APPENDIX E

EXCELLENCE IN JOINT COMMISSIONING - GLOUCESTERSHIRE

The project manager spotted a tender for service which looked interesting. Contact with the tender officer led to an interview with their Joint Commissioner who leads a team of health and social care assessment and commissioning professionals. They may have the answer to working across the unhelpful health and social care divide.

Questions to Chris Haynes Joint Commissioner, LD Joint Commissioning Team Gloucestershire CC	**Answers to Jayne Lingard of the Challenging Behaviour Foundation** Personalisation project manager
What decision-making process led you to tender for this framework agreement? Did you have external advice to draw up the tender process?	We have a strategic commissioning plan which includes bringing people back into the county. For at least two years we have had a joint LA & NHS LD commissioning team (Gloucestershire CC and NHS Gloucestershire). We work from a common plan and as lead commissioner I head up the team of 8 people. We have commissioners from both health and social care. Health team members are directly engaged with complex people including people 100% funded by health and both LA and NHS colleagues work with people placed out of county. We sought advice on our tender from NDTi who act as a critical friend to us and we have also had engagement from RIPFA – Research In Practice For Adults. They look at our customer journey and give feedback on it. Both engagements are ongoing as is the framework agreement – providers can bid to join the list at any time.
What confidence do you have in existing providers locally?	The out of county people were placed out a long time ago. More recently we felt the level of expertise available locally had improved sufficiently to bring people back to the area; in addition we had done some pre-market development and made contact with providers who said they would come into the area e.g. Reach.
How will you assess the competence of applicants?	Our Commissioning Support Officer has a procurement background. She carries out initial screening. We have rejected 50% of those who have replied so far - it is a continually open list. Once screened, the scoring is done by the team. Families get involved at the individual placement level: we send providers on our list a pen picture specifying a person's sought outcomes. Providers can then apply to provide care and families help to pick out which provider is right for their relative. The outcomes are identified through person-centred planning which is done for us by Reach, which we pay for.

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How will you monitor and ask them to evidence their competence when services are being delivered?	The commissioners on the health side all have nursing background and have continuing monitoring involvement based on the person's outcomes which are in their individual contract. In addition we do annual "Quality 360". This is delivered in two parts: the first is quality checkers: people with a LD who are trained and paid to go out and talk to service users about how they are doing. Sometimes the service user is someone who challenges, but despite this the quality checker gets a good sense of how it is for that person: their visit offers great insights. The second part is the 360: a request for feedback goes to everybody around that person – everybody. They can opt to respond in one of three ways - a telephone survey , automatic interactive voice survey (via the telephone) or a personal conversation. They are asked how they think the person is doing through simple questions like "is this person doing better or worse than they were doing a year ago?" or "would you recommend this resource to people?". The process is very inexpensive! Most of it is using technology yet it is hugely insightful. Also, if there is a safeguarding or whistle blowing issue, the system automatically puts these into the operations manager's email inbox, cc'd to safeguarding! It's a clever system created for us by Process Matrix. http://www.q360.co.uk/ It's opened our eyes to information we'd never had before. Gloucestershire is the first authority to have such a service in place to keep in touch with the quality of care being provided once the service user/patient is back with us-in county. Alan Rosenbach (Special Advisor-Care Quality Commission) has described the system as 'brilliant'. The system was a finalist in the 2012 Health Innovations Awards
What relationship do you envisage with local specialist NHS LD services? e.g. if the service is in crisis?	The NHS commissions an intensive health outreach team. This team is available if required by an easy referral via health colleagues in our team. The team operates 'out there' - in the community and is shifting more and more to community delivery rather than using the ATU model. They are now planning a new team just for people who are complex and challenging.

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Who finds the housing for people who want to move to supported living?	The support provider is responsible for sourcing the housing. It depends on the individual: some people need individual supported living environments and others share 2-3 bed resources - we are not locked down to a model. But the provider will source the accommodation which could be via a separate arm of the provider. Some of the accommodation has to be specially built (for example we have someone who needs a wood free environment as he eats wood) but the support provider would lead on that.
Is there any piece of work you are particularly pleased with?	One person was placed in Colwyn Bay years ago in a PMLD environment. Because it was so far away he became completely disassociated from his family. Now he has moved back, his family see him regularly and were involved in the planning. R who has a moderate LD was in a private hospital in another county. His medical records stated he would need to be in a private hospital for the rest of his life due to his challenging behaviour. Now he is in a local supported living service for one person: his challenging behaviour was a response to other people with LD. In his own environment he is fine. He is supported by Reach. He has made a terrific DVD about his life and does workshops for us. His family maintained some contact whilst he was away: now they are delighted about him being in the local area. We use the NDTi inclusion tool with all our providers. This measures what relationships people have. In the hospital, his only regular contacts were with paid carers (with occasional family contact). Now we have re-done his inclusion tool: all the quadrants are starting to be filled up. If you met R now you would not believe that he had ever been so complex and challenging. He would certainly make a good ambassador! His service is now half the cost of the hospital service.
Are you planning to disseminate your work?	We have been talking to CQC about the quality tool. We have not done much about our out of county placements work.

Gloucestershire welcomes enquiries about their local model

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Gloucestershire used this company to help them develop their quality monitoring system.

Further information about this way of monitoring services can be found at http://www.q360.co.uk/