



Joint Review Report

Commissioning services and support for people with learning disabilities and complex needs

Name of council	London Borough of Harrow
Name of primary care trust	Harrow Primary Care Trust
Area	Harrow
Month and year of visit	October 2008

Commission for Social Care Inspection

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Background

We wanted to place people with learning disabilities and complex needs and family carers at the heart of this joint commissioning review.

A reference group was established that included people with learning disabilities, family carers and commissioners to ensure our methodology focused on the concerns of people with learning disabilities and complex needs.

The methodology was developed for the commissioning process for people with learning disabilities and complex needs. We wanted to understand the impact of commissioning processes from their perspective. To do this we:

- Spent time with people with learning disabilities and complex needs, which we called 'A Day in the Life of...' to understand the outcomes for people.
- Carried out mystery shopping exercises to see how far local services met individuals' needs.
- Held sessions open to the public so that we heard a wide range of views from the community.
- Held individual interviews and focus groups.
- Looked for examples of good practice that we could report, enabling others to learn and improve their commissioning practices.

The review team combined people with learning disabilities and family carers and 'peer review' commissioners as team members enabling us to focus directly on what matters to people with learning disabilities and complex needs.

(For further information on the methodology please refer to the Appendix).

The commissioning of services and support for people with learning disabilities and complex needs

London Borough of Harrow and Harrow PCT

October 2008

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The joint review of commissioning services and support for people with learning disabilities and complex needs

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Introduction

A review team visited London Borough of Harrow, October 2008 to find out how well the council and PCT were commissioning services and support for people with learning disabilities and complex needs.

This report sets out, for the commissioning organisations, the findings from the review, with a summary and recommendations for action. It is also intended to be of interest to the general public, and in particular, for people who use services in Harrow. It will support the council and PCT and their partner organisations in Harrow in working together to improve the lives of people with learning disabilities and complex needs.

Local context

London Borough of Harrow has a population of 214,625 (Source: ONS 2007 Mid Year Population Estimates (MYPEs)). Based on national prevalence rates approximately 2.36% of the population (7,000 people) have learning disabilities and the proportion of people with learning disabilities is projected to rise by 9% by 2021 (Source: Harrow Joint Strategic Needs Assessment 2008). Harrow has the fifth most diverse ethnic minority population in the country with the total ethnic population estimated at 52.9% (Source: ONS 2006 Population Estimates by Ethnic Group).

The council works closely with the coterminous PCT and with the voluntary sector, in the commissioning of services. Provision of social services for the adult population sits within the Council's Adults and Housing Directorate. The Directorate incorporates responsibility for social care services for all adults and housing services and is led by the Corporate Director of Adults and Housing Services.

Harrow PCT commissions and provides services for people with learning disabilities. Harrow PCT commissions a wide range of primary, community, secondary and specialist health services for the Harrow GP registered population, which at 233,654 is larger than the resident population.

In October 2008, the Healthcare Commission published the annual health check assessment. Harrow PCT has been rated as 'Fair' for Use of Resources and 'Fair' for Quality of Services. Across all the indicators, the PCT improved its performance in 2007-2008 compared to the previous year.

In the December 2007 Comprehensive Performance Assessment update, the council was judged by the Audit Commission to be a two star council, with a Direction of Travel judgment of "improving adequately" and a score of two out of four for adult social care services. Harrow has been a council in need of improvement for over two years.

In December 2008 social care services were judged by CSCI to be one star, with adult services being assessed as adequate with promising capacity for improvement. In January 2008, a Service Inspection of Independence, Wellbeing and Choice had focused upon personalisation for people with learning disabilities services and safeguarding for all adults. The Service Inspection found that the personalisation of services for people with learning disabilities was poor.

Executive summary of findings

Sound progress had been made in setting in place processes to put people with learning disabilities and complex needs at the centre of commissioning new services. A range of forums and opportunities were in place for consulting on new and redesigned services and the engagement of service users had been particularly successful with regard to specific investment in more community-based initiatives. However, carers were less well engaged and there were examples of the voice of the service user and carers having had little impact on the plans for the services. Learning Disabilities Partnership Board (LDPB) was weak and ineffective.

Important projects had been developed to increase the personalisation of support provided but these were at an early stage and had not yet had an impact on mainstream care planning. Multidisciplinary assessment and care planning had improved from what had been a very poor baseline in early 2008 but was yet to be adequate. Despite some episodic examples of good work, overall plans were insufficiently specific to the individual needs of people with learning disabilities, were not always available in an appropriate format and lacked bespoke and individual objectives. Access to health therapies was poor.

Cultural needs were not routinely addressed and the benefits of an extensive advocacy service had yet to be capitalised upon because of an unfocussed and unstructured approach to using this support. The improvement of the council's and the PCT's complaints services had been prioritised and the service was an increasingly important part of an embryonic quality assurance process.

A Joint Strategic Needs Analysis [JSNA] had been completed but managers acknowledged that an understanding of needs of people with learning disabilities and complex needs remained inadequate. This had inhibited the development of strategic commissioning plans and had slowed the progress of commissioning modern services such as improved supported employment opportunities. Understanding the needs of people from ethnic minority communities had been a low priority.

Where priority had been accorded to areas of service development, sound plans had been made and were based on good evidence. Progress had been achieved in relation to the development of three Neighbourhood Resource Centres (NRCs), and increased supported housing opportunities. However, robust processes for recording and understanding service deficits were underdeveloped and inconsistently applied.

Particularly poor information had been available in relation to the transitions for young people from children's to adult services and this had led to serious and enduring deficits in the quality of service provision. Managers had taken effective action to strengthen the service in 2008. However, operational guidance remained inadequate, monitoring arrangements were weak and, in some cases, the care available was determined largely by providers, at short notice and sometimes was provided outside the borough.

Progress had been made in sharing information at an operational and strategic level and opportunities for more personalised support, over which service users and carers could influence more control, were improving from a low baseline. Direct Payments had been an area of poor performance but had been prioritised, had become a Local

Area Agreement (LAA) target and had improved dramatically in 2008. A range of additional housing options had become available and more were on schedule to be available from 2009. However, overall, the range and choice of services and support remained weak. Supported accommodation and day opportunities were unavailable to most service users and recreational opportunities were limited – especially for people from ethnic minority communities.

The accessibility of services was poor and the availability of information was unacceptably variable. Sharing information amongst operational staff had been encouraged in a number of ways. These included health and social care staff using one shared database of people receiving services and both the council and primary health care settings keeping registers of people with learning disabilities. However, these tools had not been used effectively to improve service users experience of services.

Processes for managing risk were underdeveloped and insufficiently structured and auditable. The improvements underway in developing less intrusive and more independent care packages, such as supported living placements for people who had been in residential care, had not been matched by similar processes for managing risk to ensure that packages of care continued to be safe and secure. This review identified deficits in effective management of the risks associated with some increasingly ambitious and personalised casework, which included insufficiently structured protection plans, lack of identification and recording of risk factors and confusion between therapeutic and risk management initiatives. The level of management awareness of the importance of strengthening risk management processes was poor.

Partnership arrangements had improved – both between health and social care agencies and within the council. Other council departments had an improving understanding of the corporate responsibility for meeting the needs of this group and the LAA had been used effectively to identify shared priorities. However, deficits remained in relation to addressing some harassment issues and engaging effectively with adult education services.

