategic Objective	The Gap - Service Developments	Rationale	Commissioning Implications
<p>Describes the overall outcomes intended for the population.</p> <p>7-8 maximum.</p> <p>Derived from the organisation purpose, legislation, national guidance.</p> <p>5-10 years timescales.</p>	<p>Specific service developments needed to meet strategic objectives.</p> <p>Based on hypotheses accepted on the basis of evidence collected.</p> <p>Which patients/service users the service developments are for.</p> <p>Where the services are needed.</p> <p>2-3 year timescales</p>	<p>Why the service developments are needed, based on guidance, research, needs, service and market analysis.</p> <p>Why existing arrangements will not meet user/ carers needs in the future.</p>	<p>Disinvestment/ decommissioning, remodelling or renegotiation required.</p> <p>Procuring and contracting with providers.</p> <p>Redistribution of resources required.</p> <p>Interim/transition costs.</p>

Some key proposed changes might need to be explored in more detail at this stage, to ensure that they are feasible and likely to deliver the outcomes which are intended for service users. Service modelling and design activities can be useful at this point. Once potential new or reconfigured services have been agreed as valuable, they need to be tested to ensure that they will actually meet the needs of service users and will not have unintended negative consequences on the overall whole system of service provision.

5.3 PRIORITISATION AND STRATEGIC COMMISSIONING INTENTIONS

Having carried out your assessment of gaps in service provision you are now in a position to move on to identify how the current configuration of services needs to be changed. This is a key element in the development of the commissioning strategy. Your intentions may include, for example:

- Continuing to invest in existing services.
- Disinvesting or de-commissioning in certain existing services.
- Commissioning new services.
- Re-configuring existing services.

In carrying out this process you will need to consider the existing commitments you have, and the service and legal implications of ending or revising existing contractual arrangements.

An Option Appraisal could be undertaken taking needs as starting point – examining the advantages/ disadvantages of each option, the risks involved, the costs, including opportunity costs; testing out options with users and carers and exploring new models / partnerships.

5.4 PRODUCING THE COMMISSIONING STRATEGY

At this point you need to:

- Write your strategy.
- Consult on the strategy with all stakeholders. Reference to good practice in working with providers is included below.
- Obtain the endorsement of the relevant commissioning agencies through their decision-making structures.
- Obtain formal agreement of agencies committing resources to the strategy through their budget processes.
- Inform existing providers of the future commissioning intentions.
- Publish the document.
- Writing your strategy is the point at which all of your work so far is drawn together into a succinct analysis

A comprehensive commissioning strategy will usually comprise a combination of the following:

- An analysis of relevant legislation, national guidance, research and good practice on services to meet the needs of people with learning disabilities.
- A population needs assessment.
- An analysis of current and potential services and resources, and the extent to which they are likely to meet future needs.
- A statement about the strengths and limitations of current services, the changes needed, and some detail about the types of services

which will be commissioned, and the types which will not be commissioned in future.

- Plans to monitor and review the impact of the strategy upon the range and quality of services delivered, and upon the outcomes for people with learning disabilities.

The strategy should outline service changes and have a clear rationale behind them and detailed analysis of the resource and service implications. It should also have addressed the hypotheses put forward at the beginning of the project.

Clear plans need to be in place to manage de-commissioning of services and to plan for the failure of a provider. The first process is essential if resources are to re-directed. The second is part of risk management, and of operating with and in both the commercial and voluntary sectors.

A commissioning strategy does not necessarily include details of budgets or planned contracts, as, by its nature it needs to offer a long-term, wide ranging overview of commissioning intentions rather than detailed plans for changes in price or volume in contracts. However, if a strategy is to influence service plans and contracts, implementation plans need to be developed to ensure that the strategy is actually delivered. It is helpful if the commissioning strategy is complemented by:

- A purchasing plan – identifying, for each service development, details of how commissioners intend to allocate resources, and what specifically they expect to be delivered for those resources.
- A market development plan – identifying what commissioners intend to do to ensure that services are specified, tendered, and contracted appropriately, including being clear about what services will not be subject to competition, and why.

These plans should be specific enough to give a clear steer to those responsible for individual contracts, SLAs and for grants to Third Sector organisations about the priorities they should concentrate on and the approach they should take, as well as giving clear direction to what providers within public agencies should be including in their service and business plans.

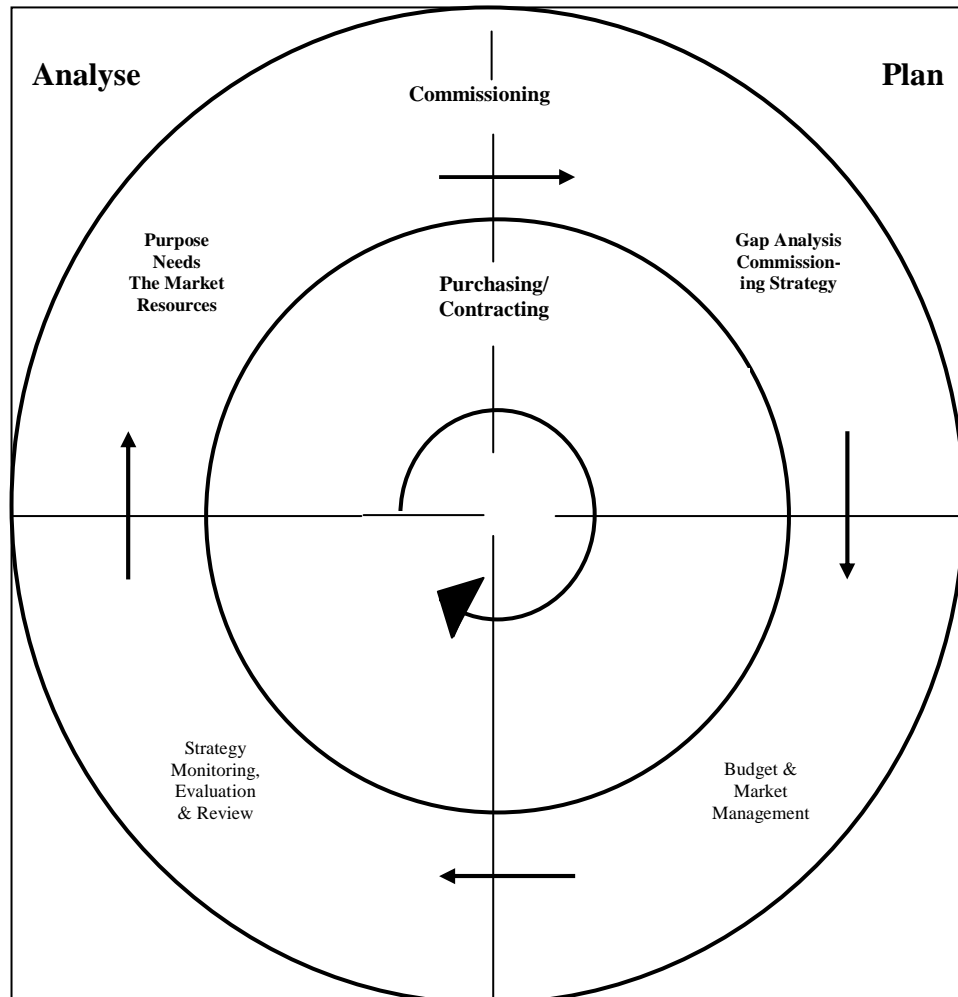
Activities that help to implement the commissioning strategy include market development, purchasing and contracting arrangements, and the development of strategic partnerships. Moreover, commissioners will need to build a market and develop enough opportunities for different providers to ensure genuine choice for service users if they are to implement government policy.

In working with providers the following are likely to further develop constructive relationships:

- ❖ Commissioning intentions that signal new market directions clearly, so that providers can see business opportunities; rather than this being lost in large strategies.
- ❖ Providers raising their own profile; being proactive in sharing business plans and discussing how to deliver with commissioners.
- ❖ Providers reassessing their own businesses – are we able to compete effectively in the new markets? If not why, and how are we going to change systems so that we can?
- ❖ Commissioners undertaking further training to improve expertise in around the different elements of their role, possibly through the introduction of the National Occupational Standards in Commissioning and Procurement. Training could include the following areas:
 - The expanding role and importance of commissioning.
 - Training in market intelligence, dialogue and shaping.
 - Basic to advanced business training and associated skills.

CHAPTER 6

THE DOING STAGE – MANAGING THE MARKET



6.1 INTRODUCTION

The next stage of the commissioning cycle deals with the day-to-day tasks of market management, particularly developing the range of services you have identified you need in your strategy. Market management is the element in the commissioning cycle where you shape and influence services to best meet the needs of people with Learning Disabilities. This stage includes the following elements:

- Managing service balance.
- Processes for specifying services.
- Processes for selecting service providers.
- Processes for contracting.
- Ensuring quality.

6.2 MANAGING SERVICE BALANCE

It is important for commissioners to influence the market on a day-to-day basis in ways that meet the needs of their client groups and help achieve the aims of the commissioning strategy. One way of clarifying the balance you are looking to achieve is to complete a statement informed by your strategy that identifies how you will address the following areas:

- The mix of providers: ensuring that there is a mix of service providers to ensure the range of needs identified in the needs assessment are adequately catered for, and that services are viable and sustainable in the long term.
- Degree of competition: competition between service providers which may help to ensure value for money.
- Degree of choice: ideally, service users, their families and carers should have a choice of services in order to select the service which best meets their needs.
- Incentives for providers: commissioners should attempt to create incentives for new providers to enter the market or existing providers to offer new services.
- Joint commissioning: the extent to which pooling resources between commissioners can be cost effective.

You will then need to undertake activities to achieve any changes you require in the service balance. Some aspects you will need to consider include:

- Re-configuring existing services – you will need to explore the extent to which existing providers have the capacity or desire to revise their services, and whether required changes could be successfully implemented.
- Investing further in existing services – this is often seen as the most straightforward of options, but careful consideration needs to be given to ensuring that additional benefits are likely to be gained from further investment.
- De-commissioning services – although often difficult and controversial, de-commissioning is a crucial option for commissioners requiring resources to develop new services. It is sometimes appropriate to end existing contracts or service level agreements, particularly where an existing service is not meeting the needs of the population, and appears unlikely to be able to do so. However careful consideration should be given to: identifying those areas which need to be de-commissioned as part of the overall commissioning strategy; agreeing the objectives of de-commissioning with all of the relevant decision makers from the commissioning partners; and developing exit strategies that seek to minimise the impact on existing service users.

- Commissioning new services – you may need, for example, to identify service providers elsewhere in the UK, and what opportunities there might be to work with them or existing local providers to develop new services.
- Capacity building and market development activities in constrained markets – proactively supporting providers to develop their services in line with the commissioning strategy.

Some examples of market development and capacity building activities include:

- Improving communications with and from providers – develop a communications plan, publish procurement strategies and processes e.g. on a procurement website.
- Publishing and distributing a forward procurement plan to give providers information about tender opportunities in good time.
- Run procurement ‘Open days’ or ‘meet the buyer’ events and appoint named officers linked to these events.
- Producing guidance on ‘How to do business with the Local Authority/LHB’.
- Capacity building activities, such as training in writing tenders or finding sources of business development funding.
- Shared information or intelligence about providers e.g. via a shared database.
- Market sounding exercises such as surveys, workshops, focus groups, interviews or consultations on strategies and procedures.
- Negotiating incentives (proportional, transparent and time limited) to encourage providers to enter new markets or to improve quality standards e.g. advance payment, extending the contract term, providing pump priming loans (or staff resources) to start up a service, reducing the capital investment required from the provider, paying a supplement to the tariff or quality bonus schemes.

