Pan-Lancashire Transforming Care Partnership: Supported Living Framework

"*The Flexible Agreement has provided a way forward for accelerating discharge for people out of long stay settings to more appropriate environments supported by providers who have met high quality thresholds to meet individuals care and support needs in their own homes. For the Transforming Care Partnership it enables us to be more creative about how these arrangements can be delivered and offers us the opportunity to achieve discharges into more innovative community settings."*

Ian Crabtree, Director of Adult Social Care Transformation, Lancashire County Council, Deputy SRO for the TCP

Synopsis

In the Pan-Lancashire flexible agreement, 39 providers have been selected through competitive tendering to provide supported living to people with a learning disability and/or autism who display behaviour that challenges. The providers on the flexible agreement are able to bid, through a mini competition process, to provide supported living care and support packages for individuals leaving hospital or at risk of needing hospital. The allocation process is person-centred – every mini competition is based on different criteria according to individual needs. Since the agreement started in October 2016, 16 people have been matched to providers, three have been discharged and 13 are in the process of transition.

The challenge

Background

The Pan-Lancashire Transforming Care Partnership is a strategic alliance of four councils – Lancashire County Council, Blackburn with Darwen Unitary Council, Blackpool Unitary Council, and South Cumbria County Council – with eight CCGs and NHS England specialised commissioners.

Lancashire is a fast-track area, as described in 'Building the Right Support', and progressed its local plan before other transforming care partnerships (TCPs) in 2015. The area had a major provider of long-stay inpatient services, Calderstones[1], which

[1] Calderstones Partnership NHS Foundation Trust was acquired by Mersey Care NHS Foundation Trust in 2016, and care for people with a learning disability, autism or both is now provided through the Specialist Learning Disability Division. The commitment within Building the Right Support was that all

provided forensic and secure services, and a range of services for people who had previously been in secure provision, as well as those with complex care needs.

One of the TCP's key priorities was to increase the range of support in the community to facilitate safe and effective hospital discharge. Developing the market was an important element in this.

Market analysis

Building on existing TCP analysis and engagement, NHS England commissioned ACEVO Solutions to identify options for developing the market of providers who offered community-based support[2]. Engaging with a wide range of stakeholders was an important part of the feasibility study.

One of the main issues identified by people with a learning disability and/or autism and their families was that services should be better joined up. People also wanted reliable and flexible support that helped them to be healthy, have their own home and a good social life, and to work towards employment.

Providers wanted better information and communication to help them with strategic planning. They also described the challenges of working with people with complex needs, such as the need for high levels of skill.

The study came to some broad conclusions about current provision across the Pan-Lancashire region. While Lancashire was a proactive region, committed to transforming the lives of people with a learning disability and/or autism, a number of issues relating to the provider market needed to be addressed for the full shift from hospital to community settings to be achieved.

- The market was very clinically oriented due to the previous high levels of use of the specialist provider, and the wider market was fragmented. Commissioners needed to develop the full market and hold all providers equally to account. Greater strategic engagement with providers would lead to opportunities to develop solutions together.
- A lack of housing solutions was leading to delays in creating support packages in the community. A strategic approach to developing flexible housing options was needed.
- There was a reliance on spot purchasing rather than coordinated commissioning and contract management; this was labour-intensive and unlikely to deliver the best value for money.

The study also found a 'very active local market' with many providers, ranging from NHS trusts to national, regional and highly local private and voluntary organisations.

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hospital beds on the former Calderstones site would be provided elsewhere in the North West, and that the site would close.

[2] Documents are listed at the end of the case study and are available through the contact.

The report suggested that it was important to enhance the ability and scope of existing providers as well as attracting more providers into the regional market.

The study made a number of recommendations relating to strategic commissioning, market development, improving partnerships and clarity about costs. A key element in meeting the recommendations was to establish a supported living commissioning framework.