The council and partners had adopted an overall transformation plan, which clearly set out the vision for modernising services, and the PCT had an effective operating plan, which included clear targets for improving learning disability services for people with complex needs and learning disabilities. Significant external funding had been secured for the development of supported housing and Neighbourhood Resource Centres (NRCs). There were plans for developing a commissioning team in the council, strengthening the commissioning function for specialist health care support within the PCT and a good vision for the council to lead a joint learning disability service from 2009 onwards.

However, there was no commissioning or joint health and social care commissioning plan for people with learning disabilities and staff and partners were unclear about the vision and the focus of the service. The transformation plan lacked sufficient specific targets and engagement with independent providers as important partners in developing new services was underdeveloped. There was no independent sector standing forum for discussing issues and the relationship with voluntary organisations was mixed and was under review. Contract monitoring was broadly satisfactory but

supervision of health care providers and the monitoring of key adult safeguarding clauses was poor.

Both agencies had increased funding for the service and shown determination and maturity in resolving a number of longstanding funding disputes between them. However, key health care services remained unavailable and funding for this service user group remained relatively low. There were some new programmes to increase opportunities for people to receive support in the community. A personalisation project was underway and well-scoped plans for developing self directed care and utilising a brokerage system were underway. However, progress had been limited.

Specialist health care assessments and services were fragmented, inadequate and often inaccessible. Health Action Plans (HAPs) were either not in place or ineffective. There was no health care facilitator or special protocols in place to ensure people with learning disabilities had swift, appropriate and accessible care from primary and secondary health care services. There were acknowledged gaps in services for some specialisms.

Support for family carers had improved markedly in 2008 but remained inadequate. Health and social care services had failed to engage purposefully with carers and continued to be viewed with some suspicion. Some decision-making and resource allocation processes were perceived as opaque and dismissive. There had been no initiatives to help carers remain in employment and many carers were unaware of important new services that were available.

Processes for maintaining minimum quality standards were poor and limited use had been made of established systems for checking progress such as routine reviews. The review process was increasingly implemented, but there was little quality control and the impact of reviews of the care provided was limited. Quality assurance of services provided was poor. Day care units had no targets for engaging people who used the service in out of centre activities and arrangements for ensuring that individualised activities were routinely made available, were invariably poor. Respite care was of variable quality and carers' views had not been gathered regarding features that could be improved.

Both the resource allocation panels worked well in allocating resources effectively but there was less transparency and rigour in relation to the council's panel than for the continuing health care panel. Care plan deficits had led to confusion amongst staff about the management of sensitive information and this had been to the detriment of people who used services on some occasions.

The vision for the service was clear at a strategic level but was yet to cascade effectively into routine commissioning and contracting processes. More progress had been made in developing supported housing options and there was a strong relationship between the Supporting People strategy and the vision for supporting people with learning disabilities.

However, there were few examples of commissioning utilising incentives or special contract arrangements to promote the development of the required services. Contracting was adequate but was not used effectively to increasingly shape differentiated and skilled services and the tendering process was not streamlined.

There was little dialogue with the independent sector about the required service developments. The relationship with the voluntary sector, though strong in parts, was variable.

The new senior managers in both organisations and elected members showed sound leadership and set a clear strategic direction. A range of strategic plans were having an increased effect. In the council, the transformation plan was a potentially effective vehicle for cascading the aspirations of the service and, in the PCT, the operating plan was backed up by a formal performance management process and a structured system for collecting frontline intelligence to inform service development.

However, mechanisms for sharing performance information with stakeholders and the public were underdeveloped and/or in a state of flux. The profile of the national Valuing People strategy had been low in both organisations and the vision for the service had yet to cascade to all staff and stakeholders. Communications systems were poor and there were limited basic management systems in place to drive up the quality of practice by setting local quality targets for improvement.

Significant improvement in the performance and morale of the care management team had been achieved alongside steady improvements regarding the availability of more modern services such as self-directed care. Nevertheless, the learning disability service had been failing for some years and recent performance for both organisations remained poor in relation to personalisation in care management, service quality and systems for promoting improvement. Business processes and training opportunities for staff had been strengthened but the span of control of some managers remained very large and basic risk assessment processes were not implemented consistently. Training opportunities for partners were limited and strengthened budget management processes remained vulnerable due to mounting spending pressures and unreliable forecasting processes.

The council, with the support of the PCT, had made a sound start in implementing the action plan, which had resulted from the January 2008 CSCI service inspection of Harrow council. A range of new initiatives from both agencies were increasingly effective in improving services.

Recommendations	
Putting people at the centre of commissioning	<ul style="list-style-type: none"> • The council and the PCT should strengthen consultation arrangements by ensuring that there is an audit trail of improvements and modifications. The impact of carer's views on service developments should be improved. • The council and the PCT should make the Learning Disability Partnership Board a more effective driver for change and strengthen its monitoring role. • The council and PCT should ensure more inclusive, individualised and culturally sensitive assessment of needs and care plans are undertaken and that more bespoke, ambitious and outcome focused care planning is provided. • The council and the PCT should ensure that care management support is available to people who need ongoing support. • The council and the PCT should commission more structured, focused and specialist advocacy services to ensure that the most vulnerable and isolated receive appropriate support.
Understanding the needs of populations and individuals	<ul style="list-style-type: none"> • The council and the PCT should understand more fully the range of needs of people with learning disabilities and complex needs. They should utilise better understanding of the current and future needs of young people with learning disabilities approaching adulthood to strengthen the transitions process and the range and choice of local services and support. • The council and the PCT should gather improved information about the needs of people with learning disabilities from ethnic minority communities and use this to develop increasingly specialist, accessible and differentiated services and support. • The council should make better use of intelligence from frontline staff about the deficits in service provision.
Sharing and using information more effectively	<ul style="list-style-type: none"> • The council and the PCT should continue to develop Direct Payments opportunities and support arrangements. • The council and the PCT should improve the range and choice of individualised day activities, adult education and supported employment opportunities. • The council and the PCT should strengthen the skills of staff at public access points to ensure that appropriate advice and guidance on how to secure services and support is available. • The council and the PCT should urgently strengthen

	<p>the processes for undertaking risk assessments and protection planning. Compliance with expectations should be monitored and reported to senior managers.</p> <ul style="list-style-type: none"> • The council and the PCT should ensure that care management led reviews take place and lead to amended care where needed. • The council and the PCT should work with partners both within the council and other agencies to ensure that a range of universal services is increasingly accessible to people with learning disabilities and complex needs.
<p>Assuring high quality providers for all services</p>	<ul style="list-style-type: none"> • The council and the PCT should use strengthened joint commissioning arrangements to secure an increased range of supported living services. • The PCT should strengthen the commissioning of health care specialist services including assessment and treatment, forensic services and the accessibility and responsiveness of primary health care services. • The council should ensure that the vision and aspirations of the Transformation Plan are cascaded effectively to frontline teams. • The council and the PCT should produce a detailed and funded joint commissioning plan for people with learning disabilities, including those with complex needs, and their carers. • The council and the PCT should ensure that robust clauses within provider contracts in relation to adult safeguarding issues are monitored and performance reported in a structured way. • The council and the PCT should develop a more service user orientated approach by strengthening quality assurance processes to ensure that managers know about the actuality of service users and carers experiences.
<p>Recognising the importance of good health services; recognising the interdependence between work, health and well-being; recognising human rights</p>	<ul style="list-style-type: none"> • The PCT should ensure that Health Action Plans are in place and of sufficient quality and detail to deliver structured and co-ordinated generic and specialist health care checks and services. • The PCT should ensure that secondary health care professionals have the skills and protocols in place to ensure an accessible and appropriate service for people with learning disabilities complex needs and their carers. • The council and the PCT should ensure that a high quality and flexible carer support service, including respite care, is available. • The council should ensure that better quality assurance processes are in place to ensure that day