Commissioners may need to work with local providers to develop their capacity to deliver services. For example, appointing a market development manager to:

- get to know the market and the players within it;
- be a named contact for enquires from potential providers and;
- Offer training to potential providers, outside of any particular tender, to enable them to improve tenders.

The concept of commissioners ‘selling’ themselves as reliable, constructive, attractive trading partners in this way may be new, and will require skills in advertising, communications and public relations management. Commissioners will also need to undertake ‘market soundings’, to assess the reaction of the market – in terms of feasibility, capacity and maturity - to a proposed service or procurement approach.

Purchasing and contracting are essential mechanisms to be able to influence the market. LHBs and local authorities will be purchasing services for some time to come, and commissioners should ensure that their purchasing arrangements reflect good practice and do not hinder the expansion of individual and locality based commissioning.

Further guidance on good practice in procurement is available on the Value Wales Route planner www.buy4wales.co.uk/prp

In Learning Disability services, many independent sector providers operate across areas and contract with more than one commissioner. Commissioners should take advantage of the opportunity this presents to share information with one another and develop common or 'lead' monitoring requirements. In this context standardised documentation and procurement processes will make the provision and sharing of information easier for all concerned and reduce transaction costs.

More formal 'strategic partnerships' are increasingly being used to scope long-term relationships with other commissioners, via public sector consortia, and providers via joint ventures with the statutory or independent sector.

It is envisaged that strategic partnerships will provide access to new skills, resources and ways of working, and will promote innovation in the pursuit of difficult and long term goals. Partnerships are particularly useful for situations where activities are beyond the capacity of one commissioner. The aim of strategic partnerships is to share risks to encourage different approaches to service delivery. Strategic partnerships include:

- Commissioning Consortia and Joint Commissioning Teams. For example, a joint commissioning team that reports to a joint commissioning board, which has delegated responsibility for budgets pooled under a Section 33 Agreement. Team tasks could include transactional contracting as well as strategic responsibilities such as planning, service development and performance monitoring.
- Long-term contracts for change. For example, a local authority and LHB have with a contract with a provider for 10 years which commits both sides to a reduction in registered care and an increase in supported living and extra care housing provision for people with learning disabilities. The shared objective of both the commissioners and the provider is to construct a long-term contractual framework that would share risk and both support and allow for significant service change and development in the future.
- Strategic Service Delivery Partnerships (SSDP). The objective of a SSDP is to identify a partner(s) to develop services to deliver required outcomes that provide value for money. The emphasis is on using provider expertise and adopting a partnering approach rather than specifying a type and quantity of service to be provided.

There is the opportunity to develop a flexible approach to service delivery options through soft market testing, which is likely to lead to more innovation and creativity. A key feature is the establishment of a formal partnership - as opposed to a traditional contractor/supplier relationship – within which a rigorous procurement process can still be applied.

6.4 ARRANGEMENTS FOR SPECIFYING SERVICES

Service specifications describe the nature and extent of the service you wish to purchase and they can be structured in different ways. They focus on the outputs and outcomes you want the service to achieve but can have varying levels of detail.

It may be helpful to clarify that:

- inputs = resources used to produce services;
- processes = systems and activities used to produce services
- outputs = services produced
- outcomes= the intended impact upon service users

Commissioners should develop or review a service specification for each of the services identified in the commissioning strategy. Commissioners may need to ensure that:

- Specifications will reflect identified needs.
- Specifications will define the people for whom that service should be provided.
- Specifications will describe the purpose and parameters of the service.
- Specifications will meet commissioning strategy objectives.
- Specifications will include specific locally agreed principles and values.
- Specification will include expectations in relation to staffing levels, training, qualification and experience.
- Specifications will set standards to which the service should be delivered.
- Specifications will comply with local or national service standards and guidance.
- Specifications will include a standardised range of output and outcome measures.
- Specifications will describe the monitoring arrangements to determine whether or not all the requirements are being met.
- Specifications have a requirement that the provider has, and keeps, registration and abides by the regulations taking National Minimum Standards into account and providing the services set out in their own statement of purpose.
- Specifications are sufficiently detailed to ensure that providers can deliver a tender that meets your requirements
- Specifications list possible key performance indicators to be used in contract.

- Specifications identify delivery requirements, including eligibility criteria and access to services, networks and links
- Specifications list the management information required and the frequency that you require the information to be provided
- Specifications focus on what to be delivered not how. The onus will be on the providers to explain how they intend to deliver the service.

Checklist:

Does the specification define:

- Purpose and objectives of the service
- Values and Working Principles
- Safe and proper conduct
- Quality
- Equality of treatment/ outcome

Are they

- Acceptable to users
- Non- discriminatory
- As clear and simple as possible
- Achievable
- Measurable or observable
- As parsimonious as possible

Does it say?

- Who?
- Does what? (and what must be done?)
- With/ for/ to whom?
- With / for/ to whom?
- Where and when?
- To what standards?
- Using what methods/ equipment?
- With what attitude? How demonstrated?
- To what ends?
- What records must be kept?
- Who must be told about which information/events?

Neil Thomas Service Specifications and Contracts INLOGOV

Contracts and specifications should be based on fundamental principles (CSIP A Guide to Fairer Contracting Part 2 Service Specifications).

- Efficiency: enabling commissioners to achieve quality services at value for money
- Sustainability: embodying a general approach to a proper working relationship which fosters sustainable, long term provision (where appropriate) in the interests of service users.
- Proportionality: achieving what is necessary or highly desirable in the simplest possible way.

- Suitability: reflecting the service that is required and the actual agreement between parties.
- Simplicity: Plain English wherever possible, with clear expectations of jargon.
- Fairness: Reflecting a fair and proper balance between commissioner and provider, with risk properly allocated.

Commissioners will need to ensure that the proposed arrangements are clear and agreed by all partners.

The Commissioner may involve a range of stakeholders in the development of specifications. Commissioning partners will need to ensure that that it is likely to deliver joint outcomes, and to dovetail appropriately with the services for which they are directly responsible.

Service users should also have an active role in specifying preferences in the way their care is delivered. Commissioners should be clear themselves, and with participants, on the objectives of service user involvement and the influence it will have.

Existing providers and / or potential providers through open forums and through structured and clearly documented engagement can provide useful information and insight whilst developing specifications. The final specification has to be determined by the commissioner.

6.5 PROCESSES FOR SELECTING SERVICE PROVIDERS

This element is concerned with determining processes that will ensure the most appropriate providers are selected to deliver good quality services that offer the best value for money. Commissioning partners need to agree:

- Which agency is going to lead the tendering process?
- How tenders are to be evaluated against specified criteria.
- How risk assessments regarding the viability of provider organisations are to be undertaken.

Commissioners may want to benefit from grouping services into fewer, larger contracts to be tendered. Potential benefits include economies of scale, less administration and a more manageable number of supplier relationships.

But there disadvantages too. Fewer suppliers may lead to market dominance of a single or small number of providers and less competitive market place. Larger contracts may also pose significant barriers to smaller providers. That in turn may mean missing out on the innovation smaller providers can offer.

6.6 ARRANGEMENTS FOR CONTRACTING

Commissioners will need to make formal arrangements for contracting which are agreed by the partners. They will need to be legal and acceptable to all members and realistically designed to meet the size and nature of the services involved. Partners need to be aware that this may be a lengthy process which may take 3-6 months. Some of the issues which will need to be agreed by the partner agencies will include:

- Which agency is to be the lead agency for contracting services?
- Whether a contract manager is required for larger contracts, who this should be and if resources need to be allocated for this.
- Type of contracts to be used e.g. block, spot, cost and/or volume.
- The format for contract conditions/clauses, including for example: the contract period and timescale; recording and reviewing arrangements; specific expectations of the provider, such as health and safety, confidentiality, insurance etc; options for variations/extensions; dispute resolution; termination or suspension.

6.7 ENSURING QUALITY

In addition to the arrangements for setting and managing contracts, commissioners need to develop quality assurance criteria that can be included in contracts. Quality assurance criteria might include the following:

- Expectations about how providers will minimise barriers to accessing services.
- Expectations about how providers will ensure service users are not excluded on the basis of race, gender, disability etc.
- Expectations about provider inputs into the single assessment process, integrated care pathways, care planning and review and/or care co-ordination.
- Expectations about the type of outputs and outcomes providers are expected to report to demonstrate the extent to which their service is achieving its objectives.
- Expectations about how providers will demonstrate that their service is cost effective and represents best value.
- Expectations about levels of training and qualifications of staff employed by providers.
- Expectations about how providers will ensure that national and local standards are met constantly.

It may be helpful to set up a team of commissioners and service providers to develop quality assurance criteria. A seemingly simple term such as 'accessibility,' for example, could entail a number of factors such as:

- Is the service available at times and in locations that would suit the client group?

- Does the service have an appropriate physical environment?
- Do service providers have access to Welsh-speaking staff? Is the service able to deliver the service through the medium of Welsh?
- Does the provider have regard to diversity, within its staff group?
- Can clients self-refer or do they need to be referred by an agency?

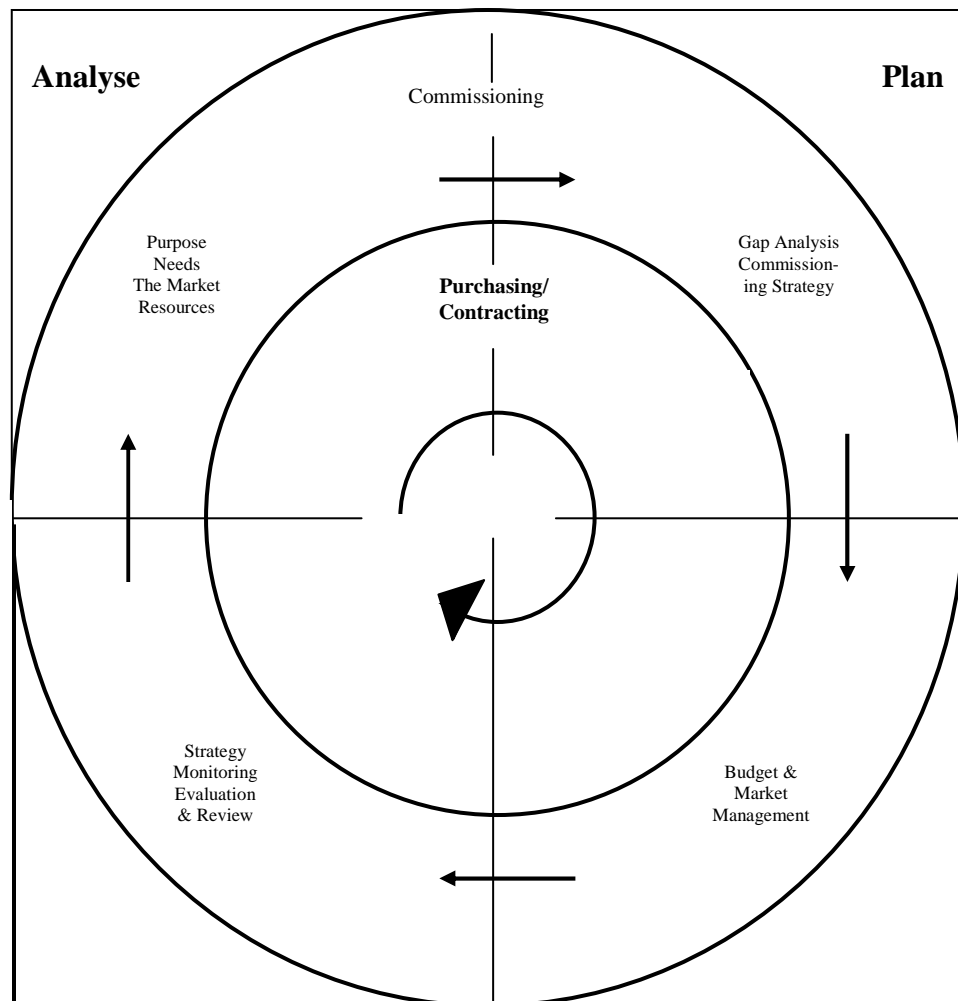
The following are likely to further develop constructive relationships between commissioners and providers:

- ❖ Meetings set aside to discuss what is going well with the contract, not just meeting when there are problems.
- ❖ Clear communication mechanisms for early identification and addressing of problems.
- ❖ Joint development of agreed mechanisms for measuring contract outcomes.
- ❖ Monitoring systems and data requirements proportionate to, e.g. the level of risk, size of the contract and past performance.
- ❖ Making the best use of providers own quality assurance systems and monitoring what matters – how far outcomes are being achieved.
- ❖ Agreed protocols on intervention with underperforming providers such as Corrective Action Plan; working together to improve performance.
- ❖ Clarity in contracts about any situations in which the commissioner would have power to employ sanctions such as withholding payment.

