ABSTRACT

Health and social care commissioners in Liverpool sought to support all people using learning disability services within the city boundaries, irrespective of their levels of need. The commissioners supported the development of Options for Supported Living, a small bespoke provider (along with three other providers), to undertake the work of bringing people back into the area and meeting their needs through a person-centred approach. From 1993 onwards, a total of 20 people were identified as living out of the area, (some in placements that were no longer meeting their assessed needs, including Ashworth and Rampton Special Hospitals) and supported them to move back to Liverpool. Many of these people have reduced support needs as a result and are now able to live more independently. The reduced need for support from other community teams has also resulted in resources being freed up for commissioners.

WHAT WAS THE ORIGINAL PROBLEM WITH OUT OF AREA SERVICES YOU WERE ATTEMPTING TO ADDRESS?

Liverpool Health Authority decided as a matter of principle and in conjunction with Mersey Care NHS Trust (the provider of clinical support) and Liverpool Social Services that everyone with a learning disability (no matter how complex – so including those in medium secure units (MSUs) and special hospitals) should be supported locally in Liverpool, where appropriate (1992 onwards). This was driven by both a belief around the outcomes that can be achieved from good local person-centred support and a belief that money would be saved over the long term as challenges reduced.

WHAT APPROACH DID YOU USE / WHAT ACTIONS DID YOU TAKE?

Options for Supported Living was established in 1993 as a small locally focused provider specialising in supporting people with the most complex needs. We have supported a number of people from MSUs, assessment and treatment units following sectioning, locked wards of the old long-stay hospitals and special hospitals. Our approach focused on initially getting to know the person wherever they lived, spending time with them, their family and friends and those who seemed to have a positive view of them. This was an essential component of the pre-move process. We developed from that a person-centred plan establishing what was essential, important and desirable to the person to be supported. We rigorously risk assessed their support and produced detailed guidelines for support that included proactive and reactive work, top tips and so forth. We also produced a team action plan establishing what the team needed to do to support the person over the next 12 months.

A team of staff (support workers and a part-time or full-time team leader) was recruited matched to the person being supported (using a recruitment workshop that did not rely solely or even primarily on a formal interview).

We also contracted staff to cover relief hours so that we do not use agency staff. People then moved back with a two-month transition period. One person had lived in a special hospital for 38 years.

Housing was also a key component in the initiative. There was a housing officer within the Commissioning Team and we invested our limited non-recurring funding from the long stay closure programme with housing associations to develop bespoke accommodation for people, where people are all tenants with the associated rights and access to Housing Benefit.

WHAT WENT WELL?

The team working approach went particularly well. Liverpool Health Authority decided that for organisations to provide supported living to people with complex needs (often dual diagnosis – learning disability and mental health) effectively, they needed to be responsive, and able to make quick decisions. In depended on great staff chosen not for their experience but for their potential; hence a slightly different approach to recruitment. Staff needed to be supported well in all the usual ways: supervision, training, team meetings, on-call service, incident management and so forth. We created a ‘can-do’ culture and a creativity that allowed us to overcome issues as they arose. A joint working between all members of the person’s multi-disciplinary team ensured high-level responsiveness to issues as they arose.

WHAT DID NOT GO SO WELL?

We made many mistakes but kept learning. Our recruitment was difficult at first but is now much better in that we are tougher in relation to who we appoint and in the use of probationary periods.

Sometimes we thought that people were fully ‘rehabilitated’ before this was actually the case, and we stopped following the care plan to the letter. Some people did respond to their better life and we could reduce support over time. We got better at spotting the people who would always need careful support – this was usually down to the nature of their long-term mental health and social care need.

In the early days we did not write down our development planning on paper as much as we should have done.

WHAT BENEFITS / IMPACTS WERE THERE IN RELATION TO:

The experience of people using services

People now live pretty ordinary lives in ordinary houses and mostly have their own tenancies, with some owning their properties too. We use Registered Social Landlords and private landlords. Many people have jobs, go to college and have increased friendship networks. Many people have reduced levels of support, down from three to one to lower levels and with some no longer requiring any support.
Other quality and safety measures
Every person’s support is reviewed each month by a development manager. They complete a quality assurance audit that looks at outcomes, and monthly performance reports are completed for all managers. Overall risk assessments and guidelines for support are updated every six months. Individual risks are managed using a MOST (Maximising Outcomes Safely Together) approach. Incidents are managed by a two-tier on-call system and are signed off by a senior manager and reviewed by the leadership team for key learning.

Financial savings or other resources efficiencies
Moving from three-to-one down to two-to-one staffing has saved £70,000 per year on a single service in the case of one person, a move to having no sleep-ins has saved £12,000 per year in another case and a move from waking nights to sleep-ins has saved £20,000 per year. This is in addition to savings made in comparison with the cost of out of area placements.

The out of area service providers (e.g. improving working relationships; encouraging new provision for a commissioner)
A more positive relationship has developed between commissioners, clinicians and providers over a number of years, partly as a consequence of our proven track record. For example, on the basis of trust we could virtually instantly increase short-term support to someone going through a difficult time, with commissioners approving the decision on the basis of a phone call rather than a comprehensive assessment of need.

Your local area (e.g. maintaining better contact with people out of area; investing in local services; etc.)
Four agencies were supported to develop these services initially and three continue to provide support to approximately 60 people. A shared vision between all parties was hammered out over a long period and has relied on several key relationships between individuals including providers, clinical director, clinical service team manager, lead clinicians, social workers and individual commissioners. The trust that developed has allowed flexibility and responsiveness in difficult situations between the different parties – provider, commissioners, social workers and clinicians.

WHAT PARTNERSHIPS DID YOU NEED TO DEVELOP IN ORDER TO ACHIEVE YOUR SUCCESS?
The key was a joint vision and agreed ways of working between the two commissioning organisations: Liverpool Health Authority (now Liverpool PCT) and social services who agreed to fund support on a equal basis for complex cases. They developed a protocol for setting up new services through a joint steering group that includes the clinical lead from Mersey Care.

HOW WERE PARTNERS / PROVIDERS CHOSEN?
 Providers were chosen to ensure flexibility and responsiveness. Options for Supported Living has only four tiers of structure inclusive of the support worker and chief executive, and remains small. We invest heavily in shaping a unique culture reflecting the demands of the work we do.

WHAT ARE THE MEASURES OF SUCCESS FROM YOUR PROJECT / INITIATIVE?
People we support live successfully in the community, in ordinary housing, with much improved outcomes (for example, one person, who was previously supported in a ‘special hospital’ setting, now runs his own allotment, has been on holiday to the Mediterranean and is very active in his local community. Other people are involved in a community enterprise making jam, most have a much expanded circle of friends, several have completed college courses, volunteer in various roles and are holding down part-time jobs in addition to being able to undertake all the usual activities of daily living for themselves) and with financial savings to commissioners.

WHAT ADVICE WOULD YOU GIVE TO OTHERS TACKLING THE SAME ISSUES?
Don't fudge things. It is vital to be brave and look at the fundamentals of what is needed. There must be a greater focus on quality of life than on risk prevention. Risk management must be rigorous but not to the extent where you are being risk averse. Risks should be assessed and then managed. There are not many that cannot be managed if you think creatively and all work together.

Providers need to have good systems, but only a few, well applied – too many and they can lose focus on what matters. You need to respect the providers, especially the people doing the actual support. Our good providers were also proactive in ‘supporting the supporters’. If something goes wrong, we all have to assume responsibility and work together to fix it.

Vision and values must be owned by everyone working in the purchasing/care management, clinical and provider teams.