Person centred commissioning for better lives

Rochdale's developing story

What's the problem?

We are working to help people with learning disabilities that the system finds hardest to serve well to have good lives. To do this we want to commission support differently, in a "bespoke" way to ensure that people don't have to be limited to "one size fits all" supports that don't help them get the lives they want and are not good value for money for local public services. We are looking for a win-win, to use local resources better and get better results for people and their families.

What are we trying?

We are modelling, initially with about ten people, an approach to bespoke commissioning which brings together people and their families with key professionals and managers and providers. We are undertaking "commissioning live" in this collective way in order to facilitate a process which is led by the person and their family with direct and immediate involvement from the key professionals and provider staff who need to co-design a plan to achieve the desired outcomes. Key decisions about how to deliver the plan, use of resources, arrangements to handle contingencies and specialist roles can flow from this direct and collective planning. We will use the learning from this modelling to make more strategic decisions about the use of resources and professional skills to support other people in similar circumstances.

We have Individual Service Funds in place in supported living. This gives us the flexibility to say to a care provider "This is the budget that you have got for this year. Work with the people and families and your staff to make it better for the individual". However, what we haven't seen is the new outcomes to match that new mechanism. We have concluded that, as commissioners we need to help families and providers more to realise the potential of ISFs. We need to have a stronger focus on individuals and the specific design and planning with them.

With a group of people who need to move, for various reasons, from where they have been living now, to somewhere new and better, we have started a more systematic process of conversations with people, families and providers about what will work best for them.

We have started modelling this with workshop style sessions to directly plan and then write a contract around an individual person – using an ISF and other relevant resources that have been brought out and identified at the workshop. Prior to the workshop a social worker would have completed a Care Act assessment to be clear about a person's eligible needs and provide an indicative budget. The support provider can input details around housing and support offers and possibilities. This is starting to lead to greater creativity and flexibility in planning and hence contracting with much greater direction from the young person and family. You then have a contract as a platform not a straightjacket. This allows combinations of support designed to the person's ideas about a good life. For example, in one instance a

combination of personal assistant focussed on a person's wellbeing and community interests combines with support provider core support. The PA is employed via a direct payment arrangement managed by the family – this means they will stay focussed on those elements of the plan they are employed to support. The main players in the workshop can agree how the plan will be delivered and managed. The format of the plan is chosen by the person and family.

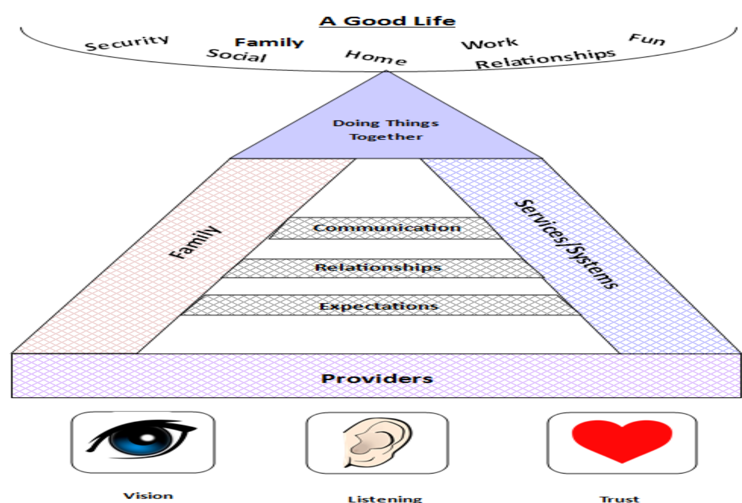
We have often found support arrangements don't work as hoped and even break down, leading to crisis and far from perfect outcomes for people. Support providers often feel left on their own, without the support they feel they need in these situations. Through working with John Waters from In Control as part of the GM Innovations project we have developed our thinking about how to make support arrangements more resilient. We are taking an approach to build in arrangements for sustainability and response to potential crisis at the first planning stage. We anticipate things that might happen – and plan how to reduce risks of various contingencies and respond better if difficulties arise. The principle for this is "the person stays at home". In practical terms this involves bringing people who can help design and deliver additional support in at the initial planning stage. This includes a range of health specialists setting up a range of supports, including "out of hours". These specialists, including people with experience of working with people under s117 orders, in effect become part of the contract. The focussing of these very specialist resources to the people and situations they are most needed to support is part of local strategic development, informed by this project.

As part of the initial planning there is a specific focus on bespoke recruitment and training. This includes specifications focussed on individual people and recruitment process similarly about both values base and individual person focus.

We are learning from the design around the first ten people that we are working with in this way. In part this will help us make the best of specific mechanisms such as individual service funds, personal health budgets, bespoke contracts, person centred job and role specifications. Beyond this it will inform a larger and longer-term strategy for others who need this type and level of support. This learning will be taken into strategic decisions about how to deploy key resources across the health and care system.

Strategic framework

To support this we are developing a strategic framework into which this learning can be embedded. This emerging framework is represented in the figure here:



A summary of the model

(1) Start with flexible contracting and ensure a full suite of assessments are available and maybe summarised so people can contextualise the professional complexities involved in the assessment world. The Care Act 2014 assessment, which will generate the care budget and probably a Mental Capacity Act and Best Interests assessments are the essentials – but any behavioural or risk management assessments that have been completed recently along with assessments the relate to the persons physical health will be necessary. Identify the key roles and players at this contracting stage – the person, health, social care, family, the provider and crucially the commissioning officer who will make sense of things and draft a contract based on a workshop style conversation covering the key elements of who will do what, in what circumstances. Then write a bespoke contract - with all the resources tabled. Say who controls how much money and consider giving the family control over a specified amount.

(2) Do a person centred plan - we know how to do that. If in doubt get the Helen Sanderson stuff out!

(3) Make sure things are factored into the plan to make sure the person stays at home. Take relevant parts of the Care Plan Approach from the Mental Health Act & factor them in. Thing like a behavioural support plan; a risk mitigation plan; restrictions on activities (maybe it's a bad idea to be near a school – for some people). Make sure clinical need management is embedded. Write down how the support provider is supported (especially on a Friday nights & at weekends).

(4) Review the contract – make sure it stays bespoke; maybe have a check list of essentials to keep it bespoke. Agree review times and make sure the commissioning officer pulls everyone together and reports on successes and issues to be supported with.