GOOD PRACTICE: Liaison Officers - Denbighshire introduced care brokers into domiciliary services 18 months ago. This has greatly improved communication between the department and independent sector providers who have one point of contact in order to discuss and iron out any service issues.

CHAPTER 7

THE REVIEW STAGE – STRATEGY MONITORING, EVALUATION AND REVIEW



7.1 INTRODUCTION

This final stage of the commissioning cycle is concerned with monitoring, evaluating and reviewing the commissioning strategy and its impact, to determine whether the strategic objectives of the strategy are being met, the effectiveness of the services being commissioned and the impact of the commissioning strategy on the outcomes for service users.

HOW WILL PROGRESS ON THE STRATEGY BE REVIEWED?

It will be helpful to decide at an early stage how the implementation of the strategy will be monitored and reviewed, and a plan, which includes the following, is recommended:

- A set of measures or indicators which, if collected and analysed regularly, will allow the commissioners to monitor activity, performance and impact of the services commissioned.

- A framework which ensures that regular review meetings are held to analyse progress against commissioning objectives using the measures identified above, consider changes in the environment, and agree any changes to objectives or action plans or resources.
- A format which allows the opportunity for commissioners, providers and other stakeholders, to contribute to the analysis of progress.
- Contracts, Service Level Agreements and grants with providers that ensure they will collect the service activity and performance data necessary to enable effective monitoring to take place.

The LDIAG has previously recommended that partners should report on achievement against the service objectives and performance indicators/ milestones, and reflect users' views of the services provided.

7.2 MONITORING

Monitoring activities should allow the partners to regularly ask questions about the services it is commissioning, such as the following:

- How are services performing against the agreed specification?
Are services meeting assessed need?
- Are services being provided, to the required standard?
- How much do they cost and are they providing value for money?
- Are appropriate services being commissioned?
- To what extent are services meeting commissioning objectives?
- What are the views of service providers, service users, stakeholders and the wider public about the effectiveness of services?
- Are outcomes being achieved? Set measurable outcomes for service users

And about the effectiveness of the strategy itself, such as:

- Are the gaps in service need being met?
- Do commissioning priorities need to be changed?
- Do services need to be commissioned differently?
- Is there a need to review and reconfigure existing services?

Commissioners will need to consider:

- Whether a core data set, to be collected by all service providers, is needed.
- What areas a core data set would cover, including for example, activity and performance, finance or user outcome information.
- What reporting arrangements you will require from each service provider. For example you might require a quarterly submission of data from each provider.
- How reliable you expect the data to be, and what data quality audit arrangements you need, to be able to check that data is reliable.

- How you will collate and analyse the data from the different providers.
- What other information relevant to the strategy you need to review.

The local authority has a responsibility to ensure that the needs of, and outcomes for, their specific users, and potentially of self funders and DP recipients are actually met. Also to obtain value for money, for taxpayers in services purchased or commissioned.

The associated interests of the local authority will be to ensure that:

- The amount of service being paid for is the amount that is being delivered
- The service users for whom the local authority paying, either directly or indirectly or via DP are satisfied with the quality of service that they are receiving.
- Individual service user's outcomes as set out in their care plans are being met.
- Services do not simply stand still, but demonstrate development and improvement.

Monitoring to ascertain progress on the last point can be about supporting provider to improve performance within the terms of the contract, about assessing whether provider is achieving performance that would attract an enhanced rate, or about working with the provider to develop capacity to deliver services in new ways, e.g. reconfiguring services to respond to research findings about effectiveness.

Monitoring should also impact on policy development and future commissioning plans and the results of monitoring should always be made available to commissioning bodies to facilitate this.

Commissioners will need to have systems in place to collate intelligence from contract monitoring, complaints/ compliments, care plan reviews with national inspection reports and draw on provider's own quality assurance systems. This is essential to address problems at the earliest possible stage.

Relationship with CSSIW

The CSSIW register, regulate and inspect for the capacity to meet needs and provide a quality service alongside its statutory duty of improving the quality of social care services.

CSSIW's role is to contribute to achieving the Welsh Assembly Government's statutory obligations and safeguard those people who use care services. CSSIW does this by:

- Registration – deciding who can provide services
- Inspecting services and publishing reports of each inspection
- Dealing with complaints
- Supporting compliance with the regulations taking, where necessary, enforcement actions to make sure that regulation are met
- Reporting on the quality and health of services regulated on an All Wales basis and how that regulation is carried out.

CSSIW ensures that commissioners of services are informed of the outcomes of regulation and six monthly meetings are held between Regional Directors and Directors of Social Services and with Local Health Board Chief Executives.

CSSIW does not commission or undertake placement monitoring or review under either the care management or local agency contracting process.

Contract Management

Contract Management is the process that ensures both parties meet their respective obligations as effectively and efficiently as possible. This means that they can deliver the contract's business and operational objectives and also provide value for money.

To assess a provider's overall performance against the contract, you will need to consider:

- Whether the quality of service delivery is satisfactory
- Whether the quality of service delivery has improved as expected
- Overall performance against performance indicators
- Relationships – whether the provider is co-operative and proactive
- Service user satisfaction
- Cost of service – whether the expected savings have been realised
- Whether the service still represents value for money, particularly in relation to services procured more recently.

These factors will help you decide whether to extend the contract or undertake a new procurement process. The contract review needs to take place in time to allow a full procurement process – including contract award and transition arrangements – before the current contract expires.

7.3 EVALUATION AND REVIEW

To complement the ongoing monitoring arrangements it will be important for partners to establish formal mechanisms to evaluate the information collected, to inform periodic reviews of commissioned services and the performance of the strategy as a whole. By evaluating and reviewing the services you are commissioning, you are kept informed of the arrangements that you have put in place. Things that you may wish to consider are:

- Establishing a strategy review group comprising, for example commissioners, service providers and service users.
- Agreeing terms of reference for the review group to use to consider activity, performance and outcomes for service users and its implications.
- Agreeing regular points in the year where data will be collected and analysed.
- Agreeing how performance problems identified by the monitoring information will be addressed by the partners.
- Agreeing how recommendations from the group about changes to commissioning priorities and consequent reviews of resource allocation will be considered and formally adopted by the partners.
- Considering how national policy and legislation impact on commissioning priorities.

For the purposes of reviewing commissioning strategies, quarterly reports to inform reviews would seem the most pragmatic approach and would allow partnerships and providers to use the information contained in the new database to its fullest potential.

CHAPTER 8

Workforce

8.1 Introduction

Workforce development is defined as all those activities which have an impact on the competence, knowledge, skills, attitudes, and self awareness of people in carrying out their responsibilities.

Workforce planning is a planned, strategic approach to meeting current and future workforce needs. It is a continuous activity that should be fully integrated into the business planning process.

The development of any commissioning strategy has important workforce implications. The development of the workforce involved in supporting adults with learning disabilities is the key link with plans to deliver improved quality for services for adults with learning disabilities.

For services to be able to deliver proper person centred outcomes there will need to be a co-ordinated approach to workforce planning. Decisions need to be taken with regard to the size and composition of the workforce. Workforce developments need to respond to the needs of users and carers. Training should reflect the needs and life aspirations of the people that staff is supporting.

Commissioners and providers will need to meet the challenge of creating a workforce which is:

- Competent to meet the needs of users and carers
- Available in the required number and skill mix
- Able to promote choice and control and independent styles of care.
- Trained within a framework of national occupational standards (NOS)
- Committed to lifelong learning and with clear career pathways identified.

Commissioning partners need to decide on how they develop a coherent approach to workforce issues. Where services are developed by agencies in isolation of each other they may well end up competing and undermining each other in relation to workforce development. Local commissioners need to develop a coherent joint approach to workforce development. They need to create the capacity for change beyond organisational boundaries. All key stakeholders need to be involved.

Workforce planning requires a range of activities to take place including:

- A snapshot of the current workforce and associated issues
- An understanding of needs
- The opportunity to look into the future at service delivery and corporate development to assess the impact that this will have on the organisation and the skills people will need
- Information on the labour market and how this will effect service delivery

In essence this will allow the partnership and its member organisations to consider

- Where are we now?
- Where are we going to?
- What do we need to ensure success?

The gap analysis stage is critical and has to be informed by information that is appropriate accurate and timely.

- Are there existing recruitment, retention and training strategies in place?
- Are existing workforce strategies joined up?
- Has any analysis of the workforce been undertaken; including staff turnover rates?
- Are there plans to integrate the workforce between partners?

What formal mechanisms exist to discuss workforce development in relation to services for people with learning disabilities? There may be regional partnerships involving local authorities but do these include stakeholders from the NHS and independent sector?

If formal mechanisms are in place, who are the members? Local Authority (education, social services, supporting people, NHS. Independent sector, further education, careers, etc).

Where there are formal partnership arrangements in place (section 33 agreements) formal governance arrangements are essential (see Care Services Improvement Partnership; Integrated Care Network; 'Bringing the NHS and Local Government Together Integrating the Workforce: A Guide').

This guide notes the benefits of integrated workforce planning. Integrated workforce plans can variously extend between commissioner and provider roles and across partnerships. They can include some or all of:

- Built around peoples needs as identified in joint commissioning strategies
- Linked to profile of how those needs are envisaged to change over planning period.

- The number and job roles of the workers, their skills, competencies and ways of working that will be required to meet those needs
- Integrated with service and financial planning
- Responsive to service changes and developments
- Supportive of multi-disciplinary learning, development and working
- Properly supported by management information systems the subject of a realistic implementation programme.

This will help partners to:

- Know the range of information about the employees they have and what will be needed in the future.
- Managing employment expenditure by anticipating changes
- Ensure that sufficient and appropriate training and development is provided.
- Cope with peaks and troughs in supply and demand for different skills.
- Deliver improved services by linking business strategy to people plans
- Retain employees and identify longer term workplace accommodation requirements.
- Identify current staffing provision mapped to current services.
- Work in conjunction with managers and service specialists to identify current and future workforce needs
- Forecast demand and supply issues
- Analyse current workforce and labour market trends and develop appropriate strategies and plans to manage workforce issues.
- Make effective links between business plans, the human resource strategies and workforce plans required to deliver effective human resource support services.
- Put in place a strategy for plugging skill gaps, taking full account of future business and service plans, linked to current and future skill issues, long term employment markets, relocation strategies and succession planning based upon staff retiring and turnover rates.
- Define how strategy will support performance and drive performance improvement and cross organisational development
- Identify the specifics which the strategies and plans will address
- Implement their plans to target.

Training sometimes only focuses on basic technical issues such as lifting and manual handling. Core training will usually involve Health and Safety awareness, Moving and Handling, Fire Safety, Food Hygiene, administration of medication, risk assessment and first aid. Although these issues are important, equally so is the training that promotes an understanding of person centred planning, advocacy and rights, working with family carers and community inclusion.