The solution

Supported Living Commissioning Framework – Pan-Lancashire Flexible Agreement

Lancashire County Council took the lead on developing the commissioning framework, working with the other TCP councils and CCGs. Aims of the framework, which is known locally as the Pan-Lancashire Flexible Agreement (FA), are to:

- Identify a set of providers who have demonstrated the ability to provide high quality, person-centred and cost-effective supported living in the community in line with the good practice identified in 'Building the Right Support'.
- Create an environment of co-production between providers, commissioners and individuals, so that planning and problem-solving are done together.
- Support providers to be able to plan their business strategically through clearly established communication processes and regular data on future levels of need.

A service specification for the FA was developed with considerable input from the full range of stakeholders, including people with a learning disability and/or autism and families, co-production partner Pathways Associates, professionals such as social workers, nurses and psychiatrists, and providers. The specification is outcome-based and includes standards relating to matters such as positive behavioural support and safeguarding, staff and training, personalisation and advocacy. Extracts from the service specification are included in appendix A.

Scope of the FA

The FA applies to people with a learning disability and/or autism with behaviour described as challenging, including mental health problems, who need a placement in the community following an inpatient stay, or to prevent admission to a specialist hospital. This includes people with a history of forensic care. The FA is also used for young people with a learning disability and/or autism making the transition to adult services and who are at risk of hospital admission

The FA only includes services that provide community-based, person-centred supported living. There is a separate process for people assessed as requiring residential care.

The FA covers supported living, not accommodation. It is the responsibility of providers to source and secure suitable accommodation; providers are expected to work in partnership with housing providers to identify housing options.

Procuring the FA

A tender process was carried out to select providers who met the criteria to be accepted into the FA. A panel, made up of staff from the multi-disciplinary team (MDT) and commissioners, evaluated 44 applications and selected 39. The tender process started in July 2016 and the contract became operational in November that year. Being part of the FA means that providers can apply to provide supported living packages.

Allocating support packages

Support packages are allocated in two main ways:

- Mini-competition – in which providers on the FA are invited to apply to provide a service.
- Direct award – where it would be significantly detrimental to the health or wellbeing of a service user to have a change in service provider, or for placing a service user within a suitable vacancy within an existing supported living tenancy, or if other specific factors apply, such as service user's choice, provider's specialism or location.

It is also possible to award a contract to providers outside the FA via competitive tender or direct award for similar reasons to the direct award described above.

Personalisation

Allocating support packages involves close working between the multi-disciplinary team (MDT) who support the individual, commissioners and the procurement team.

Personalisation is central to the process. Mechanisms are in place to ensure the best match between the individual and the provider. These include:

- An individual service plan (ISP), compiled by the MDT together with the individual and, where relevant, their family.
- A pen picture template which allows the individual to describe his or her priorities and aspirations, including where they wish to live (the template is included as appendix B).
- A mini-competition questionnaire for providers, with questions based on the ISP and pen picture.

Questions are selected by members of the MDT and workers from commissioning and procurement. A list of questions has been developed by a range of stakeholders, including people with a learning disability and family members. The questionnaire is used to score the suitability of providers, and has the following sections:

- Service outcomes 20% – example question: *'How will you ensure co-production in the development and flexible delivery of support plans?'*
- Transition 15% – example question: *'How will you support the individual through the transition, identifying their key needs and ensuring the least disruption?'*
- Staffing 20% – example question: *'What specific training would the staff delivering the services be provided with?'*
- Supporting Independence 25% – example question: *'How will you enable the individual to develop their interests and aspirations and build these into day to day life both within the home and in the wider community?'*

While some questions are set, other questions can be added because each package is tailored to individual needs. An example of a question added by a family member is:

- *'What is your policy with regards to working with someone who has sexualized and challenging behaviour, and what specific training have the staff had to manage this?'*

Support packages can be for individuals or for groups of people. A personalised approach is maintained for groups through providers having to demonstrate how they will meet the needs of each of the individuals involved.

Selecting a provider

The ISP, pen picture, and questionnaire are compiled into a pack and made available to providers on the FA through the e-procurement portal. Potential applicants can submit questions for the purpose for clarification through the portal. Providers who believe they can meet the needs of the individual or group submit an application.