	<p>opportunities are increasingly person centred and routinely offer community based activities.</p> <ul style="list-style-type: none"> • The council and the PCT should ensure that the criteria used by the resource allocation panel, and the reasons for individual decisions, are communicated effectively to people who use services and their carers.
<p>Developing incentives for commissioning for health and well-being</p>	<ul style="list-style-type: none"> • The council and the PCT should communicate more effectively with providers and agree the range of new support services required to deliver increasingly personalised support plans. • The council and the PCT should raise the profile of the new commissioning team with providers and establish formal and regular communication systems. • The council and the PCT should use a range of incentives in commissioning to develop a wider range of services. • The council and the PCT should streamline and make more timely the tendering process for purchasing health and social care provision.
<p>Making it happen: local accountability, capability and leadership</p>	<ul style="list-style-type: none"> • The council and the PCT should ensure that the vision of the service is articulated in a set of monitorable and specific team and unit targets. • The council and the PCT should improve the numbers of specific and personalised care plans for people who use services. • The council and the PCT should extend training opportunities to a wide range of staff to increase specialist skills in meeting the needs of people with learning disabilities and complex needs. • The council and the PCT should continue to develop and utilise emerging quality assurance processes and stronger business processes to secure better outcomes for people who use services and their carers. • The council and the PCT should speed up the process of strengthening the staffing and skills at middle management level to deliver the required improvements.

Key review findings

Putting people at the centre of commissioning

Outcome: People with learning disabilities, their families and their carers are routinely involved in the planning, design, development and evaluation of services, resulting in a far more personalised approach to service delivery.

Summary

Some sound processes were in place for engaging with service users and carers. These included good representation on the LDPB, regular meetings and the involvement of service users and carers in the development of new policies such as the carers' strategy. Service users and carers were closely involved in the initial stages of developing the well resourced plans to create three multi-agency NRCs which will provide flexible community based care from 2009. Employment of people with disabilities within the council and PCT had improved and structured programmes for developing employment opportunities were in place.

Evidence of the impact of service users and carers' views on service development was less consistent. In addition to the NRCs, there had been involvement in the development of self-directed care, the personalisation team and the wording used in the Transformation Plan. However, the impact of their views on mainstream provided services was less apparent and some senior managers were unaware of any modifications that had been made to policies because of the views of service users.

The LDPB was weak. The meetings were not used consistently to prioritise carer's views, the board did not set the strategic direction for commissioning, officers dominated some discussions and some board members found the process of meetings tokenistic. Some key organisations felt omitted from consultation processes and some frontline staff in organisations were not as well engaged as their senior managers.

Overall, engagement with service users was markedly better than with carers. Carers felt uninformed and that there was a culture of lack of transparency in decision making at both an individual casework and service development level. During the protracted period of the council and PCT negotiating with funding bodies for the development of the NRCs, carers were not consulted or kept informed of developments. Carers' confidence in the agencies prioritising the carer contribution to the modernisation process had been eroded.

Consultation arrangements were insufficiently strategically driven. Processes focused on groups with whom the agencies had established and longstanding relationships. The selection of groups for consultation and development of stronger partnership arrangements was driven more by custom and personal contacts than by a systematic analysis of the key groups with which a relationship should be developed.

Good, initial, progress had been made, through the incremental implementation of the action/improvement plan following the January CSCI 2008 Service Inspection, by the Harrow Learning Disabilities team (HLDT), and some interventions were increasingly service user centred. The practice of health and social care workers had become more closely aligned and better co-operation around sharing funding costs freely on a needs driven, rather than agency budgets dominated, basis had been more evident. Delays in processing social care assessments had been eliminated by

more creative and co-operative working.

There were recent and episodic examples of sound user focused work. A small personalisation project and yet smaller intensive support team were beginning to have an impact. Under resourcing of health care professionals within the HLDT had been addressed and vacant posts had been filled with agency staff pending resolution of recruitment difficulties.

Despite these improvements within the HLDT, multidisciplinary assessments remained generally poor and unstructured. Only social workers could undertake overview assessments and staff from both agencies were unable to routinely deploy the resources of the other agency. Health managers acknowledged that health staff often completed forms with limited attention or detail in a bid to ensure a speedy service was delivered to service users.

There were significant delays in the provision of health therapies. Where they were available, they were often expert and valued, but there were insufficient occupational therapists and there was no structured approach to managing the waiting list to reassess the fluctuating priority of needs of those awaiting a service. GPs were unaware of the services that were available.

Some care plans were missing, many were inadequate and most were not set out in a form that was accessible to service users. Objectives were routinely generic and insufficiently ambitious. There was no settled model of personal care plans and some people who used services were not effectively involved in developing their care plans. Few carers assessments were available on files and carers were not informed of the range of services that might be available to them.

Cultural needs were not prioritised in care plans and securing the services of a paid specialist carer who was of a similar cultural background was an unstructured and unplanned process. Some staff found that it was a matter of chance whether the requested carer from a similar cultural background would be available and some staff assumed, with no hard evidence that, as the care staff in certain units were of a diverse mix, they would automatically be able to meet a wide variety of cultural needs.

The commissioning of care plans and the extent and accessibility of ongoing care management support was inadequate. Individual care plans had broken down on occasions because there was little ongoing assistance to supervise and manage the inevitable stresses and strains of initiatives such as supported work placements. Service users and carers felt that getting in touch with a social worker was difficult, that social workers changed repeatedly without warning or notification and that when the assessment and procurement of a care package was complete, the care management service was seemingly arbitrarily withdrawn. This had led to some incidents of service users suffering harassment and bullying while engaged in community activities, which were not addressed by care managers. This eroded the confidence of service users and carers in some of the more ambitious care packages.

Older carers told us about a lack of planning for the future care of their relatives, when they were no longer able to provide family care. Care management decisions

had seemed to be short term and had lacked the required consideration of how needs would be met in the long term.

Advocacy services were not well commissioned, focused, specialist or consistently deployed to support those who were most vulnerable or most isolated. Advocacy were available and well deployed in some individual situations and there were good arrangements in place for Independent Mental Capacity Act (IMCA) advocacy in association with other Local Authorities. However, a clear remit for the service and a range of specialist advocacy functions and skills had not been secured. Staff were unaware of the criteria for deploying the service and the provision of advocacy often reflected individual workers preferences rather than the policies of the agencies.

The complaints service had improved. Complaints were increasingly resolved at an earlier stage and advocates had been used on occasions to enable and encourage people to pursue concerns. Analysis of complaints had led to more general learning and improvements in policies and procedures. However, arrangements for informing service users and carers about how to complain were under developed, information about how to complain was not available in an accessible format, there was little knowledge of the Patient Advice and Liaison Service (PAL) service and access to IMCA assessments for people undergoing transitions was subject to significant delays.