Additional training should be designed around the individual, for example, covering specific health conditions, culturally appropriate support, autism and communication techniques as appropriate.

Good staff training often involves people with learning disabilities and family carers as paid trainers.

The workforce includes all the people who support people with learning disabilities and they include:

- Support staff and their managers in all agencies (SSD, the NHS and commissioned services in the private and not for profit sectors.
- Specialist and clinical staff
- Senior managers and commissioners. Managers are frequently involved with client support. As such they act as professional role models.
- People who work with people with a learning disability in generic services such as GPs, teachers, etc. This will be particularly important if we want to improve access to mainstream services.
- Volunteers and carers. The role of volunteers and carers is extremely valuable.

The Care Standards Act has introduced targets for all staff within the sector to be involved in training to achieve formal qualifications. The intention should be to develop a workforce which meets minimum standards of competence.

Qualifications will need to be accredited within the NVQ framework.

Finally, there are opportunities to use social clauses to encourage providers to set up apprenticeships or provide opportunities for unemployed people and encourage workforce development within the contracting process.

Workforce Profile

It may be helpful to develop a workforce profile. Commissioners could ask providers to complete an updated version of the workforce information template previously used by the Care Council for Wales. This included information regarding name, DOB, gender, ethnic origin, languages, job title, role, service setting, statutory/private/ voluntary sector, nature of contract – permanent, temporary, and training and qualifications attained or working towards. Qualifications are listed in the Qualifications Framework produced by the Care Council for Wales.

As listed above the workforce can be made up of the following:

Staff Groups	
Assessment staff	Provider Staff
Care Managers ____ Numbers ____ Care manager assistants	Team Leaders Residential Managers Residential Staff Day Service Managers Day Service Staff Care Staff Employment Services staff Job coaches Community Support Managers Support workers Drivers/Escorts Catering Staff Domestic Staff
Health Professional Groups	Managerial and Administrative staff
Psychiatrists Psychologists Community LD Nurses Speech Therapists Occupational Therapists Physiotherapists	All managerial staff Commissioning and contract Officers Support services Assistants

Table 8:1

Table 8:2

Total Workforce working exclusively with people with learning disabilities:

- (a) Social Services _____
- (b) NHS _____
- (c) Independent Sector _____

Table 8:3

Qualifications

Range of Services		
	No. of staff employed	% with appropriate qualification
Assessment & Care Management		
Residential Care		
Supported Living		
Respite Care		
Day Care		
Supported Employment		

These figures can be broken down to each service provider.

Table 8:4

XXXX DAY CARE SERVICE					
	Age	Male	Female	Years working / Learning Disabilities	Qualifications
Manager					
Senior Care worker					
Care worker					
Care worker					
Administrative worker					

Table 8:5

Expenditure on Training/ Qualifications 2007/08 for staff employed in services for people with a learning disability.

	Total expenditure	Recipients employed by social services	Recipients working in the independent sector	Recipients from other agencies – please specify	Family Carers
Social Services					
NHS					

The above table could be broken down by service area.

CHAPTER 9

Roles and Responsibilities ¹⁹

Councillors have a number of key roles in commissioning.

Cabinet members

Councillors who serve in Cabinet and especially those who hold the social services portfolios, provide political guidelines for commissioning:

- The level of corporate priority to be given to the social care agenda and the contribution of non social services directorates
- The contribution of social care to the corporate agenda
- Ensure the organisational capacity to commission
- The needs over and above the statutory minimum, to be met on a discretionary basis
- The degree of delegated authority devolved to officers
- The role of in house service provision and the balance with independent sector provision.
- The use of the charging policy to manage demand
- The extent and pace of change, including integration with other services, such as health
- The scope for joint commissioning with local authorities
- Setting the authority's commissioning strategy
- Ensuring that consultation has taken place with stakeholders
- Determining allocation of resources to fund commissioning strategy.
- Satisfying themselves of the quality of services.

Members of Scrutiny Committees

Councillors, who serve on scrutiny committees, also have a key contribution to make in advising the Cabinet and Council colleagues in a number of ways:

- Keeping the relative priority of social care within the corporate agenda under review
- Commenting and making recommendations on strategic priorities
- Checking the organisational capacity to deliver the required scale and pace of change
- Monitoring the core set of performance indicators and benchmarking performance against similar authorities.
- Taking note of other internal and external inspection, audit and review reports.
- Commissioning investigations into service areas of concern

¹⁹ Audit Commission

Other Councillors

Councillors who do not sit on either Cabinet or Scrutiny Committees still have an important role to play in:

- Endorsing/ challenging the strategic priorities of the authority
- Championing the social care interests of constituents and/ or of particular user or carer groups
- Holding Cabinet to account for the delivery of specified outcomes

Lead Commissioning Managers need to:

- Adhere to a common set of principles and processes
- Define commissioning priorities, matching ambition to capacity
- Co-ordinate the inputs from all parts of the authority, bridging operational and support services
- Maintain a networked dialogue with users and carers and their representatives as well as with service providers in all sectors
- Provide scope for other stakeholders both to influence commissioning priorities and to hold commissioners to account for delivering specified outcomes.
- Identify opportunities for joint or collaborative commissioning with other commissioning bodies.

Chief Officers of other commissioning bodies will find mutual advantage in identifying where commissioning priorities reinforce or complement each other.

Care Managers

Care Managers have a responsibility to feed back into the commissioning process:

- Eligible needs unable to be met by current services
- Outcomes delivered by the various services
- Report any concerns about service provision to division responsible for co-ordinating intelligence about providers.
- Ideas/proposals for new or amended services

Finance Staff

Finance staff have a vital role not only in ensuring that budgets are balanced but in helping operational managers to identify more creative and cost effective ways of using available resources:

- Providing timely monitoring data on financial commitments
- Calculating ever more robust comparative unit costs
- Developing predictive financial models based on current trends

Information and Performance Management staff

- Identifying and analysing the key monitoring data
- Highlighting the strengths and weaknesses of current services
- Developing data on outcomes and quality of care to set alongside the data on finance activity

Contracting Staff

Contracting staff have to support operational managers with the lead responsibility for commissioning services:

- Devising comprehensive strategies
- Undertaking appraisals of all relevant options
- Prioritising services for increase or decrease
- Moving from input based specifications to outcome based contracting
- Driving down transaction costs of commissioning

Providers

- Maintaining and developing good quality services in line with good practice.

Appendix 1.

Table 1 Prevalence rates of adults with a severe learning disability						
	Adults	Adults	All	Prevalence rate at	Prevalence rate	
	18 - 64	65+	Adults	0.4%	0.6%	
Isle of Anglesey	40,670	13,365	54,035	216	324	
Gwynedd	70,247	22,749	92,996	372	558	
Conwy	63,052	25,826	88,878	356	533	
Denbighshire	55,598	19,415	75,013	300	450	
Flintshire	93,040	23,399	116,439	466	699	
Wrexham	80,919	20,974	101,893	408	611	
Powys	76,569	26,398	102,967	412	618	
Ceredigion	49,108	14,700	63,808	255	383	
Pembrokeshire	67,902	23,166	91,068	364	546	
Carmarthenshire	104,590	34,624	139,214	557	835	
Swansea	137,359	41,198	178,557	714	1,071	
Neath Port Talbot	81,371	24,885	106,256	425	638	
Bridgend	79,022	22,034	101,056	404	606	
The Vale of Glamorgan	72,963	20,727	93,690	375	562	
Cardiff	203,342	44,348	247,690	991	1,486	
Rhondda, Cynon, Taff	140,667	38,088	178,755	715	1,073	
Merthyr Tydfil	33,135	9,079	42,214	169	253	
Caerphilly	103,586	26,655	130,241	521	781	
Blaenau Gwent	41,183	11,793	52,976	212	318	
Torfaen	53,918	15,572	69,490	278	417	
Monmouthshire	51,596	16,168	67,764	271	407	
Newport	83,093	22,544	105,637	423	634	
Wales	1,782,930	517,707	2,300,637	9,203	13,804	

	Adults	Adults	All	Prevalence rate between		Prevalence rate
	18 - 64	65+	Adults	2.0%	2.5%	0.3%
Isle of Anglesey	40,670	13,365	54,035	1,081	1,351	1621
Gwynedd	70,247	22,749	92,996	1,860	2,325	2790
Conwy	63,052	25,826	88,878	1,778	2,222	2666
Denbighshire	55,598	19,415	75,013	1,500	1,875	2250
Flintshire	93,040	23,399	116,439	2,329	2,911	3493
Wrexham	80,919	20,974	101,893	2,038	2,547	3057
Powys	76,569	26,398	102,967	2,059	2,574	3089
Ceredigion	49,108	14,700	63,808	1,276	1,595	1914
Pembrokeshire	67,902	23,166	91,068	1,821	2,277	2732
Carmarthenshire	104,590	34,624	139,214	2,784	3,480	4176
Swansea	137,359	41,198	178,557	3,571	4,464	5357
Neath Port Talbot	81,371	24,885	106,256	2,125	2,656	3188
Bridgend	79,022	22,034	101,056	2,021	2,526	3032
The Vale of Glamorgan	72,963	20,727	93,690	1,874	2,342	2810
Cardiff	203,342	44,348	247,690	4,954	6,192	7431
Rhondda, Cynon, Taff	140,667	38,088	178,755	3,575	4,469	5363
Merthyr Tydfil	33,135	9,079	42,214	844	1,055	1266
Caerphilly	103,586	26,655	130,241	2,605	3,256	3907
Blaenau Gwent	41,183	11,793	52,976	1,060	1,324	1589
Torfaen	53,918	15,572	69,490	1,390	1,737	2085
Monmouthshire	51,596	16,168	67,764	1,355	1,694	2033
Newport	83,093	22,544	105,637	2,113	2,641	3169
Wales	1,782,930	517,707	2,300,637	46,013	57,516	69,019

Table 3

Prevalence rates of adults with a severe learning disability (July – 07) LDIAG 1990									
	Age Group	Prevalence rate between:		Age Group	Prevalence rate between:		Age Group	Prevalence rate between:	
	25 - 44	3.5%	4.0%	45 - 64	2.0%	2.5%	65+	1.0%	1.5%
Isle of Anglesey	16,245	569	650	19438	389	486	13381	134	134
Gwynedd	27,834	974	1,113	30951	619	774	22739	227	227
Conwy	25,652	898	1,026	29940	599	749	25812	258	258
Denbighshire	23,273	815	931	25796	516	645	19315	193	193
Flintshire	41,637	1,457	1,665	39729	795	993	23358	234	234
Wrexham	35,780	1,252	1,431	33978	680	849	20823	208	208
Powys	30,801	1,078	1,232	37709	754	943	26490	265	265
Ceredigion	16,563	580	663	21021	420	526	14616	146	146
Pembrokeshire	27,111	949	1,084	32723	654	818	23137	231	231
Carmarthenshire	42,427	1,485	1,697	49306	986	1,233	34502	345	345
Swansea	56,692	1,984	2,268	56716	1,134	1,418	41133	411	411
Neath Port Talbot	34,036	1,191	1,361	36336	727	908	24811	248	248
Bridgend	35,255	1,234	1,410	33831	677	846	21974	220	220
The Vale of Glamorgan	31,251	1,094	1,250	32317	646	808	20788	208	208
Cardiff	94,189	3,297	3,768	66812	1,336	1,670	44087	441	441
Rhondda, Cynon, Taff	61,565	2,155	2,463	58037	1,161	1,451	37916	379	379
Merthyr Tydfil	14,120	494	565	13997	280	350	9006	90	90
Caerphilly	46,142	1,615	1,846	43181	864	1,080	26476	265	265
Blaenau Gwent	17,555	614	702	17547	351	439	11769	118	118
Torfaen	22,969	804	919	23397	468	585	15633	156	156
Monmouthshire	21,432	750	857	24965	499	624	16217	162	162
Newport	37,256	1,304	1,490	33787	676	845	22297	223	223
Wales	759,785	26,592	30,391	761514	15,230	19,038	516280	5,163	5,163