An evaluation panel meets to select a provider. Panels must have a minimum of three scoring members, to include a social worker, a commissioner, and a learning disability nurse, supported by procurement as a non-scoring member – where the individuals are in-patients a member of ward or forensic specialist staff are also invited to join the panel. Applications are evaluated on a ratio of 80 per cent quality to 20 per cent price.

After a provider is appointed, the MDT and the provider work together with individuals to prepare them for a successful move.

The impact

Implementation in Lancashire

The TCP agrees strategies and policies that apply on a Pan-Lancashire basis, but because each area has different circumstances, operational activity, such as procurement and contract management, is carried out separately by each local authority and its partner CCGs. The information in this section covers how the FA has been implemented by Lancashire County Council and the six CCGs in this area.

As at October 2017:

- 48 requests for supported living packages have been received, and of these 23 are inpatients and 9 people at risk of admission, and 16 young people at transition.

- Ten contracts for individuals have been awarded – 11 inpatients and five at risk of admission. Three of these people are now being supported in their own tenancies, the others are preparing to move to the community.

- A contract for a group procurement for three places with two vacancies in a five-person house/flat scheme with individual own front doors has just been awarded.

- A contract for a group procurement for three in-patients and two vacancies is about to be tendered

- A proposal to procure specialist support for 13 young people with a learning disability and/or autism who display behaviour that challenges who are due to leave residential college/school in 2018/19 is being developed and considered.

Provider partnerships

Providers are described as being enthusiastic about the Flexible Agreement, particularly access to data to assist their future planning. Lancashire provides information about discharge trajectories on a quarterly basis via Prior Notifications issued on the e-procurement portal

Arrangements are in place to enable partnerships between providers, commissioners and health and care workers. The Learning Disability Provider Network includes an update on progress on transforming care and the FA. The Learning Disability Partnership Group is attended by provider representatives and self-advocates, and provides a forum for jointly developing ideas and influencing the design of future commissioning and procurement. Shared training for providers is taking place within the TCP, with an initial topic being positive behaviour support.

With the FA working effectively, there are no immediate plans to open this up to new providers. This may take place in the future, dependent on need.

Value for money

On the matter of value for money, early indications are that placements through the FA can result in significant savings. However, this is counter-balanced by some extremely large costs for bespoke individual placements. Overall, it is believed there will be some potential for savings. The financial situation will continue to be monitored.

How the new approach is being sustained

Monitoring and evaluation

An outcomes framework is part of the service specification and service providers must be able to demonstrate that they are meeting outcome measures and standards. The framework is built around twelve 'I' statements.

1. I am safe.
2. I am treated with compassion, dignity and respect.
3. I am involved in decisions about my care.
4. I am protected from avoidable harm, but also have my own freedom to take risks.
5. I am helped to keep in touch with my family and friends.
6. Those around me and looking after me are well supported.
7. I am supported to make choices in my daily life.
8. I get the right treatment and medication for my condition.
9. I get good quality general healthcare.
10. I am supported to live safe in the community.
11. Where I have additional care needs, I get the support I need in the most appropriate setting.
12. My care is regularly reviewed to see if I should be moving on.

Each of the statements has a number of outcome measures. For example, the standard on 'involvement' has the measure, 'Number and percentage of staff that have been recruited with service user/family, carer involvement'.

A streamlined version of the outcomes framework based around key performance indicators is currently being developed in collaboration with contracts officers; performance will be monitored via self-evaluation and 6 monthly visits.

Lessons learned

Securing accommodation

Both providers and commissioners are learning as the process develops. There remain challenges in securing the right sort of accommodation for people, such as investors more inclined to want to back housing projects for larger numbers of individuals. The TCP are commissioning a Housing Strategy to identify needs and assets, and to stimulate the development of housing options, which will support the FA.

It seems that some vacancies and voids in existing supported living schemes have proved suitable for some people's needs, but, for others, more creative solutions to finding suitable accommodation will be required, including developing new builds, and taking better advantage of existing housing stock.

Key messages

- It is essential to make sure that systems and culture are in place to help workers from multi-disciplinary teams, commissioners and procurement to work well together. This means understand each other's roles, and developing an ethos of person-centred practice based on promoting independence.