Recommendations

- The council and the PCT should strengthen consultation arrangements by ensuring that there is an audit trail of improvements and modifications. The impact of carers views on service developments should be improved.
- The council and the PCT should make the Learning Disability Partnership Board a more effective driver for change and strengthen its monitoring role.
- The council and PCT should ensure more inclusive, individualised and culturally sensitive assessment of needs and care plans are undertaken and that more bespoke, ambitious and outcome focused care planning is provided.
- The council and the PCT should ensure that care management support is available to people who need ongoing support.
- The council and the PCT should commission more structured, focused and specialist advocacy services to ensure that the most vulnerable and isolated receive appropriate support.

Understanding the needs of populations and individuals

Outcome: Local authorities and PCTs have an improved understanding of the current and emerging health and social care needs of their learning disability population, particularly those with complex needs, and their family carers, and have secured the resources and investment to meet their requirements.

Summary

The Joint Strategic Needs Assessment had been completed but this had not been used to underpin and inform either a social care or a joint agency commissioning plan. Both organisations had identified a serious deficit in relation to their understanding of the needs of people with learning disabilities. Plans were in place to collect further information about the broad range of needs of people with learning

disabilities, complex needs and challenging behaviour and the needs of carers.

The transitions process for people moving from children's services to adult services had been weak for many years and this had led to ad hoc placements and unplanned and inappropriate services. Due to a lack of planning and commissioning of appropriate forms of care, many of these services had been commissioned from outside the borough. The development of a steering group, transitions board and information-sharing protocol had strengthened the transitions service in 2008.

However, these improvements in the transitions process were yet to have an impact at the frontline. Operational guidance was inadequate and the policy read like a good practice guide rather than a specialist and auditable set of interagency procedures to drive consistently good practice. There were no monitoring arrangements to ensure that practice complied with the standards set out and reviewers identified recent unplanned transitions placements into out of borough settings. Providers found the transitions process 'un-managed' and managers acknowledged, and were addressing, a culture of transitions planning often being led in practice by special schools and placements made according to local contacts. Inter team protocols and management arrangements for transitions from adult services to older people's services had received little attention. Nevertheless, progress had been made in 2008 and adult services had begun managing some cases on an ongoing basis where the primary need was that of learning disabilities.

Local managers had identified three major service deficits. These included; in borough and specialist day and residential care, support regarding challenging behaviour within supported housing units and some continued use of historic residential care block contracts as weaknesses in the service provided. An action plan had been implemented and this included initiatives in relation to developing increased health care support. The importance of developing supported employment opportunities for people with learning disabilities had been acknowledged and the improvement process included a LAA target and a corporate initiative led by another department in the council.

There had been a lack of attention to equality and diversity issues. Specialist services to support people from ethnic minority communities was under developed and individual needs assessments did not effectively highlight service deficits. Little proactive work had been undertaken to scope the specialist services required for people from minority communities and for gender specific services. One particular gap identified by some Asian carers was the dearth of provision of single sex services such as day and respite care.

At a strategic level, overall analysis of particular elements of the needs of the service was stronger. Sound needs analysis had underpinned the development of initiatives in relation to the three NRCs, the strategic agreement to use the council as the lead commissioner for learning disability services in the future and the plans to use the north west London framework project to increase independent living units. However, the overall processes for cataloguing and understanding gaps in services were ad hoc and ineffective. Expertise and intelligence gathered from frontline staff was not collated and used to inform the commissioning of new and improved services in a structured way.

Recommendations

- The council and the PCT should understand more fully of the range of needs of people with learning disabilities and complex needs. They should utilise better understanding of the current and future needs of young people with learning disabilities approaching adulthood to strengthen the transitions process and the range and choice of local services and support.
- The council and the PCT should gather improved information about the needs of people with learning disabilities from ethnic minority communities and use this to develop increasingly specialist, accessible and differentiated services and support.
- The council should make better use of intelligence from frontline staff about the deficits in service provision.

Sharing and using information more effectively

Outcome: Local authorities and their partners apply the principles of *Putting People First* so that information about people with learning disabilities and complex needs is shared across agencies and used to deliver improved, personalised services and supports, tailored to people's expressed needs and wants.

Summary

The provision of, increased control over, and individualisation of packages of care had been underdeveloped in both agencies for some years. However, Direct Payments and individual budgets had been prioritised in 2007/08, take up had increased, there had been increased investment in the support agency and an increase in the hourly rate paid. A specialist team had been developed and there was an LAA target. 40 service users with learning disabilities were accessing the service and this was anticipated to rise to 30 by the end of 2008.

Nevertheless, we were told that Direct Payments progress continued to be hindered by practical difficulties including the support agency consistently being overwhelmed with demand, the hourly rate remained too low to be practicable to secure care and there was a continued lack of suitably skilled Personal Assistants.

Housing options had improved and the use of residential care, though still rising slightly, remained at the lower end of the London average. The Supporting People strategy was strong and included specific targets and impressive efforts had been made to publicise information regarding Supporting People services including visits to community groups. The service was involved in the North West London housing plan and the benefits of an integrated housing and adult social care department were being realised.

However, the overall range and quality of social care and health services remained weak. Day opportunities, education and supported employment opportunities were few. Some service users remained supported employment preparation training for up to five years and some had attended five days per week buildings based day care for over 10 years. HAPs and annual health checks were either not undertaken, poor or of an unacceptable quality.

Information about services and accessibility of support remained a significant

weakness and a substantial barrier to the most vulnerable receiving the appropriate care. Some access points had staff who lacked skills in engaging with and responding warmly to service users and carers with mobility problems, complex needs or communication difficulties. Signposting to voluntary organisations was poor. One council service indicated that if visitors lacked communication skills, then they would simply not get a service. The Patient Advice and Liaison Service (PALS) providing information for the public was widely variable.

Partnership work had been promoted at the frontline through the aligned health and social care team all using the Framework client database processes. There were good links between GP and local authority held registers of people with learning disabilities, but this had failed to deliver tangible improvements for people who used services and their carers. There was limited use of the learning disability register in social care or in health as a tool for developing new services.

Some senior managers and elected members were aware of the need to strengthen risk management and contingency plans for supporting vulnerable people in the community, risk assessments were undertaken and incidents of suspected adult abuse were investigated. The Self Directed Support (SDS) initiative included a structured approach to the management of the new and extended risks associated with care packages that promoted increased independence, engagement with universal services and community based activity.

However, the identification of the breadth of potential risk factors, risk management consideration and the effectiveness of protection plans in practice was unacceptably weak. There was no clear audit trail of management decisions about whether to utilise safeguarding adults procedures or not. No arrangements were in place to performance manage and monitor accountable staff for agreed actions within protection/contingency plans. There was confusion between therapeutic interventions and protection arrangements and some senior managers mistook enthusiastic casework for effective risk management.

Overall leadership for adult safeguarding issues was unclear and plans to create a specialist adult safeguarding unit which could set out standards and monitor compliance of practice within both formal safeguarding interventions and ongoing care management protection arrangements, had yet to be achieved. Monitoring of standards in health services was variable.

The effectiveness of the use of the Learning Disabilities Development Fund grant had been variable but was improving. The PCT had not deployed the resource in 2007-2008 but good use had been made by both agencies to develop alternative services for 2008-2009.