Register of persons with learning disabilities on 31st March 06						
County	Total Persons aged 16	Persons 16 and over living with parents/ family	Persons 16 and over in lodgings/ supported living	Persons 16 and over in placements (includes some other categories)	Persons 16 and over in health accommodation	Persons 16 and over in residential accommodation (private/ voluntary/ staffed/ unstaffed)
Anglesey	253	134	48	204	6	37
Gwynedd	534	296	113	477	11	17
Conwy	475	149	61	372	12	88
Denbighshire	299	116	85	238	1	59
Flintshire	460	267	118	426	11	23
Wrexham						
Powys	634	185	5	539	5	77
Ceredigion	284	125	57	208	4	67
Pembrokeshire	490	290	50	392	10	88
Carmarthenshire	609	257	72	441	7	141
Swansea	762	354	185	621	9	105
Neath Port Talbot	522	258	3	360	2	150
Bridgend	511	320	114	443	8	25
Vale og Glamorgan	481	196	53	289	4	78
Cardiff	976	595	22	878	0	98
Rhondda Cynon Taff	830	424	205	700	5	54
Merthyr Tydfil	186	102	13	157	0	16
Caerphilly	608	258	121	523	1	69
Blaenau Gwent	280	125	31	218	2	48
Torfaen	315	139	68	255	1	53
Monmouthshire	268	123	21	195	0	71
Newport	481	216	75	378	4	97

This information is useful, to an extent, in drawing comparisons throughout Wales. However, it is

Appendix 2

Introduction

The information formats suggested below are designed to stimulate questions about the information required for commissioning to help with decision making. They provide information for the needs analysis, market analysis and resource analysis. Inevitably these areas are not totally mutually exclusive. In some cases the information below may be too detailed whilst in other areas more work should be undertaken. Gathering information is time consuming and expensive. Do not try to develop perfect information. Use the information below to stimulate what you need and what is already easy to hand. Some local authority areas are referred to for illustrative purposes only.

The tables above concerning prevalence rates and their application to local authority areas contain general information relating to the needs analysis. Information on specific domains follows in terms of accommodation and support, short breaks, supported employment etc. Finally there is a large section on resources. This requires much more detailed consideration. It would be helpful, for example to explore the breakdown of NHS resources for services for people with learning disabilities in far more detail.

Table 1.

e.g. Powys				
Mid Year Estimate				
Area	0-17	18-64	65+	All Ages
Montgomeryshire				
Radnorshire				
Brecknock				
Total				

Table 2

Prevalence or Validated Management information. Note Powys covers a vast geographical expanse which poses a challenge for commissioning

e.g. Numbers of children and adults with learning disabilities in Powys 2008					
Age	Montgomeryshire	Radnorshire	Brecknock	Total	%
0-17					
18-29					
30-39					
40-49					
50-59					
60-69					
70-79					
80+					
Adults					
All Ages					
%					

Trend Data to illustrate numbers going up or down during past few years or future years.

e.g. Are numbers of older people with learning disabilities going up, staying the same or declining? If they are increasing state numbers +

Table 3

How has demand changed and how will it change?

Age	1998 numbers	%	2008 numbers	%	2016 numbers	%	
10-19							
20-29							
30-49							
50-64							
65-75							
75+							
Total							

Table 4

Ethnicity of learning disabled children and adults e.g. in Powys						
		Mixed	Asian	Black or Black British	Chinese or other ethnic group	Total Black and Minority ethnic groups
Adults	Montgomeryshire					
	Radnorshire					
	Brecknock					
	Powys					
Children	Montgomeryshire					
	Radnorshire					
	Brecknock					
	Powys					

Future Needs - Transition

Transition is a key area for future planning and it is important that we understand the needs of people coming through from children’s services in order to meet their collective needs.

Local authorities and their partners will have agreed procedures for transition planning in place. Year 9 reviews will produce person centred transition plans that will inform the commissioning and provision of future services and supports to be reviewed each year and will be at the core of a smooth transition to adult services. Employment must feature highly within the school year 9 review.

The tables below allow for more years than the period from year 9. There is no reason why commissioners of services for adults with learning disabilities cannot plan on a longer timescale. The numbers of children moving to adult services may be small each year but they may involve considerable cost in terms of the services required so planning needs to begin early.

There are no excuses for adult services being surprised by a sudden demand for expensive care packages from young people transferring from children’s services. That is not say that some of the needs of some of these young will not pose challenges but they should not pose surprises.

Table 5

Year	Complex needs – number Yr 9 Pupils	Unknown needs – number Yr 9 Pupils	Total numbers – Yr 9 Pupils	Total cost of existing care packages
2008				£
2009				£
2010				£
2011				£
2012				£
2013				£
2014				£
2015				£
2016				£
2017				£

The table below may be used as a tool to help plan for accommodation and support needs. Accommodation required may include regular periods of respite care, nursing care (continuing health care case), supported accommodation, etc.

Table 6

Year	Total No's Yr 9 pupils	Complex needs	Challenging behaviour	Special needs	Accommodation required
2008					
2009					
2010					
2011					
2012					
2013					
2014					

Table 7
1st April 2008

Case No	DOB	Male/Female	Name	Total costs of existing care package per annum	LA contribution	LHB contribution	Receiving direct payments	Transition plan in place
Those Aged 17 last birthday								
				£	£	£		
Those aged 16 last birthday								
Those aged 15 last birthday								
Those aged 14 last birthday								

Needs Analysis - Accommodation and Support

Who has the partnership identified to lead on the work required on the accommodation and support part of the commissioning strategy?

Joint working between the Health, Social Care, Supporting People and Housing is essential if an efficient, effective and coherent local accommodation and support strategy for people with learning disabilities is to be developed.

Aim

Give adults with a learning disability and their carers a greater choice about where, how they live, who they live with, if anyone and who provides housing related support them. In fulfilling this aim it is vital that they and their parents are given:

- Increase the spectrum and range of housing and support options to choose from
- Accessible and appropriate information about what is available
- The opportunity to plan for the future

The minimum information required on needs includes:

- Number of adults with learning disability
- Number known to housing related support providers.
- What form of housing related support users currently receive
- What intensity of support do individuals presently receive?
- Where people live now
- How many live with older carers
- How many users are expected to transfer into adult services over the next three years
- How many want to move in the next 3 to 5 years
- Support levels needed including any special needs e.g. wheelchair access
- What people say they want
- Gaps in our information

A number of sources of information can be used to provide an accurate estimate of the number of people with learning disabilities currently receiving housing and support services.

Supporting People teams will already have collected information on the supply and the amount of resources invested in different models of support for housing related support services.

The first step is to establish where people live now. It should be possible from the information held on individuals in receipt of services to establish most of this information. However, it may be necessary to use other networks (carers groups, Mencap, etc.) to check out findings given that some people living with carers will not be in receipt of services.

To code the information you will have to use a consistent set of headings to describe the accommodation.

Table 8

	How Many?	% of total
Home of relatives (parents)		
Own individual home/ tenancy		
Own home / tenancy with partner		
Hostel/ residential home (24 hour staffing)		
Nursing Home		
NHS long term accommodation		
Shared supported housing		
Self-contained supported housing		
Intensive floating support		
Low level floating support		
Adult placement		
Telecare services		
Other – please specify		

This may be further broken down by area if required. This will probably be the case in large rural areas like Powys.

The example may be too complicated – if so just replace it with one that makes sense locally.

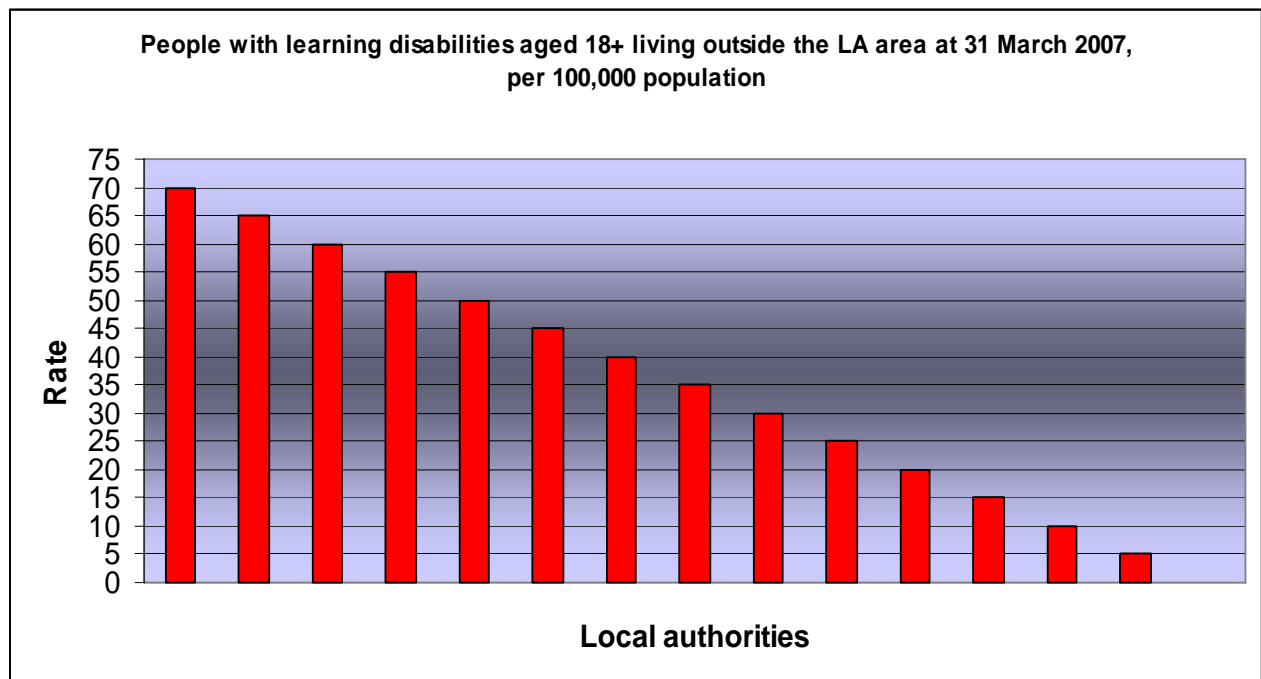
Out of County Placements

In examining where people are now out of county placements should be considered. This may be an area for benchmarking.

Benchmarking

People with learning Disabilities aged 18+ living outside the LA area at 31st March 2007 per 100,000 populations.

Example



There needs to be a clear rationale for out of county placements. If specialist services are required what exactly are these services? What are the inputs, outputs and outcomes? How is the quality of services checked?

Out of area placements make it difficult for people to stay in contact with family, friends and local communities.

The same table could be used for packages costing less than £50,000.

Average weekly fee for out of area placements in:

(a) residential care - £_____

(b) residential care with nursing - £_____

(See Social Care Institute for Excellence – Commissioning person –centred, cost effective, local support for people with learning disabilities).

The number of out of area placements made by each authority should be measured.

Commissioners need to be talking to commissioners from neighbouring authorities to examine the potential for developing more local solutions.

Table 12

Hospital Provision

Hospital	No of users	Average weekly cost	Total cost pa
		£	£

People living with elderly carers

In determining future accommodation requirements it will be important to establish how many people live with parents aged 70+. If this information is not available it can be estimated (about 53 per 100,000 population).

Table 13

Prevalence rate of older carers aged 70+		
	Age Group	Prevalence rate
	70+	0.053%
Isle of Anglesey	9,425	5
Gwynedd	16,437	9
Conwy	18,989	10
Denbighshire	14,052	7
Flintshire	16,223	9
Wrexham	14,960	8
Powys	19,165	10
Ceredigion	10,552	6
Pembrokeshire	16,511	9
Carmarthenshire	25,019	13
Swansea	29,812	16
Neath Port Talbot	17,928	10
Bridgend	15,574	8
The Vale of Glamorgan	15,027	8

Cardiff	32,409	17
Rhondda, Cynon, Taff	27,064	14
Merthyr Tydfil	6,345	3
Caerphilly	18,608	10
Blaenau Gwent	8,380	4
Torfaen	11,354	6
Monmouthshire	11,702	6
Newport	15,941	8
Wales	371,477	197

Do we know anything about the health conditions of carers that will make caring role difficult?

Developing a housing and housing related support strategy for people with learning disabilities will involve collecting some very basic information on the level of support needed by people. In the context of a housing and support strategy, support needs include personal care, emotional support and housing related support tasks that are eligible under the Supporting People programme. This support will in many cases be supplemented by additional services (often provided by other agencies) to enable access to employment, education, and leisure activities.

In the majority of instances it should be sufficient to simply record level of need in the following five broad bands that have been derived from the supply mapping form SP3.

- *Visiting /floating support:* Visiting support staff or substitutes (e.g. 'life-sharing' co-tenants, carers in adult placement schemes) provide support for a variable amount of time (per day or per week). Generally they would not be present for the purposes of providing support for the majority of time during which the person with learning disabilities is in their home.
- *Day time support on site with emergency call out:* Support staff or substitutes are present for the purposes of providing support for the majority of time during which the person with learning disabilities is awake in their home. Support staff are not present at night (except on an emergency call out basis).
- *24 hour support with sleep in staff):* Support staff or substitutes are present for the purposes of providing support for virtually all of the time the person with learning disabilities is in their home. Support staff are present at night but are permitted to sleep.
- *24 hour support (with waking staff):* Support staff or substitutes are on duty and awake for the purposes of providing support for virtually all the time the person with learning disabilities is in their home.
- *24 hour intensive support:* Support staff or substitutes are on duty and awake for the purposes of providing support for all of the time the person with learning disabilities is in their home. Due to the complexity or severity of the person's needs it will be necessary to provide sustained periods of at least 1:1 support.

In some instances it may be advisable to collect more detailed information on the level of ability and behavioural needs of potential service users.

Person Centred Planning

Research undertaken by the Joseph Rowntree Foundation found that choices which framed individual lives – including where to live, who to live with and who to receive support from were still typically made by service managers and commissioners. A Person Centred Approach to making housing and support choices will help people think about whether they want to live alone or with others, and if they do want to live with others, who they want to live with.

- Is there accessible information available about options?
- Can people and their families get help to choose through person centred approach to planning?
- Do all professionals know about the range of housing and support options?
- How do people get on the housing register?
- Are there robust procedures in place between housing and social services?

Consultation

Consultation with local people with learning disabilities, their families and other stakeholders (including people from ethnic minority communities).

The requirements of service users and carers will often differ. Service users may want support services that will:

- Help of a practical or personal nature
- Someone to go to if they have problems
- Help in dealing with fears or feelings of isolation
- Assistance in developing independent living skills.

Carers may place more of an emphasis on:

- Trained experienced staff
- Secure and permanent accommodation offering stability
- Accommodation that reflects homely qualities
- A stimulating living environment for the resident

Research

Research undertaken by the Joseph Rowntree Foundation on the impact of the supporting people programme on adults with learning disabilities found that the housing and support of people who received Supporting People funds varied considerably, both to the amount of the support they received, but also to the structure of their housing and support services.

In practice these dimensions of difference were not independent of one another: shared tenancies were associated with accommodation based support and individual tenancies were associated with floating support.

The advantages and disadvantages of these different ways of providing housing and support are summarised below.

Table 14

Advantages and Disadvantages of different methods of providing housing and support	
Shared Tenancies with accommodation based support	Individual tenancies with floating support
Danger of less individualised support	Fully individual support
24 hour support cover sometimes possible	Limited number of support hours available each day
Maximum flexibility of support, as staff are always at hand	Difficult to change support hours at short notice
Less privacy/ time alone	More privacy/ time alone
Less chance of being lonely	More chance of being lonely
Support and housing often managed by the same organisation (England).	Clear separation between landlord and support provider
Possibility of minimising costs per hour of support	Potentially higher costs per hour of support, because of the need to allow for staff travel time
System suited to the employment of fulltime staff – giving greater consistency of support	System suited to the employment of part time staff – giving less consistency of support
Source Support for Living? The impact of the Supporting People programme on housing and support for adults with learning disabilities.	

The research found that it was difficult to identify how some of the shared tenancy arrangements differed from high quality, small scale registered care homes.

Adult Placement (see SCIE – Practice Guide 8 – Improving Outcomes for Service Users in adult Placements).

Adult placement provides highly flexible, short or long term accommodation and for support for up to three adults in the family home of an adult placement carer. In ideal circumstances people living in adult placements live an ordinary, domestic life in the local community, sharing in the life and activities of the adult placement carer.

Adult placement services are defined by their association with adult placement schemes, which are subject to regulation under the Care Standards Act 2000.

Extra Care Housing

Extra Care housing developments are increasingly seen as more suitable option than residential care for older people with care and support needs. Extra care models also provide opportunities to address the needs of adults of all ages with learning disabilities, whether younger or older. (see LIN Care Services Improvement Network – New Initiatives for People with learning disabilities: extra care housing models and similar provision – Jenny Pannell).

The most important fact is that extra care housing is housing first. People who live there have their own homes. They have legal rights to occupy. This means there is a clear distinction between extra care housing and residential care. Care and support is available on site (usually 24/7). Buildings are designed for people who are frail or

have physical disabilities, and include flats or bungalows with one or two bedrooms. People have their own self contained dwelling and their own front door. There is usually a range of communal facilities, often open to the wider community, including leisure facilities and a café or restaurant providing a mid day meal.

Different tenures may be available, sometimes within the same development:

- Rent
- Shared ownership
- Outright sale

People with lower or higher support needs, and those with additional disabilities and impairments, can achieve much greater independence in extra care models than residential care. The range of tenures offers the same choices as those enjoyed by the wider population, and the benefits system and family money can make ownership options possible for people with learning disabilities. Extra care schemes can also provide a very suitable solution where an older carer is finding it difficult to continue to care, but the learning disabled adult and older carer do not wish to live apart from each other.

People with learning disabilities can access more general extra care schemes as well as those designed specifically for people with learning disabilities.

Priority Category

The commissioning strategy may use a system for prioritising accommodation. Category 1 people who have an urgent need for accommodation (e.g. situations where a carer is suddenly no longer able to continue caring, where current placement breaks down).

Category 2 people who are identified as requiring accommodation within next two years

Category 3 people who are identified as requiring accommodation within next 2-5 years

Category 4 people who are identified as needing accommodation in the future (over 5 years).

Telecare

Telecare should be considered when exploring accommodation options. Telecare has been largely used by older people and people with physical disabilities.

However, assistive technology can be used as a way of providing extra support to people with a learning disability. There is no space here for a detailed consideration of Telecare and other forms of assistive technology but its potential should not be overlooked. Each local authority should have a telecare strategy in place and there is a learning and improvement network in place. Commissioners should give consideration as to how telecare together with other assistive technology can be exploited to support people with learning disabilities.

Assistive technology is a way of helping people with learning disabilities to live as independent a life as possible.

- To support an independent life for the first time following a move from an institution, or relative's home.
- To help or relieve carers so they are better able to continue to provide support
- To provide more reliable support to provide support in a less intrusive way.
- If the person is at risk it can support them 24 hours a day.
- The person does not have to do anything to make it work.

Some people with a learning disability have telecare as their only form of support as a safety net and may not have needed to use it yet. For others it may be used as part of a wider support package to enhance the quality of support.

Potential Benefits (see Gadgets, Gizmos and Gaining Independence, Assistive Technology and People with Learning Disabilities; Advance 2006 – this also includes excellent assessment format)

Service Quality for Resident

- Privacy
- Dignity
- Control of environment
- Enable to do more for self
- Enable to do more independently
- More reliable in delivering safety
- Quicker timelier response when needed
- More timely response can result in greater comfort and/or less harm to self
- Fewer disturbances – in particular sleep at night

For Staff

- Safer working environment
- Less routine monitoring required
- Greater satisfaction when enablement occurs extend skills, create wider range of jobs
- Can create better career structure.

Financial

The principal financial benefit flows from needing fewer staff doing very limited tasks. The cost savings lie in these areas:

- Eliminating need for permanent staff, in particular sleep-in staff 'just in case'.
- Replacing working night staff by sleep in.
- Reducing overall number of staff
- Allowing residents to do more tasks themselves or unaccompanied.

The guidance places important caveats on the proposition that telecare or other assistive technology will automatically achieve savings. Introducing telecare may mean, for example, changing the way some support is provided i.e. some sleep in staff become mobile staff covering a group of residents. This may mean higher travel costs or higher salaries.

Other Equipment

As noted above it is not our purpose here to describe in detail services such as community equipment or adaptations but people with learning disabilities will often have other disabilities and will need access to these services. There may also be gaps in service provision. The Joint Committee on Human Rights, for example, brought attention to the devastating impact which poor access to communication aids can have on the ability of some adults with learning disabilities to communicate with others and thus participate in social relationships and the life in the community. Commissioners need to ensure that these technical support services in terms of equipment, adaptations, telecare, telehealth, wheelchair services, etc, actually join up.

Gap Analysis

Any gap analysis should take into account not only more or less of different types of services but where this may be achieved by 'reshaping' older services.

Gaps may not just be numerical but should take account of the shortages of certain types of housing or support before going on to what's needed.

It is important to identify over supply, substandard or inappropriate provision prompting service changes.

Key issues which may emerge from the gap analysis may include:

- Limited range of housing and support options
- Few local services for people with complex needs and severe disabilities – people placed out of area
- Old fashioned residential facilities
- Limited use of ordinary tenancy
- Lack of services in rural area
- Poor information to people with learning disabilities and their families
- Lack of communication with providers
- Lack of quality monitoring or incoherent quality monitoring among commissioning partners
- Low take up of direct payments

Of course balanced against these issues will hopefully be a range of strengths or opportunities for reinvestment.

Evidence based approaches to commissioning will be characterised by the use of efficient and effective performance management systems.

Based on the gap analysis future strategy may involve:

Goals

- Increase in the numbers who are supported in independent living
- Reduction in numbers occupying long-stay hospital beds
- Reduction in numbers of out of county placements
- More support for people with challenging behaviour

Try to quantify the proportions of different types of service

Table 15

	existing	propose	% change
Home of relatives			
Own individual home / tenancy			
Own home / tenancy with partner			
Hostel/ residential home (24 hour staffing)			
Nursing home			
NHS long term accommodation			
Shared supported housing			
Self contained supportive housing			
Intensive floating support			
Low level floating support			
Adult placement			
Other please specify			

Domiciliary Care

Table 16

Service Type	Area available	Approximate No of users supported	Average number of hours per week	Total expenditure 06/07	Average expenditure per user per week
SSD sessional workers					
SSD inhouse home care					
Dom. Care from independent sector					

Average hourly cost of providing home support, including transport

- local authority
- independent sector

Breakdown by individual agency

Is there a correlation between the intensity of support required by the service user and the cost of providing care/ support?

Direct Payments

Number of People with Learning Disabilities getting direct payments in March 2007

Annual expenditure on care packages taken by adults with a learning disability is presently £-----

Average payment to service user per week (excluding ILF?)

Average cost per week (including support service cost)

Number of people with learning disabilities with split care packages combining direct payments and traditional care packages.

How many people with learning disabilities are using direct payments (a) in place of day opportunities ____ (b) respite care ____ (c) domiciliary care ____

Number of people with learning disabilities in receipt of direct payments with weekly budgets in the following cost bandings:

Table 17

Mainstream	Number	%
• Under £200 per week		
• £200 to £500 per week		
Specialist		
• £500 to £1000 per week		
• £1000 to £5000 per week		
• £5000 per week		
Total		

% of total direct payment expenditure spent of people with learning disabilities.

Number of people using ILF

Total ILF expenditure on people with learning disabilities

Number of learning disability care packages started and average cost

Number of learning disability care packages terminated and average cost

Net impact on budget of review decisions on continuing cases.

Table 18

Number and % of care packages and average cost of care packages funded by	Number	%	Average weekly cost
Social Services only			
NHS only			
Education only			
NHS and education			
NHS & Social Services			
Tripartite- NHS, Education, SSD			
Social Services and Housing			
Housing only (supporting people)			

Short Breaks

Considerations

Adults with learning disabilities and their carers will have access to short breaks away from home.

Service users will receive a quality service from small scale unit/s

Service users with additional needs will be able to access specialist provision

People using short break services will have their specialist health needs identified and met.

Carers will be able to receive support at home, including evenings and weekends.

Number of People who had short –term breaks in the last year as a percentage of all people with a learning disability receiving services:

_____.

(This indicates the use of short breaks opportunities).

Table 19

Type of provision	Users - number	Total cost	Comment
Adult family placement		£	Range of nights pa Average number of nights per individual
Residential Care			
Holiday accom.			
Total			

Total number of people using short term breaks _____ during the year.

Breakdown by intensity of care or condition?

Expenditure

Table 20

Resource Used	Cost pa	Number of places	Weekly unit cost per place
e.g. Name of establishment			
1			
2			
3			
4			
5			

Average daily cost of short term breaks

- (a) adult placement - £
- (b) residential home - £
- (c) nursing home - £
- (d) other please specify £

Employment, Supported Employment, and Day Services

Employment is important. It can give people:

- Feelings of worth – doing something valuable
- A structure to their lives
- Opportunities for meeting new people and making friends
- Wages

Many people with learning disabilities want real jobs and help to get these jobs and to keep them or supported employment or valued occupation in a day centre. Support for employment needs to be ongoing.

They want opportunities to try out different jobs so they know what different sorts of work they like.

Community Care assessments need to consider work options rather than fall back on traditional day services as the first or only option. Care managers and other staff involved in transition planning may need training on good practice in supported employment.

Need to ensure that people with learning disabilities in supported employment are financially better off through a combination of wages and in work benefits.

Who is the more effective in securing jobs?

- (a) job centre disability officers
- (b) local charities and advocates

The Present situation

Are there clear aims and objectives of day and employment services and how do the work together?

Do we have good links between employment, day services and education?

What services do we have now?

Education

Table 21

Provider	Location	No of places	Total Cost	Average weekly cost

Day Opportunities

Placements available _____

How many sites/ locations?

Cost per year _____

Average cost per place per day _____

Average cost varies from £_____ per week to £_____ per week depending on provider.

Table 22

Day opportunities			
Local Authority Provision	No of Places	Total Cost 2006/07	Location
1			
2			
3			
4			
NHS (Special Care)			
1			
2			
Independent sector			
1			
2			
3.			
4.			
Outreach			
To include transport or not?			

Are the independent sector places purchased through spot or block contracts?

Is there a correlation between the cost of services and the intensity of support required by the service user?

The above table could be replicated and focused on people with profound and multiple disabilities.

Contribution of adult placements to day time opportunities

Adult Placements provide small, personalised service, provided by individuals in the community.

Number of people receiving home based day services and outreach from adult placements _____

Age range served _____

Average length (hours) of each session _____

Average number of sessions per week _____

Total cost £ _____
 Average cost per day £ _____
 Number of emergency adult placements during previous financial year _____
 Waiting List for adult placements day services _____

Benchmarking

Places per 10,000 population aged 18 and over _____
 Day opportunity costs per 100,000 population = £ _____

Day Opportunities

Table 23

Name of service	Current Annual Budget	No of places per day	Unit cost per week	Location

Employment

Projects and agencies engaged in job finding and supporting people with disabilities in the employment market.

Expenditure on Supported Employment

Table 24

Scheme	Number of Places	06/07 Budget
Total		£

Is there support for vocational training courses?

Are there opportunities for training which is time limited and outcome based?

Is there access to after work activities for those who benefited from supported employment to reduce isolation and prevent work problems.

- Number of people with learning disabilities aged 18 to 60 in paid employment
- Number of people with learning disabilities aged 18 to 60 in supported employment
- Number of people with learning disabilities aged 18 to 60 attending day services which have a defined skills development focus
- Number of people aged 18 to 60 who have attended formal education programmes during the previous 12 months

Waiting list for supported employment services? _____

Health

- % of people with learning disabilities who received annual health check during previous 12 months
- Number of people with learning disabilities dental check within last 12 months
- Eyesight check last 2 years
- Hearing test last two years

For people with learning disabilities who have other inter-related health care problems which may include : physical disabilities, hearing and eyesight problems, communication difficulties, epilepsy, chest and heart problems , swallowing difficulties, other chronic medical conditions, mental health problems and psychological problems it will important to access annual health checks and have access to the range of professional staff.

Challenging Behaviour

- % of people with learning disabilities with defined problems of challenging behaviour are supported in their own home.
- % of people with learning disabilities with defined problems of challenging behaviour placed in residential care.
- % of people with learning disabilities with defined problems of challenging behaviour in paid employment or supported employment.
- Number of people with learning disabilities with challenging behaviour have received an assessment and treatment programme in their own home
- Number of people identified as having challenging behaviour have seen a reduction in the severity and frequency of behaviour during the last year.
- Number of carers helped with training to respond to challenging behaviour
- Number of people with learning disabilities supported through specialist interventions
- Number of people with learning disabilities with challenging behaviour placed in residential care for a temporary period to allow treatment and management strategies to be developed
- Number of people with learning disabilities and challenging behaviour placed in specialist residential provision on a long term basis.
- Number of people with learning disabilities convicted of criminal offences
- Number of people with learning disabilities with mental health problems.

Categories

- Self injury
- Physical confrontation with others
- Verbal confrontation with others
- Other behaviour

Dementia

There is evidence that adults who have Down's Syndrome are at high risk for developing Alzheimer's disease in later life. Prevalence increases systematically in adults with Down's Syndrome who are over the age of 30. It is estimated that between 10 and 25% of people with down's syndrome in their 40s have dementia, 50 % of those in their 50's and between 30 and 75% of those over 60 (Mental Health Foundation Briefing No 17 'Aging in Adults with Down's Syndrome).

The table below shows the numbers who might be expected to be at risk of Alzheimer's Disease.

Table 25

Age	Total number of people with Down's	% who may develop Alzheimer's	Number who may develop Alzhiemers
40-49		10-25%	
50-59		50%	
60+		30-75%	
40+			

Resources Analysis

Before exploring the needs analysis concerning specific domains it may helpful to have an overview of how resources are expended beginning with the social services budget through to the social care budget for adults with disabilities and specific services. It would also be helpful to establish the budget or expenditure from other agencies concerning learning disabilities, e.g. supporting people, NHS, etc.,.

Headlines

The resource analysis could begin with income

E.g. LA budget; NHS budget; Supporting People Grant; Carers Grant; Service Charges: Money transferred from section 28A payments.

Where is the money spent?

Total Gross Spend on Services for People with Learning Disabilities = £_____

Total expenditure on children's and adult services: £

See chart 1 below. Pie Chart E.g. children = __% adults = __%

Proportion of expenditure on children with a disability.

Pie chart E.g. total children's budget = ___ ; total budget on services for disabled children = £_____ which = ___% of children's budget.

This could again be broken down by physical/ sensory or learning disabilities and by services such as local authority residential care, independent residential care, foster care, respite care (again broken down by residential/ foster care, etc) day care and home care.

Proportion of expenditure on adult services

Total = £

See chart 2 below e.g. Older People = __% £__; Physical disabilities = __% £__; Mental health = 3_% £__; Learning Disabilities = __% £__ .

Proportion of expenditure on services for people with learning disabilities.

Total Budget = £

e.g. Home care = __% : LA residential care = __%; Independent residential care = £____ or __%; Day care = £____ or __%; **Direct Payments = £____ or %.**

The authority could add the budget of the community learning disability team(s) to this breakdown.

Breakdown of expenditure on voluntary sector for learning disabilities. Or balance between inhouse SSD provision, private sector provision and voluntary sector provision.

Figure 1: Total Expenditure on children's and adults services

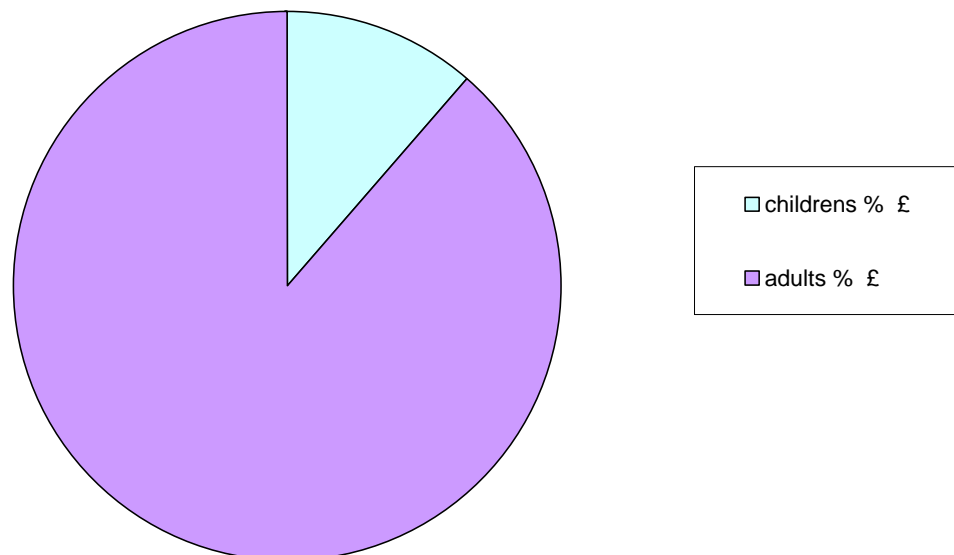


Figure 2 - Proportion of expenditure on adult services
Total: £

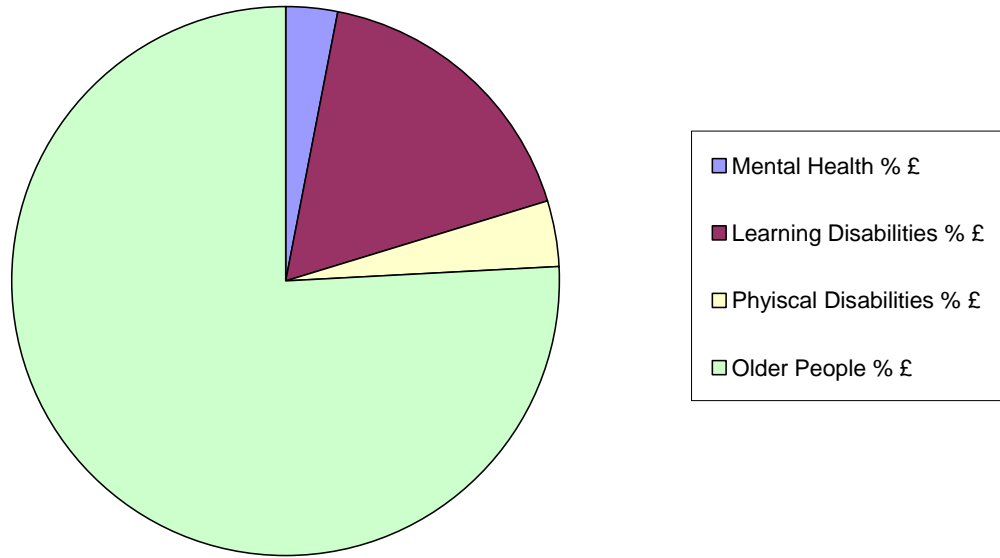


Figure 3 - Proportion of expenditure on services for people with learning disabilities
Total: £

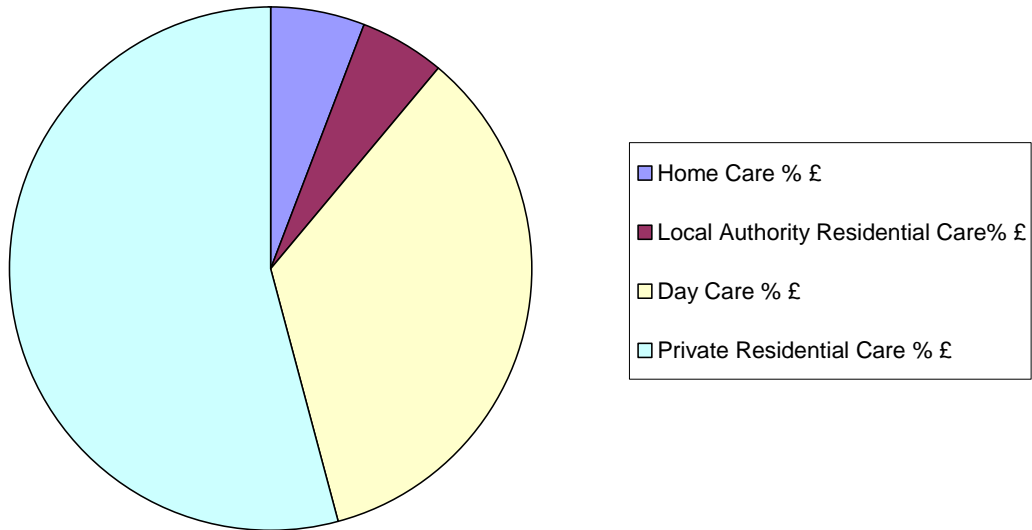


Table 26

2006/07 Spend and average weekly rates

	Total £ expenditure	Average weekly cost per place per week
Assessment and Care Management		
Residential Homes		
Residential Homes with Nursing		
Supported Living		
Day Opportunities		
Domiciliary Care		
Short Term Breaks/ Respite		
NHS long term beds		
NHS medium term beds		
NHS Acute Assessment Beds		
Specialist health services		
TOTAL		

Average weekly cost of health staff in supporting a person with a learning disability in mainstream services in the community.

LA Spending Profile 2007/08

NHS Spending Profile 2007/08

Trends in Joint Expenditure on Learning Disability services 2004 -07

Growth in LHB spend on continuing healthcare for adults with learning disability from 2003/04 to 2007/08

Benchmarking

Total expenditure on Services for people with Learning Disabilities per 100,000 population

Table 27

Spend £____ millions						
	LA1	LA2	LA3	LA4	LA5	ETC

Resource Analysis

Residential Care

Based on cost residential care and residential care with nursing accounts for _____% of total expenditure (LA & NHS) providing around _____ beds/placements.

Number of people with Learning disabilities placed in residential care during
2006/07 = _____
2007/08 = _____

Number of people with Learning Disabilities discharged from residential care during
2006/07 = _____
2007/08 = _____

Total number in residential care on:
31st March 2008
31st March 2007
31st March 2006
31st March 2005

Table 31

Number of people with Learning Disabilities funded by LA in residential care _____
Total LA expenditure on residential care _____
Average weekly cost of LA residential care per service user per week _____
Average weekly costs range from £_____ per week per service user to £_____ depending on the provider.

Table 32

Number of people with Learning Disabilities funded by LA in residential care with nursing _____
Total LA expenditure on residential care with nursing _____
Average weekly cost of LA funded residential care with nursing per service user per week _____
Average weekly costs range from £_____ per week per service user to £_____ depending on the provider.

Table 33

Number of people with Learning Disabilities funded by NHS in residential care _____

Total NHS expenditure on residential care _____

Average weekly cost of NHS funded residential care per service user per week _____

Average weekly costs range from £_____ per week per service user to £_____ depending on the provider.

Table 34

Number of people with Learning Disabilities funded by the NHS in residential care with nursing _____

Total NHS expenditure on residential care with nursing _____

Average weekly cost of NHS funded residential care with nursing per service user per week _____

Average weekly costs range from £_____ per week per service user to £_____ depending on the provider.

Profile of weekly fees, per type of service and contract type.

Residential weekly fee ranges – contract types 2006/07

Table 35

Weekly fee range	Residential Care		Residential Care with Nursing	
	Block	Spot	Block	Spot
<£500				
£501-£750				
£751-£1000				
£1001-£1500				
£1501-£2000				
£2001-£2500				
>£2501				
Total no of users				

Residential Care – funded by local authority

Table 36

	Total expenditure	Average cost per placement per week
Externally purchased services		
Inhouse services		

Breakdown comparative costs all service providers of residential care.

Benchmark

Weekly rates for spot contracts

Table 37

Weekly Range	LA1	LA2	LA3	LA4	LA5	LA6
<£500	%	%	%	%	%	%
£500-£750						
£751-£1000						
£1001-£1500						
£1501-£2000						
£2001-£2500						
>£2501						
Total Users						

Average total residential care per week 2006/07

Table 38					
£1500					
£1000					
£900					
£800					
£700					
£600					
£500					
£400					
£300					
	LA1	LA2	LA3	LA4	LA5

Is there a direct correlation between the intensity of care/support required and the cost of placement?.

Supported Living

Total number of service users _____

Average weekly fee = £

Scale of weekly fees range from £_____ to £_____ per week for a **spot** placement.

Table 39

Supporting Living Service Providers	Number of service users
1	
2	
3	
4	
5	
6	
7	
8	
ETC	

Supported Living Fee Ranges

Table 40

Weekly Fee Range	Number of service users
<£250	
£251- £500	
£501-£750	
£751-£1000	
>£1000	
Total	

For the development of its accommodation Swansea has broken down information as follows:

Swansea have broken down costs as follows:

Table 41

Cost breakdown residential care				
Number of people	Total cost	Social services cost	Service user cost	External cost

Table 42

Average cost of residential care per head				
Number of people	Average total cost	Average social services cost	Average service user cost	Average external cost

Table 43

Cost breakdown on residential care packages over £50k				
Number of people	Total cost	Social services cost	Service user cost	External cost

Table 44

Average costs of residential Care on packages over £50k				
Number of people	Average total cost	Average social services cost	Average se4rvive user cost	Average external cost

Table 45

Numbers of people receiving residential care packages, over £50K, by package cost							
Package cost	£50-59k	£60-69k	£70-79k	£80-89K	£90-99k	£100k +	
Numbers							

Breakdown of costs**Cost Breakdown on Residential Care****Table 46**

Number of people	Total Cost	Social Services Cost	Service User Cost	External Cost

Average Cost of Residential Care per head**Table 47**

Number of people	Average Total Cost	Average Social Services Cost	Average Service User Cost	Average External Cost

Cost Breakdown on Residential Care on packages over £50k**Table 48**

Number of people	Total Cost	Social Services Cost	Service User Cost	External Cost

Average Cost of Residential Care on packages over £50k**Table 49**

Number of people	Average Total Cost	Average Social Services Cost	Average Service User Cost	Average External Cost

Numbers of people receiving Residential Care Packages, over £50k, by package cost

Table 50

Package cost	50-59k	60-69k	70-79k	80-89k	90-99k	100k+
Numbers						

Cost Breakdown on Residential Care on packages under £50k

Table 51

Number of people	Total Cost	Social Services Cost	Service User Cost	External Cost

Average Cost of Residential Care on packages under £50k

Table 52

Number of people	Average Total Cost	Average Social Services Cost	Average Service User Cost	Average External Cost

Number of people receiving Residential Care Packages, under £50k, by package cost

Table 53

Package cost	<20k	20-29k	30-39k	40-49k
Numbers				

Cost Breakdown on Supported Living

Table 54

Number of people	Total Cost	Social Services Cost	Service User Cost	External Cost

Average Cost of Supported Living

Table 55

Number of people	Average Total Cost	Average Social Services Cost	Average Service User Cost	Average External Cost

Cost Breakdown of Supported Living – over £50k packages

Table 56

Number of people	Total Cost	Social Services Cost	Service User Cost	External Cost
				£892,619 (sp)

Average Cost of Supported Living per head, over £50k packages

Table 57

Number of people	Average Total Cost	Average Social Services Cost	Average Service User Cost	Average External Cost
	£	£	£	(sp)

Number of people receiving Supported Living Packages over £50k

Table 58

Package cost	50-59k	60-69k	70-79k	80-89k	90-99k	100k+
Numbers						

Cost Breakdown of Supported Living – under £50k packages

Table 59

Number of people	Total Cost	Social Services Cost	Service User Cost	External Cost
			£	

Average Cost of Supported Living per head, under £50k packages

Table 60

Number of people	Average Total Cost	Average Social Services Cost	Average Service User Cost	Average External Cost

Number of people receiving Supported Living Packages under £50k

Table 61

Package cost	<20k	20-29k	30-39k	40-49k
Numbers				

Resources

Find out more ideas on supply management and development activities from the Office of Government Commerce website at www.ogc.gov.uk. OGC offers advice and publishes guidance on subjects such as the efficiency review, procurement and the Gateway Process. Publications include 'Early Market Engagement: principles and tools of good practice' and 'Market Creation'.

Find out more about risk management from the Institute of Risk Management at www.theirm.org/index.html. The Department of Environment, Food and Rural Affairs offers a concise and readable guide to developing a risk management strategy at www.defra.gov.uk/corporate/busplan/riskmanage/. The Office of Government Commerce has a risk allocation model for project strategy and procurement at www.ogc.gov.uk/documents/RiskAllocationModel.pdf.

Find out more about good practice on the procurement of services from the Office of Government Commerce website at www.ogc.gov.uk. Publications include 'EU Procurement Guidance: introduction to the EU procurement rules - updated' and 'Think Smart, Think Voluntary Sector! Good Practice Guidance on Procurement of Services from the Voluntary and Community Sector'.

Find out more about purchasing care placements and domiciliary care services from the Care Services Improvement Partnership's 'Guide to Fairer Contracting, Part One' at www.cat.csip.org.uk/library/docs/CATReports/Fairer_contracting_guide.pdf.

Find out more about outcome-based commissioning from the Commissioning eBook at <http://www.cat.csip.org.uk/index.cfm?pid=359>, there is a video podcast on the subject and a paper in the purchasing CHAPTER. Commissioning News also has information about outcome-based commissioning at <http://www.commissioningnews.com/outcome-based-commissioning/>

Find out more about building better relationships between commissioners and third sector providers from the voluntary sector compact website at www.thecompact.org.uk. For guidance on commissioning from the third sector, see the Funding and Procurement Compact Code of Good Practice.

Find out more about framework agreements from the Office of Government Commerce website at www.ogc.gov.uk/documents/guide_framework_agreements.pdf.

Find out more about the contract developed by Gloucestershire County Council and PCT and Brandon, from the Commissioning eBook at www.cat.csip.org.uk/index.cfm?pid=515. 'Contracting for change and innovation' looks at an example of contracting used as a mechanism to shape the market and encourage change, whilst still giving some security and stability for the provider..