- Barriers between multi-disciplinary teams, commissioners and providers need to be broken down, and relationships established based on transparency and respect, recognising that providers have built up considerable expertise in working with individuals.

- Finding suitable accommodation and preparing people to live there can take a very long time. Expectations on the time it takes to reach successful outcomes need to be realistic.

Contact

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Pan-Lancashire Transforming Care Partnership website.
http://righttracklancashire.nhs.uk/

List of documents

The following documents are available from the contact above:

- ACEVO Solutions, Pan-Lancashire transforming care market development feasibility study.
- Service specification – Schedule 1 to the contract for a flexible agreement for learning disability supported living services – transforming care.
- Outcomes framework – Annex 1 to the contract.
- Transforming care individual service plan template.
- Pen picture template.
- Mini-competition questionnaire.
- Mini-competition questionnaire – group living.
- Information pack for tender evaluation panel – process overview and scoring system.

Appendix A Key features from the service specification (extracts)

Service objectives

To provide a specialist supported living service for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. The service will be underpinned by the ethos of self-directed support and person-centred care and planning approaches.

Statement of purpose

The service must be provided at all times in accordance with the specification and should incorporate the following core principles:

1. To have a good and meaningful everyday life.
2. To provide care and support that is person-centred, proactive and co-ordinated.
3. To provide choice and control for individuals over how their health and care needs are met.
4. Families and care staff get the help they need to support individuals to live in the community.
5. To support choice and control about where the individual lives and who they live with.
6. To ensure individuals receive good care and support from mainstream health services.
7. To ensure individuals can access specialist health and social care support in the community.
8. Exceptionally, if any individual has behaviour that could involve the criminal justice system, they are supported to stay out of trouble.
9. To work with local multi-disciplinary teams to prevent unnecessary hospital admissions, and where hospital treatment is necessary the individual does not stay there longer than is needed.

At all times the service will respect the human rights of individuals and their rights of personal freedom, choice in daily living, dignity and self-respect, independence, privacy, fulfilment and the exercise of self-determination.

Nature of the service

The care and support Provider will be appropriately registered with the Care Quality Commission and deliver a personal care service consistent with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

The type of service delivery model for persons in supported living should be based on the principles of the REACH standards[3].

- I choose who I live with
- I choose where I live
- I choose who supports me
- I choose how I am supported
- I choose what happens in my own home
- I have my own home
- I make friendships and relationships with people on my terms
- I am supported to be healthy and safe on my terms
- I have the same rights and responsibilities as other citizens.

The objectives of the service will be to:

- Ensure that the individual is at the centre of planning and commissioning and that services are developed flexibly and adjusted to changes in need over the individual's life course.
- Ensure that any interventions are developed through clear person centred planning approaches.
- Ensure that active positive behaviour support plans are in place which consider proactive approaches to manage risk and crisis whilst ensuring that any reactive plans are proportionate and least restrictive to manage need.
- Support individuals in their own home in order to maximise their independence irrespective of their level of need now or in the future.
- Enable individuals to develop networks of support in their local communities and to live as independently as possible.
- Ensure the principles of positive behaviour support are embedded across the staff team.

This will be achieved through:

- Personalised assessment of need and preparation of an integrated care and support plan to meet these needs.
- Provision of a 24 hour on-site team 365 days per year (where necessary) with the necessary skills to meet the needs of the service users as identified on their care and support plan.
- The Provider will maintain sufficient staffing levels to facilitate this.
- Responding flexibly to unexpected fluctuations in service user needs.
- Ensuring that the service is staffed according to the needs of the service users as described in the care plan with access to on-call.
- The provision of waking-night or sleep-in staff (where needed) to address the planned needs of service users and respond to emergencies.
- The provision of non-care and support related tasks.

[3] REACH: Support for living an ordinary life: Service review – Pavilion Publishing and Media Ltd and its licensors 2013

- Positive working relationships and links with other professionals (including, for example, Social Care and Health professionals, other social care Providers, specialist learning disability advocacy services and local community organisations) involved in the lives of the individuals supported by the service.

An estimated budget will be set for each individual.