The impact of frontline intelligence about the needs of service users and carers on the commissioning process had improved from a low baseline. There were better links between the resource allocation panel and the commissioning and contracting staff. However, although reviews were taking place increasingly frequently, the quality remained poor. Reviews routinely failed to deliver amended or improved care plans. Where they occurred, assessor led reviews were held at inappropriately short notice while some only took place when instigated by family carers. Some reviews lacked involvement of other agencies, some did not involve family members and

outcomes were simply vague aspirations. One review had a recommendation that:

"She should be encouraged to become involved in the local community at weekends"

However, there were no implementation proposals to achieve this aim. Another review had determined that the person using the service should maintain contact with their family but no action had been taken with the result that contact had lapsed. Health needs – such as visual impairments – went unaddressed and some vulnerability issues were inadequately handled. One record identified risks and noted,

"staff should be kept informed"

but no action had been taken.

The council had increasingly embraced a corporate approach to developing services. Progress was mixed but improvements had been realised in relation to a sound directory of all council services being available, cohesion between the LAA targets and other council policies such as the sustainable communities strategy and the involvement of service users and carers in the development of wider council strategies such as the housing plan. Nevertheless, key areas of huge practical importance for the quality of life of service users and carers remained to be tackled, including effectively addressing hate crime and working purposefully in partnership with education organisations to develop accessible training courses and opportunities.

There was a lack of services for the significant proportion of people in Harrow who were from ethnic minority communities. The LDPB had identified a lack of recreational opportunities for people from minority groups as an area of need but neither the council nor the PCT had prioritised this issue until recently. The lack of knowledge of, and interest in, the particular requirements of this group had led to a dominant culture of expecting local communities to provide their own care in their own way. Some senior figures acknowledged that both agencies had failed to prioritise services for people from ethnic minority communities.

Recommendations

- The council and the PCT should continue to develop Direct Payments opportunities and support arrangements.
- The council and the PCT should improve the range and choice of individualised day activities, adult education and supported employment opportunities.
- The council and the PCT should strengthen the skills of staff at public access points to ensure that appropriate advice and guidance on how to secure services and support is available.
- The council and the PCT should urgently strengthen the processes for undertaking risk assessments and protection planning. Compliance with expectations should be monitored and reported to senior managers.
- The council and the PCT should ensure that assessor led reviews take place and lead to amended care where needed.
- The council and the PCT should work with partners both within the council and

other agencies to ensure that a range of universal services is increasingly available.

Assuring high quality providers for all services

Outcome: People with learning disabilities and complex needs have services and support in place that are personalised according to their needs and reflective/sensitive to changes in their requirements.

Summary

Improvement proposals within the council had been set out in 2008 in a Transformation Plan that sought to prioritise flexible spot purchasing to extend the range and choice of services available. The council and PCT had started to withdraw from a historic large block contract for residential care and was utilising the resources realised to develop additional supported accommodation options. A range of new services had been developed, including additional independent living units and floating support, including provision for people with learning disabilities and complex needs. A limited number of tenancies were in operation but more were planned for 2009. Significant external funding from the Department of Health and the Housing Corporation had been secured to progress the development of NRCs and to enable the re-design of warden-controlled accommodation into extra care units.

Immediate initiatives included plans to develop a discreet commissioning team within adult social care services and to strengthen commissioning specialist health services within the PCT in relation to specialist health services. There was a joint agreement between the PCT and the council for the council to take lead responsibility for the commissioning of the majority of learning disability services and the PCT had agreed to commission specialist health services. Plans included clear lead responsibility for learning disabilities services being located with the adult social care department and the joint development of self directed care, telecare and reablement services. The plans had been carefully developed and external consultants had been utilised to craft the new joint commissioning arrangements.

In social care, small-scale efficiencies had been delivered in relation to cost savings and quality improvements in some early service redesign initiatives. Specific improvements set out in the PCT operating plan included acknowledged areas of deficit in relation to health services such as assessment and treatment services, specialist forensic services and links with generic primary and secondary care services.

The Transformation Plan was sound but was yet to become fully effective in setting a clear vision for the service. The plan was well structured, included some clear percentage improvement targets, had been developed in partnership with people who used services and set out seven clear work programmes. However, the document was very new and this had led to confusion amongst staff and partners about the status of the plan and many targets were insufficiently specific to be utilised by operational managers as effective drivers for change. The plan had not been shared effectively with key partners, the underlying understanding of the needs of people with learning disabilities was weak and monitoring arrangements were poorly set out.

Plans for commissioning specific social care services were less well developed than plans for the structure and processes for joint commissioning in the future. There was no learning disabilities commissioning plan or joint commissioning plan in place and capacity for commissioning with both organisations was weak. Nevertheless, additional resources from both agencies had been used to resolve longstanding financial disagreements and a dysfunctional joint commissioning unit had been disbanded. Supporting People services had been developed and were part of the west London joint development initiative for independent living options. The PCT had also engaged with the London wide procurement programme.

Both agencies had increased investment in Learning Disability services – including a 5% uplift in the PCTs continuing care budget and a £1.2m increase in the council's adult social care budget for this service user group in 07/08. A joint Director of Public Health was being planned and a range of fragmented partnership and joint funding arrangements had been rationalised. However, the overall investment in learning disabilities services remained relatively low in the council. The provision of general health services was variable but the range of health services available through traditional services was limited; there were no healthcare therapies available at day care centres.

The relationship with the voluntary sector was variable. Some organisations were better engaged than others. Overall, working arrangements with voluntary sector providers had been strengthened through more robust service level agreements and proportionate, but effective, contract monitoring arrangements. Nevertheless, all organisations felt insecure about long term funding.

The relationship with independent providers was under developed and unproductive and tendering processes were perceived as slow and unresponsive. Despite the significant changes in the services that were being commissioned by both organisations, there was no routine 'forum' for discussing service development. Providers were not clear about the vision for the service and had not been engaged in joint planning service developments.

Contract monitoring arrangements were satisfactory. Adult safeguarding clauses within contracts were strong, monitoring had been strengthened in the PCT and some joint contract monitoring had been undertaken in 2008. However neither contract specification nor monitoring had yet been used to promote a good range of specialist and differentiated services. Adult Safeguarding clauses in contracts were sound but there were no performance management processes to monitor compliance with the expectations. Performance data regarding compliance with key clauses such as the requirement to report all incidents within 24 hours was unavailable. Health staff had not undertaken contract monitoring in the past. Providers found contracts largely 'standard' and treated as a 'requirement' rather than a driver for excellence.

Quality assurance processes were mixed. Some processes that utilised customer feedback through questionnaires had been developed, some performance indicators were improving and carers assessments were now above the average for London. However, the review process was not used by either organisation to deliver intelligence about the appropriateness or quality of the provided services. Reviews were often led by providers and focused only on reviewing the provided service. Providers told us that assessors were often reluctant to prioritise assessor led

'reassessments' and consequently providers felt obliged to undertake reviews as best they were able to try and keep pace with the changing needs of people who used their services.

Recommendations

- The council and the PCT should use strengthened joint commissioning arrangements to secure an increased range of supported living services.
- The PCT should strengthen the commissioning of health care specialist services including assessment and treatment, forensic services and the accessibility and responsiveness of primary health care services.
- The council should ensure that the vision and aspirations of the Transformation Plan are cascaded effectively to frontline teams.
- The council and the PCT should produce a detailed and funded joint commissioning plan for people with learning disabilities, including those with complex needs, and their carers.
- The council and the PCT should ensure that robust clauses within provider contracts in relation to adult safeguarding issues are monitored and performance reported in a structured way.
- The council and the PCT should develop a more service user orientated approach by strengthening quality assurance processes to ensure that managers know about the actuality of service users and carers experiences.

Recognising the importance of good health services; recognising the interdependence between work, health and well-being; recognising human rights

Outcome: People with learning disabilities and complex needs have the right to live a fulfilling life with good, accessible health care, social care and employment opportunities close to home.

Summary

Both agencies had prioritised the development of an improved range of support services. Helping people to live at home and the development of supported employment opportunities had been agreed as LAA targets and three voluntary organisations had been commissioned to provide additional support. However, performance regarding both issues remained poor. People who used services had few opportunities to engage in purposeful activity, were often bored with activities that were provided and had little access to social or health care support outside office hours.

Use of residential care was improving slowly. There were few people who were placed in NHS campus accommodation and there was an active programme for returning people in out of borough placements to more local settings and placements. A number of successful re-settlements from residential care to an independent living placement in the community had been achieved in 2008 and this had resulted in major quality benefits for those involved.

Self directed support was increasingly offered and, in some situations, a 'taster' of different types of services had been offered so that service users could choose the

way in which care was to be provided based on their experience of the range of care available. A deaf blind register had been developed, some specialist day care was available and there was an independent living scheme. A 'training house', with associated floating support had been provided to develop the independent living skills of some people considering a move to supported accommodation. Plans were in place to provide more appropriate support for people with learning disabilities and mental health needs from 2010 onwards.

Specialist health care services were not widely available and the absence of Health Action Plans meant that where they were provided it was in a chaotic way. Managers acknowledged widespread gaps in accessible and responsive healthcare services, especially in relation to children with learning disabilities, services for people from ethnic minority communities and services for older people with learning disabilities. We were told of a lack of access to speech and language therapies, physiotherapy and support for people with challenging behaviours. Service users had not been referred for sensory impairment assessment/rehabilitation and some occupational therapy reports were very out of date. There was limited specialist support for people with asperger's or the autism spectrum disorder.

There had been no specialist training or protocols for managing people with learning disabilities who required secondary health care treatment. Reviewers were told of consequent poor and inappropriate management of people with learning disabilities that led to them failing to receive appropriate medical attention for their physical illnesses. There was no health facilitator and where community support workers were engaged to provide individualised care in the community this was neither differentiated nor especially skilled. The deficit of health care support had been discussed at the LDPB and referred to the health services sub group but progress on securing improved outcomes for people who used services remained slow.

Support for family carers had improved significantly from a low baseline, the national performance indicator had improved but experience remained mixed. A range of carers services had been strengthened, some carers had had positive individual experiences and a carers 'emergency card' provided access to respite care at short notice. There was a carers register, priority had been given to support for older carers, a scheme for carers breaks was in place and a new carers strategy was under discussion. However, deficits remained. Respite care was limited, inflexible and on some occasions of indifferent quality. Services were perceived as limited and rationed by carers. Carers support was often inaccessible, not widely publicised and it was hard to access support when there were emergency situations. Many carers were unaware of the newly introduced carers emergency card. There were no initiatives to maintain/return carers to work and reviewers met a number of carers who had felt that they had been forced to give up work to care for their relatives.

The quality of Day Care services was variable and systems for quality assuring activities and programmes were poor. There were no targets for engaging in out of centre activity and limited daytime transport led to a high proportion of activities taking place within the building. Staffing and sickness problems reduced the potential for taking people out of the centre to undertake the activities they wanted to do in the community. Staff skills and their capacity to undertake these activities were not well managed.

The continuing care panel was streamlined and effective in processing applications and managing the budget. The panel had made efforts to involve service users and carers, had addressed the boundary between social and health care with increasing flexibility and had used a special joint panel in 2008 to resolve some longstanding funding disputes. However, despite improvements in the administration of continuing care, the threshold between social care and continuing care remained problematic for some service users. Some practice was led by a need to meet the criteria rather than prioritising the care that was most appropriate.

Funding decisions by the resource allocation panel were not as quick, well communicated or as well understood as for the continuing care process. Information to service users and carers did not include a clear explanation of the criteria to be met or give a coherent explanation of the rationale for the decision. There was no systematic process to promote the dignity and autonomy of those involved by ensuring transparency in the decision making process.

The inadequacy of care plans compromised both the quality of the support provided and the arrangements that were in place to promote the dignity and human rights of the person using the service. Some care plans lacked essential details as required under the Mental health Act. Information regarding capacity and consent for individual service users was not disseminated to staff who required that information to make day to day decisions about managing care. This left service users vulnerable to improper management of their rights to make decisions and staff vulnerable to allegations that they had denied the human rights of some service users. Some staff were confused about conflicting priorities and understood that by not sharing such personal information they were protecting the confidentiality of the person using the service.

Recommendations

- The PCT should ensure that Health Action Plans are in place and of sufficient quality and detail to deliver structured and co-ordinated generic and specialist health care checks and services.
- The PCT should ensure that secondary health care professionals have the skills and protocols in place to ensure an accessible and appropriate service for people with learning disabilities complex needs and their carers.
- The council and the PCT should ensure that a high quality and flexible carer support service, including respite care, is available.
- The council should ensure that better quality assurance processes are in place to ensure that day opportunities are increasingly person centred and routinely offer community based activities.
- The council and the PCT should ensure that the criteria used by the resource allocation panel, and the reasons for individual decisions, are communicated effectively to people who use services and their carers.

Developing incentives for commissioning for health and well-being

Outcome: There is effective partnership working that results in the development of a health and social care market that puts people first, and delivers the kinds of services that are important to them.

Summary

There was a clear vision to move away from large 'one size fits all' contracts and towards individual purchasing of specific packages of care. Self directed support arrangements were in place, growing in influence and there were plans to develop provider's capacity to meet growing demand. A system of brokerage to secure packages of care devised through person centred planning was to be introduced. A number of provider events had been undertaken and providers were aware of the priority of bringing service users in out of borough placements nearer to their home address. There was close and effective working with the Supporting People team. Quality standards and value for money factors were beginning to be used to develop, with providers, a wider array of choices for service users.

However, the relationship with the Independent sector had been neglected in favour of utilising block contracts and in house services for some years and the residual effect of this low priority remained evident. There were no regular forums for discussing market management/development and providers remained unclear about the vision for the service or the part they and emerging provided services might play in an improved service. Staff involved in commissioning in both the health and social care services had not had a high profile with independent sector providers and providers had not been engaged in the review of commissioning arrangements.

Commissioning decisions were not routinely used to influence the type and quality of service provided. A tiny minority of providers had received a premium for specialist care or particular quality standards. Increased casework consideration of individual needs was not matched by strong commissioning mechanisms to deliver improved health and social care services. The PCT was at a very early stage in developing their commitment to world class commissioning.

There were flexible arrangements for contracting with parts of the voluntary sector in both health and social care. The relationship with the voluntary sector was strong in parts, there was a Compact in place and the council's overview and scrutiny committee was reviewing the role and function of the voluntary sector.

Contracts or service level agreements were in place for all providers and there was some differentiation in the type of service provided and variation in the prices paid for home care services. Contract monitoring of basic expectations took place within the council commissioned services. However, business processes underpinning commissioning were slow and awkward and tendering was a longwinded and tiresome process – especially for smaller providers.

Recommendations

- The council and the PCT should agree with providers the range of new support services required to deliver increasingly personalised support plans.
- The council and the PCT should raise the profile of the new commissioning team with providers and establish formal and regular communication systems.
- The council and the PCT should agree with providers a range of initiatives and incentives to develop a wide range of services.

The council and the PCT should streamline and make more timely the tendering process for purchasing health and social care.

Making it happen: local accountability, capability and leadership

Outcome: People with learning disabilities and complex needs, their families and carers are aware of what services and support they can expect and have a right to receive from councils and the NHS.

Outcome: Commitment at a corporate, strategic and operational level means that local authorities and PCTs know what services need to be delivered and how to deliver them to improve the quality of life for people with learning disabilities and complex needs and their families.

Summary

In 2008, elected members and PCT board members gave sound leadership to developing a range of individual and personalised support systems for people with learning disabilities and complex needs. Resolute decision-making had been evident in withdrawing from block contracts and promoting more individualised care plans. Senior managers from both agencies gave clear and consistent leadership in relation to developing a wider range and quality of individualised support.

Within the council, a range of strategic plans including the transformation programme, the budget integration plan for health and local government and the joint commissioning plan had been well publicised and overall performance was monitored through monthly reports.

However, there had been few initiatives to report information in a transparent and effective way to the public. The PCT communication plan was being revised, the council website was being redeveloped and the publication of information about the work of the LDPB was poor. Nevertheless, although the profile of Valuing People within the PCT operating plan was poor, it was a generally strong document that was freely available and had some clear and quantified targets. Overall, strategic monitoring of the progress of improvement was well established in the PCT. The performance scorecard was a structured and clear way of monitoring performance and regular meetings were held with the main providers. The PCT had established an effective system for collating frontline intelligence to inform commissioning decisions.

The council and the PCT had agreed important joint targets for planned improvements regarding supported employment, supported accommodation and more regular health checks. These priorities had been set out in a clear and transparent way within, and were monitored through, the LAA process. However, notwithstanding the vision for the service being clearly understood by senior managers, it had yet to cascade to frontline managers and staff in provided and commissioned services as sets of tangible objectives and team priorities and targets. Communication systems were under developed and where they existed, targets were focused on process issues such as completing tasks on time, rather than quality issues which were of central importance to people who used services and their carers.

The details of the way in which services were to be reshaped or re-commissioned was not clear to staff. The lack of a commissioning or joint commissioning plan contributed to uncertainty and although a strategic commissioning group was in place, staff in the new commissioning team were yet to be appointed. This deficiency in capacity within the commissioning function contributed to ongoing service deficits

such as a lack of specialist support for people with learning disabilities and mental health problems.

The action plan from the CSCI January 2008 service inspection had been used as an effective vehicle for rescuing a failing service. The plan was well monitored, compliance with new requirements was increasingly managed through spot audits and basic systems such as complaints were better managed. 75% of targets had been achieved within 4 months of the plan being agreed. Increased management and practitioner capacity had been made available to the Harrow Learning Disabilities team (HLDT), customer service initiatives had been pursued and vacant posts had been filled. More stable management, more effective leadership, clearer systems and new services to promote independence had contributed to improved team morale. Management issues regarding capacity and competency were being addressed and team building initiatives had been pursued. Annual appraisals were completed and a structured system of supervision – absent at the time of the January 2008 Service Inspection had been implemented.

Nevertheless, quality assurance processes were underdeveloped and this had led to continued inadequacies in the care provided for the majority of people who used services and their carers. Deficits remained in relation to the adequacy of care planning and service provision and the systems and levers for exerting improvement and promoting a health/social care quality cycle, continued to be fragmented. Supervision, though happening was of uncertain quality and was yet to prove sufficiently challenging to deliver consistently ambitious and person centred care planning. Where progress had been achieved, it reflected personal commitment rather than systematic processes of setting out required behaviour and monitoring compliance to assure minimum standards of practice.

The services provided remained weak and the experiences of service users and carers were, at best, of variable quality and at times of an unacceptable standard. Respite care, home care, day care and access to health care services remained problematic issues. The processes for identifying deficits were underdeveloped and managers did not always take action to rectify problems. Social care processes were less well developed than those for the PCT. Overall the cultural change towards focusing on quality of service users experiences was evident amongst senior managers but had yet to percolate through the organisation to all practitioners/frontline staff.

The services had prioritised training opportunities for directly managed assessment and care management staff. Opportunities were freely available, valued by staff and included training for managers. A good practice forum had been established. However, specialist training opportunities for provider staff, both in house and in the independent sector, were more limited and specific training initiatives to develop specialist skills for working with people with complex needs, were underdeveloped.

Business processes had been strengthened with the appointment of additional finance and commissioning staff within both organisations. Project managers had been used effectively to pursue priority improvement projects. Overall budget management had been improved and a balanced budget had been achieved for the first time. Spend was beginning to shift from traditional, provided services to bespoke, individualised care plans through the development of individual budgets.

Both organisations recognised the challenge of building on achievements in budget management by developing higher quality services that delivered increased value for money.

However, budget pressures remained a significant inhibitor of progress. Financial forecasting has been strengthened through the creation of weekly meetings and the provision of enhanced financial support for budget holders. However, financial forecasts were not completely accurate and there was uncertainty about the extent of anticipated new financial pressures, such as transitions. Budgets were devolved to local managers, but the extent and effectiveness of financial support for these staff was variable.

Nevertheless, some business processes remained under developed. Sound strategic performance management and information processes were not matched by frontline quality assurance processes. A range of improvement projects and the service inspection action plan remained 'work in progress' and a number of important improvements had focused on building systems and processes for the future management of the service which had not yet had an impact on the experiences of people who used services and their carers.

Some managers had a significant span of control and the lack of capacity at a middle management level had yet to be satisfactorily addressed on a long-term basis. Plans to enhance management capacity below head of service to focus on developing learning disability services were being implemented.

Recommendations

- The council and the PCT should ensure that the vision of the service is articulated in a set of monitor able and specific team and unit targets.
- The council and the PCT should improve the numbers of specific and personalised care plans for people who use services.
- The council and the PCT should extend training opportunities to a wide range of staff to increase specialist skills in meeting the needs of people with learning disabilities and complex needs.
- The council and the PCT should continue to develop and utilise emerging quality assurance processes and stronger business processes to secure better outcomes for people who use services and their carers.
- The council and the PCT should speed up the process of strengthening the staffing and skills at middle management level to deliver the required improvements.

Joint Learning Disability Commissioning Review

Glossary

Campus Provision	<p>Provides long-term care</p> <ol style="list-style-type: none"> 1. Are through the NHS, in conjunction with NHS ownership/management of housing (residents do not have an independent landlord and housing rights). 2. Is commissioned by the NHS. 3. Includes people who have been in assessment and treatment beds more than 18 months who are not compulsorily detained or undergoing a recognised and validated treatment programme. 4. People living in such accommodation are technically and legally NHS patients.
Care Management	A process where by an individuals needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented and needs are monitored and re-assessed.
Care Manager	A practitioner who, as part of their role undertakes care management.
Care Pathways	A method of organising all of the care a person receives from different professionals and organisations, to make sure it is coordinated.
Care planning	<p>A plan outlining support and care needs for the person. This plan must include the whole person including health needs, emotional well being, employment and leisure.</p> <p>A care plan must be regularly reviewed with the individual and multidisciplinary team if appropriate.</p>
Contingency planning	Plans which are developed for the purpose of 'back up' where the planning factors (e.g. scope, forces, destination, risks, area of responsibility etc.) have been identified or can be assumed. These plans are produced in as much detail as possible, including what is needed and how to do it, as a basis for future planning.
Continuing Care Funding	Fully funded care for people who do not require care in an NHS acute hospital, but who nevertheless require a high degree of ongoing health care. Anybody can qualify for NHS continuing care funding if their needs satisfy eligibility criteria.
Care Programme Approach	A plan of care for people receiving mental health services or support from more than one professional.

Commissioning	<p>Commissioners understand people’s needs now and how to plan for the future. They are able to shape services that are fair, of good quality and change in accordance with people’s needs and wishes. Commissioners use the resources they have in the most effective ways to ensure that localities have the capacity to meet people’s needs and wishes.</p> <p>Commissioning includes a range of activities, such as:</p> <ul style="list-style-type: none"> ▪ Knowing what services people need to live a good life ▪ Using this knowledge to plan changes for the whole local area ▪ Taking action to change services where they are not good enough ▪ Paying for services to meet individual needs ▪ Checking that outcomes from services are of a good quality and changing services and plans if needed
Direct Payments	Local council payments for people who have been assessed as eligible for help from social services and who would like to arrange and pay for their own care and support services instead of getting them from the council.
Forensic Services	Services offered to people who are likely to become a danger to themselves or others and as a result have been or likely to be in contact with the law.
Gap analysis	The difference between what is needed and what is available. The difference between where you are and where you want to be.
Health Action Plans	A Health Action Plan (HAP) details the actions needed to maintain and improve the health of an individual and any help needed to accomplish these. It is a mechanism to link the individual and the range of services and supports they need, if they are to have better health. Health Action Plans need to be supported by wider changes that assist and sustain this individual approach. The Plan is primarily for the person with learning disabilities and is usually co-produced with them.
Health facilitator	<p>Someone to help support and navigate people through the NHS to access the best and most appropriate healthcare.</p> <p>Health Facilitation involves both casework to help people access mainstream services and also development work within mainstream services to help all parts of the NHS to develop the necessary skills.</p>
Independent Advocacy services	Services which support a person with learning disabilities either as an individual or as a group to raise issues with councils or Primary Care Trusts when making decisions about situations which directly affect their life.

Independent provider	Any private, voluntary, or not for profit provider that physically delivers health or social care services.
Joint Strategic Needs Assessment	A process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. Joint Strategic Needs Assessment identifies 'the big picture' in terms of the health and wellbeing needs and inequalities of a local population.
Learning Disability Development Fund	Money from the government to pay for some of the new ways of working in the Valuing People strategy. Learning Disability Partnership Boards influence locally the way in which this money is spent.
Learning Disability Partnership Board	The Board brings together council departments, health services and other sectors that give people with learning disabilities support. This means that everyone can share information about what is happening in the local area. Partnership Boards are to take responsibility for local delivery of the Valuing People strategy, led by the local Council and with the active participation of all key stakeholders.
Local Area Agreement	Three-year funding arrangement between central Government and a local area, as represented by a Local Strategic Partnership (LSP) The LSP will set out a plan of priorities for its area, in return for greater flexibility of funding streams.
Out of Area Placement	Adult social services and or Primary Care Trusts commission placements of individuals from the council area in provision outside of the council geographical area.
Patient Advice Liaison Service	A service to help patients, their families and carers, to find answers to questions or concerns regarding the care or treatment they receive from all NHS services.
People with Learning disability and complex needs	For this review the definition of people with learning disabilities and complex needs are : 16 years old and over, and experience difficulties because of: <ul style="list-style-type: none"> • The extent of their intellectual impairment; • Having physical disabilities which severely affect their ability to be independent ; • Having sensory disabilities, which severely affect their ability to be independent; • Having a combination of physical and/or sensory disabilities ; • Any behaviour that can severely challenge services; • Having a form of autistic spectrum disorder;

	<ul style="list-style-type: none"> • Having complex health needs; • Having enduring mental health needs; and • Having a forensic history. <p>And their needs require health or social care organisations to provide ongoing support and assistance, no matter how this is funded.</p>
Person centred approaches	<p>Person centred approaches look at the whole of the person and the whole of their lives, support networks, family, friends, health, leisure, education and employment needs.</p> <p>Person centred approaches are based on the ownership of the planning process by the individual with learning disabilities.</p>
Person centred planning	<p>Person Centred Planning means putting the person at the centre of planning for their lives and at the centre of the services they receive. Person centred planning is about:</p> <ul style="list-style-type: none"> • Listening to and learning about what people want from their lives; • Helping people to think about what they want now and in the future; and • Family, friends, professionals and services working together with the person to make this happen.
Safeguarding people arrangements	<p>The systems, processes and practices in place to safeguard people from abuse. Councils lead and coordinate local arrangements with partner organisations.</p>
Self directed support	<p>People who are eligible for social care knowing what they are entitled to and controlling the way they use their money to get the support they need in the way they want it.</p>
Strategic planning	<p>Strategic planning is an organisation's process of defining its strategy, or direction, and making decisions on allocating its resources to pursue this strategy, including its capital and people.</p>
Supervision	<p>A structure by which management oversees the performance or operation of a person or group.</p>
Transition	<p>When someone moves from one time in their life into another. For instance, when children are moving into adulthood, adults move in to older adult services. It can also mean when people have major changes in their life, for instance when someone moves home.</p>

Appendix

Review background and methodology

This joint review has been commissioned by the three commissions due in part to the findings of the national audit for specialist inpatient services 2007 by the Healthcare Commission (HC) and Commission for Social Care Inspection (CSCI) joint investigation into Cornwall Partnership Trust and Sutton and Merton. It also sits in the context of high level reports that have recently been published highlighting poor health and social care services and commissioning practice: *Death by Indifference*, *Mencap*, *Mansell 2* and the Disability Rights Commission *Equal treatment*, closing the gap, and most recently the Joint Committee on Human Rights *A Life Like Any Other?* and the *Sir Jonathan Michael Inquiry*.

There is also a revised edition of *Valuing People* due to be published later this year which has had considerable consultation and is expected to address specifically issues facing people who have more complex needs.

The methodology for the joint reviews was devised with an expert reference group which included people with learning disabilities, family carers, commissioners in local authorities and the NHS, academics, *Valuing People* Support Team and the Department of Health.

An assessment framework was used to assess how well the local council and PCT[s] were commissioning services and support for people with learning disabilities and complex needs. The assessment framework has eight high level statements with a set of outcomes and underpinning descriptors. The review team based the assessment framework on the *Commissioning Framework for Health and Wellbeing* (Department of Health 2007).

The joint review process was designed to reduce demands on the council and PCT[s]. Before visiting London Borough of Harrow the review team collated and analysed nationally available data held by CSCI, Mental Health Act Commission (MHAC), HC, the Office of National Statistics, key information graphical system and the information centre. The team also gathered information from the council and PCT[s] in the form of a self-assessment document, which provided evidence unavailable from elsewhere. The strategic health authority, *Valuing People* Support Team and the Audit Commission were also asked about the commissioning practice within the area.

The purpose of the site visit was to:

- Further explore findings from the data analysis; and
- Focus on the experiences and outcomes for people with learning disabilities and complex needs and their family carers.

During the site visit the review team met with people who use services, their families and carers, staff and managers from the council and PCT(s) and representatives of other organisations. The following activities were included as part of the review visit:

- “A day in the life of...” which involved spending time with people with learning disabilities and complex needs
- Mystery shopping
- Interviews
- Meetings
- Focus groups
- Good practice visits
- An Open to the public session