- In line with the estimated budget, individuals will develop a Support Plan with the full inclusion of their family (where the person at the centre consents to their involvement) or any other nominated individual and facilitated by the Provider. It will be required that each individual will have their own Person-Centred Plan that will be a live document that is regularly reviewed.

Support Plans must:

- be in an approved format
- demonstrate that the individual will be supported to be safe, healthy and well
- meet needs in broad terms
- enable the individual to exercise high levels of choice and control
- maximise the use by individuals of universal services, natural unpaid supports and assistive technology
- be reliable, flexible and allow creativity and innovation in a way that meets individuals' needs
- make use of the personal budget only by legal means.

The resources will be used to contribute to shared daytime and overnight support (where appropriate) and for individual support (e.g. 1:1or 2:1) that will be agreed in the Support Plan and in relation to which the Provider's costs will be stipulated. After validation by the Contracting Body of the Support Plan the Contracting Body will finalise the individual's Budget and commence payment of the Budget to the Provider in line with this Agreement.

- Each individual's Personal Budget will be subject to review and may change as an outcome of that review.

- Provider staff will ensure that, an individual's support needs are met outlined in the Support Plan.

- Provider staff should demonstrate respect for the individual and his/her way of life. This will mean a recognition and awareness of working in someone's own home.

- The Provider will provide opportunities for each individual to make his/her own choices about how he/she wants to spend his/her Personal Budget and encourage him/her to determine from whom the Services are to be provided.

- The Provider will monitor the effectiveness of the Service and Supports to individuals and shall also inform the Contracting Body of any significant changes

to the personal situation of any individual or any individuals needs as soon as is practicable upon becoming aware of the same.

Personalisation

The Provider will be committed to person-centred support planning and will ensure that:

- Individuals have up-to-date support plans in a format that is meaningful to the person.
- They know and have a record of each individual's gifts and strengths. The Provider will actively use this information to support individuals to develop relationships and to contribute to their community.
- Staff in the organisation are trained and coached to use person-centred thinking, tools and practices.

The Provider will seek to promote the independence of the service user, wherever possible. The Provider's approach to risk will be developed in conjunction with the people they support, based on listening to what is important to an individual.The Provider will facilitate options for more natural supports, such as volunteers, neighbours, friends and family and the wider community. The Provider will ensure effective communication with service users through:

- developing an understanding of how each individual communicates (particularly those who do not use verbal communication)
- the use of techniques such as one-page profiles and communication passports
- training the workforce to have the required range of communication skills.

The Provider will ensure that the details of the personal budget is presented to each service user in a format that is meaningful to the service user. The Provider will make it clear that the budget can be used flexibly.

Advocacy

The Provider will commit to ensuring that all relevant staff are fully aware of the role and purpose of formal advocacy – Independent Mental Capacity Advocacy, Independent Mental Health Advocacy, Care Act Advocacy, and provisions therein, as well as non-instructed advocacy and self-advocacy. The Provider will commit to active referrals and support to access advocacy provisions.

The Provider will ensure that every service user is aware of the different forms of advocacy available to them, and that they are supported to access it whenever it is in the person’s best interests.

Involvement of family carers

The Provider will commit to and will be able to demonstrate that families are kept informed (where the person at the centre consents to their involvement) in a way which

works best for the family carer but with the service user remaining at the centre of the communication.

Appendix B Pen picture template

This template is filled in by the individual, helped by support workers, to identify their personal needs, priorities and aspirations. It forms part of the pack which is used for mini-competitions to select providers.

My Name: (Q number)
Age:
Current Living Situation:

Current Service Provider & Provision:

Area of needs…
Personal Care
Health Needs
Communication
Behavioral Needs
Mental Health Needs
Other

What people like and admire about me…

What's important to me…

Interests/favourite activities & skills:

Aspirations:

Dislikes:

Type of accommodation: e.g. Supported Tenancy/Residential Care

Level of support required: e.g. 1:1 support, 2:1 Support, night support/wake night support…

Staffing Considerations:

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Housing Requirements:

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Compatibility Requirements:

- Restrictions e.g. under MH Act

Additional Information/requirements

Completed by:
Role:
Team:
Contact details
Date Completed: