NDTi

National Development Team for inclusion

Incentives for Private Sector Change

A Report of the Local Services for Local People: Learning Disability Private Sector Hospitals Project

learning
disability

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Background to the Project

1. The growth of private sector hospitals for adults with learning disabilities has attracted considerable attention. They have, it is claimed, replaced the NHS long stay institutions in a policy vacuum that has closed NHS provision whilst allowing private hospitals to grow. This belief system largely ignores the facts.

2. In 2002/3, at the start of the Valuing People policy for the closure of hospital beds, there were 6,009[1] NHS long stay and campus beds in England. There has been a steady growth in private hospitals opening since 2001, but even so, when the Local Services for Local People project began in 2008 there were 1,150[2] private hospital beds[3]. Given that the overwhelming majority of NHS beds had been closed down (with some of the campus beds in the last stages of closure/replacement), there were about 75% fewer hospital beds in 2008 than at the start of the Valuing People closure programme. Also, over half of private hospital beds were occupied by people either placed there by the courts or detained under the Mental Health Act. Anecdotally, a significant proportion of people are also on the autistic spectrum without a significant learning disability. People in those situations only formed a very small proportion of those in the old long stay hospitals. This means that in addition to there being fewer beds, the population profile of the people using the private hospital beds was significantly different to that which previously made use of NHS hospital provision.

3. Many people are living in these private hospitals on a long-term basis rather than being admitted for short term 'assessment and treatment'.   It is hard to see how the principles described in the Mansell Report of individualised service design can be fully brought to bear within such hospitals. Services are generally congregate in nature, frequently very expensive, usually in settings well removed from opportunities for community engagement and often remote from the person's home community and connections. However, it is important to note that this paper is not suggesting that it is only is such private sector hospitals that poor practice and outcomes for people who challenge services might arise. CQC has identified good and poor practice from all

1 Emerson E. An Analysis of NHS Long-Stay Beds and Residential Places for Adults with Learning Disabilities. (2003) Lancaster University.

2 Data provided by healthcare Commission to NDTi October 2008.

3 More detail on private sector provision can be acquired through the Laing Buisson annual market report.

types of provider – including the NHS and voluntary sector. Rather, such poor outcomes are more likely to arise within the (predominantly private sector) hospital facilities because of how its design is at odds with the evidence base and recognised good practice.

4. An additional complication is the question of what is, and what is not, a hospital. Not all the providers of hospitals registered with the former Healthcare Commission described their services as hospitals. In some cases there might only be limited differences between the 'care regime' in these hospitals and that of some larger residential or nursing care providers, though the legal status and rights of people living in the former are clearly those of a 'patient'. Some current hospitals were registered care homes until the Care Standards Act 200 require them to be re-designated. The new arrangements for providers to be registered with CQC appear to add further complications that at the time of writing this paper are unclear.

5. There is also an alternative view held by some that private hospitals provide a service for people that have been let down by NHS, local authority and voluntary sector services. People are often placed in private hospitals because all else has failed and, often, other services have given up on them. They offer a service and a degree of continuity in life for people that other services have failed to deliver – sometimes with a degree of success, helping people move on and supporting them to remain in more independent living arrangements.

6. These differing views risk generating a polarised debate with two valid points not being recognised by opposing protagonists, i.e. that (i) private hospital service design is generally at odds with policy and recognised good practice and also (ii) that some (possibly even many) people using those services have been 'failed' by other 'ordinary' services and find a degree of stability in their lives within the hospitals.

7. Consequently, the Government's Valuing People programme instigated a project, through the National Development Team for Inclusion (NDTi), to explore how to support private sector hospitals modernise their (non-secure) services in line with Valuing People Now and the Mansell Report. The aim was to help them reduce large-scale institutional provision and explore other approaches to offering to commissioners and providers the skills they describe in supporting people who present significant challenges.

8. Free development support was offered over an eighteen-month period to work at strategic and operational levels – both with the provider and to engage commissioners in a process of change. The expectations the project wished to place on providers were that three outcomes would result over the lifetime of the Project:

- Some people would be supported to move out of the hospital to individually designed supports at a faster pace than would otherwise have happened

- As a result, the number of beds provided in the institution would have started to reduce as part of a process of service re-design, though the provider may end up working with at least as many people but in alternative ways and settings.

- The provider would have been supported to develop an alternative approach to provision that retained its position in the market, but by offering its skills through a service model less based on in-patient, bed based provision.

9. This last point is particularly crucial as it was recognised that hospital providers would wish to protect their business interests. If private providers were to be engaged in a process of change, then they would have to see a continuing role for themselves that would maintain their financial viability. Seeking to close or reduce the size of the private hospitals without supporting the providers to develop alternative services would clearly have been a non-starter. It is important to emphasise that this project **was not** about seeking to close down or reduce the role of private sector provision, but rather was aiming to reduce the size and availability of learning disability hospital provision that is out of line with policy intent and which, nowadays, is largely located in the private sector.

10. Finally, it is important to note that this work was undertaken and the report was written prior to the BBC Panorama programme in June 2011 that highlighted the abuse of people with learning disabilities in a private sector learning disability hospital in Bristol. This report has intentionally been written in a factual manner to report on the project undertaken with funding provided by the DH. Comment and analysis (page 17 onwards) on the implications of the findings has been limited to that directly deriving from the project. Clearly, these findings potentially take on a new perspective in the light of the recently disclosed abuse. A supplementary 'comment' on how the findings from this work could be applied to recent developments can be found on the NDTi website at www.ndti.org.uk/publications/ndti-publications/supporting-change-in-private-sector-learning-disability-hospitals/. That commentary is exclusively owned by the NDTi and in no way reflects the views of the DH as the original funders of this work.

Finding Participant Providers

11. On this basis every provider of private hospitals registered in England with the Healthcare Commission (as was) was invited to express an interest in joining the project. The original intention was to work with three different hospital providers. Hospital providers were written to individually, and asked to submit a short expression of interest.

12. The response was disappointing. Despite follow-up approaches, less than half of the registered providers responded. Some of the largest providers of the bigger hospitals were amongst those who did not engage. Of those that did, aspirations were limited and the three changes outlined above (i.e. people moving on, 'bed' numbers reducing and new service models being developed) did not seem to be on most organisations' agendas. The conclusion we were forced to draw from this was that there simply did not appear to be a general desire to move towards achieving these changes amongst the majority of private hospital providers.

13. This created problems in identifying providers with whom we could work. A basic starting point for achieving change is that people need to want to change. It was agreed at the outset that unless there was evidence that at least some key players in the organisations were 'up' for the change agenda, there was no point in engaging with an organisation. In an eighteen-month change support programme, if the case for change is not accepted, then it would have taken significantly longer than the time available in this project for progress to be achieved.

14. To illustrate this here are examples of the position reached after telephone conversations with some senior provider managers:

- The only agenda for one provider was to improve their person centred planning processes. Having recently invested in refurbishing their hospital unit, they stated they had no intention to change that further or amend their service model, but wished to encourage staff to be more person centred within that environment. These aims were too limited for the project.

- Several discussions were held with one major national provider that operated a number of hospitals. Particular efforts were made to engage with this provider given their position in the market. However they were unable to offer any vision of intended change. The NDTi was informed that they could choose which hospital

site to work with (the provider not being able to identify a need for change themselves at any particular location) and when one site was finally identified, and the senior provider manager was pressed about desired outcomes, these were stated as being to (i) partition wards to make the environment more homely and (ii) undertake work with the local community to support them to be less hostile towards the hospital and the patients there. These were insufficient aspirations for this project.

- A third provider was unable to identify any plans or wishes to change their service, but described the problem as being others (e.g. commissioners) perception of what they offered and saw engagement in the project as a way of addressing that and their image.

There are clear lessons to be drawn from this that will be discussed later in this paper

15. However, it must be emphasised that not all private providers responded in this way. Two providers presented the NDTi with a strong organisational intent to change elements of their existing hospital provision and following discussions with their senior managers, it was agreed to start working with those two organisations.

Organisational Agendas for Change

16. The two organisations were coming from significantly different positions as described below. As we wish this paper to be a discussion of the policy and delivery issues around changing hospital provision, and not about the individual providers, the organisations are not being named and the level of detail written around their particular plans will be limited. The important information is the contextual narrative that follows.

17. **Organisation A** provided a number of hospital-based services and also other services that were not registered as hospitals. They had, for some time, been engaged in a programme that involved changing both the design and practice within existing services as well as developing a new model of working that would reduce future dependency upon (particularly large) hospital provision.

18. The invitation to the NDTi was to work with them and focus around one hospital service that had been the last major development they had made under the 'old model', and was thus a relatively new facility operating within a model that they wished to leave behind. Essentially, it was a medium sized hospital unit for people who presented significant challenges – largely people with less severe learning disabilities. It broadly operated as two units on different floors – with one being for people whose challenges were greater and thus were deemed to require a slightly different 'regime'. The hospital operated at close to 100% occupancy and we were informed of a reasonable 'throughput' of people in terms of partnership working with local commissioners to design and support people moving back to more local services. People were placed by a large number of different commissioners from across broadly one region.

19. **Organisation B** had a smaller number of services and operated predominantly in one relatively defined part of the country. They were aware of the need for significant change and of shortcomings in the current services, but were not that clear on what the future would look like for their services or their role in the market. What Organisation B offered was an openness and willingness to explore options for change.

20. The invitation to the NDTi was to work around one hospital that provided for people with a wide range of needs – many of whom had lived there for some considerable time. Whilst a number of commissioners were involved, there was a relatively close relationship with a local commissioner who was supportive to the desire to change and develop the service. The inside of the property had been adapted to create a number of 'flats' for small numbers of people along with additional investment in connected services in the grounds. The constraints of the building were recognised both by the provider and their main purchaser.

Common Challenges

21. As will be noted below, the journey with these two organisations took different paths – but the initial analysis of the challenges to be faced was broadly similar between the two organisations. The key managers and clinicians articulated a number of frustrations with the existing hospital model that could be summarised as follows:

22. *Dissonance with acknowledged good practice.* Key players from the organisation's senior management and local managers and clinicians (particularly in provider A) were all aware that the design of the service was not in line with recognised best practice and wanted the opportunity to lead a different type and style of service

23. *Environmental constraints.* Linked to this, a strong view that the physical environment created restrictions on being able to support people in the way that staff wanted, and there was a desire to be able to work with people in both a different physical environment and in settings that were closer to peoples 'natural' home and community life.

24. *A frustration about 'place' in the service process.* People were unhappy (again particularly in provider A) that they were generally the end-point in a story of service failure. Almost without exception, people entered the hospital because all other local services had failed people. This meant two things – firstly that staff were not able to work with people at an earlier stage to prevent a decline in people's lives and be more pro-active with interventions (as staff would wish). Secondly, it meant that the staff, and the hospital they worked in, did not feel a valued part of the service system (though they did note that many commissioners and others respected their interventions). In the words of local managers "No-one ever places someone here out of choice – it's because they have run out of other options".

25. *Frustration about relationships with commissioners.* The quality of relationships with commissioners varied. With some, there was limited contact and the relationship was purely one of 'purchasing' a place and then moving the person back out at a later date. With others there was a close relationship that involved joint work on planning for the individual, designing the new service a person would move to and supporting that move. The latter was more valued and satisfying. For Provider B, a positive relationship with a local commissioner had developed over the previous year or so.

26. *Variable relationships with other providers*. Linked to this, there were (particularly with provider A) some (limited) good relationships with providers of services that people moved out to and support was provided over a transitional period. With other providers, there was limited contact, a feeling that the advice and interventions that had been part of people being able to move on were not being followed through and, all too often, services broke down again and people returned to hospital.

The Journey

27. The early part of the work with **Organisation A** was to assist them in developing embryonic ideas about a future service model that would enable them to address these concerns and find a new place in the 'market'. In order to protect the commercial sensitivities of that organisation's thinking, the detail will not be described here. Suffice to say it involved the organisation developing an 'offer' that it would present to local commissioners of a partnership around working with the people who most challenge services. This was for a comprehensive range of services that could be brought into place with individuals on an ongoing basis, including:

- Specialist input and expertise (including clinical services) to support people at home and/or in supported housing/residential care as an early or ongoing intervention to help maintain the situation and prevent breakdown

- Training and other support to independent support providers

- The back-up of a small number of hospital beds if needed

- 'Move-on' accommodation run directly by Organisation A as a 'step down' facility

- Ongoing supported housing/residential services provided as part of a local market of options.

28. Whilst this raised a number of questions, this vision offered the potential of a way forward that could be attractive to local commissioners. The outstanding questions included:

- What this model said about the role of local NHS provision as it would be overtly moving into competition with the NHS over areas like clinical advice and input to people living at home

- The risk of a perception of 'vested interest' of the organisation was both providing its own supported housing and advising/training other providers.

- What the evidence base was to support the concept of 'move-on' accommodation rather than people being supported to move directly to an individualised support package.

29. However, after some initial discussions about this model and starting work with the staff team to prepare for change, a decision by the senior managers of Organisation A meant that their involvement had to come to an end as they were unable to continue to fully commit to all the criteria for participating in the project. Essentially, whilst they wished to explore developing this new service model, they wished to do so <u>alongside</u> the existing hospital provision and were not prepared to commit to either changing or reducing the size of the current hospital in the foreseeable future. As this DH supported project had the explicit objective of supporting a reduction in the number of beds in larger hospital provision, continued work with organisation A would not achieve that and the NDTi felt it would have been inappropriate to support one private provider to develop new models of working for the market and thus potentially expand its market share without it also being associated with a commitment to the desired reduction in hospital beds. Following amicable discussions, it was therefore agreed to end Organisation A's involvement with this project.

30. **Organisation B** recognised that one of its hospitals was in need of significant change in both its building structure and fabric, and in the mode of service delivery. At the outset, the organisation was unclear what specific role it wished to see, for the hospital and the organisation, in the market. However, the senior management, which was undergoing some significant changes at the time this project started, recognised the need to bring provision more in line with national policy and the evidence base, and there was clearly a strong executive and senior management commitment to embrace change. The local commissioners (although they were not majority purchasers) were also clear that they wanted and would support change. Work continued positively with this organisation through to the end of the project.

Positive forces for changes

31. Some important factors can be identified from our work with both organisations to inform how to make change happen.

- *National and external perspectives.* Some people in key senior positions had both (i) a wide national perspective of policy and good practice and (ii) in part had come into the organisation from other elements of public services (i.e. not primarily concerned with hospital provision). This brought a knowledge base and an ethos that was around seeking excellence in terms of outcomes for individuals based upon policy and evidence.

- *Local leadership for inclusive outcomes.* Linked to this, leadership (both managerial and clinical) at a local level saw the quality of life for individuals as the key outcome, defined by people being able to return to 'ordinary lives' in communities as opposed to success being measured by managing behaviour within a defined environment or people leaving the service being viewed as a loss of 'business'.

- *A partnership approach.* A recognition that the organisation is part of a network of services and supports that are essential if people are to experience a good life and challenges be overcome. From commissioners through to other providers of services, there was a willingness to work with others who might, in other situations, be seen as competition or threats and this was something that created a sound basis for change.

Obstacles and challenges

32. We identified two significant factors that we believe are obstacles to change in terms of private sector hospital provision.

33. *A multiplicity of commissioners.* The fact that both hospitals had a multiplicity of commissioners provided a challenge from the outset. Organisation A had 11 different commissioners, most of whom only purchased one or two places. Organisation B had 16 different commissioners, 14 of whom were health commissioners purchasing 86% of the places, and 2 of whom were local authority commissioners (only 3 places were jointly purchased). For either organisation, with so many commissioners in the frame, it was difficult for one commissioning authority to have a sufficient scale of interest to make engagement in a change process a priority for them. Bringing such a large number of (fairly scattered) commissioners together to agree a joint strategy and approach is notoriously difficult, and, in many ways, having a hospital available as a fall-back position when local services failed may have been seen as a useful option by commissioners. Most NHS long stay hospitals were closed because of an external drive and imperatives from the old regional health authorities. There was no such driver for change for these current commissioners. For either organisation to have confidence in developing a new model, they needed to get 'sign-up' from a number of commissioners who were likely to see them as marginal players in their local market. Our attempts to generate this interest and sign-up from commissioners met with limited success as they did not have a pressing imperative to engage with the process. The evidence from this project is thus that the 'levers' available to develop such cross-commissioner momentum are limited.

34. *A challenging economic climate.* We believe that this was the most significant obstacle, though must emphasise that the following analysis is our interpretation rather than being derived from explicit statements by either organisation. We have no doubt about the genuine desire by both the senior and local/clinical management present at the time in the organisations to change the identified hospital service and move away from the preponderance of hospital beds they were providing. However, a private sector provider has obligations to its owners/shareholders (often including elements of the senior management team itself who may hold significant levels of shareholding). Two of these obligations are to remain financially viable and to show a return on investment. Key to this is the value of the company – which is particularly important at times such as the sale or refinancing of the company.

35. Most private providers are financed in part by debt. Banks lend the organisation money to invest in developments and base that lending (in part) on current financial performance (generally measured by EBITDA – earnings before interest, tax, depreciation and amortization). Put simply, banks will lend an organisation an amount of money based on a multiple of their current EBITDA. Therefore, in order to service that debt and satisfy the banks that they are financially viable, an organisation has to retain its level of present and projected profitability as defined by EBITDA. Thus a significant consideration of managers when considering service change is the impact of proposed changes upon short-term profitability.

36. This question is compounded if the general economic climate changes. It is stressed that we do not know and did not seek out the confidential arrangements between the organisations and their bankers, but we are aware that, in general, the banking system has been reducing its multiple factor on EBITDA to their customers in all sectors as part of the banking systems response to the current recession. In other words, rather than (for example) lending eight times an organisation's EBITDA, they might only lend a multiple of five. As a result, if a loan comes up for renewal, the organisation will need to increase its profitability to be able to continue to service its debts to the banks.

37. Linked to this, the value of a company is also viewed in terms of the collective profitability of its constituent parts. A hospital is an easy 'unit' to conceptualise – beds sold at a given fee that generate a surplus after costs towards organisational profit. The traditional private sector model is to grow the business (financed through debt) and thus the profitability by adding new business units (hospitals) that contain safe predictions of profit based on past 'unit' performance. If alternative service models more in line with the Mansell Report are developed, consisting of preventative services, sessional input and flexible contracts for support, these are more complex to cost and predict. At a time when banks are less willing to lend, and are looking for greater security from companies, a move towards untried (in business terms) models that have no recognised framework for costing and predicting profitability will be attractive to neither the provider nor the bank.

38. The conclusion we draw from this comment on the general economic situation is that, at a time of economic recession and a tightening of bank lending, a private provider will feel less able to take decisions that involve closing off an existing income source in favour of a (largely untried) alternative approach that may take a couple of years to show a comparable financial return - even if the senior managers believe it would be the right thing to do in terms of outcomes for individuals as the consequence could be the banks calling in the debt. The risk of reducing EBITDA at a time when they need to increase it because of changing bank lending arrangements could be sufficient to deter adventurous service change.

Key Lessons and Learning To Date

The Role of Policy

39. The first piece of learning from this work was the largely irrelevant nature of national policy in terms of influencing change. The difficulties described in sections 10-14 around identifying organisations to work with were underpinned by <u>most</u> providers of private hospital provision not seeing the need to deliver government policy. Policy for non-secure services is fairly clear, as described in Valuing People, Valuing People Now and the Mansell report. Services for people who are labelled as challenging and/or who have mental health needs are expected to be individualised, delivered in 'ordinary' small scale settings where people are accorded the same rights as other citizens as far as is possible. The evidence base supports this and indeed informed the development of the policy. Large, hospital based settings are clearly not what policy intends – as evidenced by the fact that institutions of that type that the state directly controls, i.e. NHS provision, have been or are being closed down (the long stay hospitals and the campuses) - just leaving a small number of small scale assessment and treatment beds where occupancy levels are expected to be short-term.

40. Despite this, we were only able to identify two private sector hospital providers who appeared to have a serious intent to change their provision to be in line with policy – despite the offer of eighteen months of free development support to assist them in that journey. We cannot comment on those providers who did not even respond to our attempts to engage them in this work, but of those that we spoke to that we did not subsequently engage with, there was clearly one or both of (i) a lack of knowledge of what policy said, and (ii) an intention to carry on with existing provision even though it was known that government policy indicated otherwise. They saw themselves as running a business and the correlation between that business's 'product' and national policy did not seem to very much concern them.

41. This has to raise serious questions about the real impact that policy has on parts of the private sector provision of hospital care for people with learning disability. On its own, policy seems to be an ineffective tool for achieving change. Unless those responsible for regulating private hospitals (nowadays the CQC) are required to enforce the policy in a more rigorous way (rather than just review standards within service design that is out of line with policy) then direct influence of policy upon providers does not appear to be a route to change. Similarly, the lack of requirement upon the private hospital sector

to engage with the Valuing People delivery support programme appears to have enabled a significant proportion of private providers to continue with existing provision without the challenge that was being presented to local authorities, the NHS and voluntary sector providers. Decisions by the Coalition Government to reduce or end national and regional delivery support programmes risk exacerbating this problem.

The Role of Commissioning

42. This therefore places an important role upon commissioners and the commissioning process if national policy is to be delivered. There are two main conclusions from this project in relation to commissioning:

43. Commissioning and commissioners that are knowledgeable about policy and are interested in developing a working relationship with an existing hospital provider can be a powerful force for effecting change. This requires an approach that is not based upon an 'arms length' relationship, but recognises the mutual benefit of partnership working in the interests of achieving policy outcomes and changed services that deliver better outcomes for people.

44. This positive impact does, however, require a degree of critical mass in terms of commissioning purchasing a sufficient proportion of services within a hospital. This creates a dynamic where the commissioner can justify investing time in supporting or driving change i.e. demonstrating leadership. It is also important for NHS and local authority commissioners to be commissioning in an integrated manner. Where this is not the case, and there is a multiplicity of commissioners, such a dynamic is unlikely. This problem was overcome in previous NHS hospital closure programmes through the RHA/SHA taking on a co-ordinating or programme management role. However, there is no policy imperative for that to happen with private sector provision and the recently announced NHS reforms will remove this tier of NHS management – leaving such strategic initiatives to GP commissioning consortia who will clearly need to work in partnership with neighbouring consortia if they are to have a positive impact upon the nature of private sector hospital provision in this sector.

The Importance of Leaders with Vision

45. It may be stating the obvious, but having leaders/managers/owners in the private sector who are fully committed to national policy and the vision described in it is essential if change is to be achieved. In NHS reforms (such as long stay hospital closure) it was partly possible to overcome opposition by local managers through 'command and control' mechanisms (for example the Minister authorised 'visitations' to SHAs and PCTs where long stay hospitals were not being closed) – but these levers do not exist to impact upon the private sector. If an owner/manager is either unaware of (for example) the Mansell report and/or decides they can continue in business

without paying due regard to it, then they are quite at liberty to do so, as long as they meet with the minimum regulation requirements.

46. Change instigated from within the sector depends heavily on leaders, managers and owners wanting to make it happen. The work carried out with Organisation B particularly demonstrated this. Clinical and front-line manager commitment to such change is also vital, but at the end of the day a decision to instigate change will come from those senior players who can be sufficiently entrepreneurial to see the medium term market and financial benefit from re-positioning their organisation as one that achieves better outcomes for people by being 'leading edge' in policy and service terms – even if this means taking a short-term financial risk. The work we did with Organisation B also demonstrated that there are positive ways of supporting this.

The Impact of the Finances and the Economic Climate

47. The work of this project confirmed one of the starting assumptions in its design – that private sector providers will be unlikely to engage in a change programme unless they can see (at worst) no commercial loss and (at best) commercial advantage from the change. Approaches to the private sector and strategies to support change must be grounded in that reality.

48. A further conclusion is that, as described in paragraphs 32-34, the potential for private providers to take the financial risk associated with changing services that are still proving commercially viable but which might be weak in terms of outcomes, appears to be significantly reduced if the economic climate in which they are operating is challenging. Put more bluntly, the chances of achieving values driven change is greatly reduced during difficult economic times unless private sector owners/senior managers have the will **and** authority (with regard to banks and shareholders) to manage the risks of their entrepreneurial vision – planning for the future rather than playing safe with the current market.

49. Whilst this paper is about private sector hospital provision, it is important to note that many private sector providers are increasingly seeing NHS Foundation Trusts as their 'competition'. In that spirit, and given the increasing emphasis on NHS Foundation Trust independence from the state alongside requirements for them to demonstrate financial viability and a return on their capital investments, it may be interesting to consider the impact this may have on Foundation Trust behaviour in the future. Will a combination of changing regulatory frameworks and financial imperatives lead to NHS Foundation Trusts prioritising financial concerns over policy delivery in the way that this paper identifies is substantially the case for the private sector?

Conclusion

50. The work on this project has resulted in us having a significant degree of admiration for a number of staff and clinicians working in some elements of private sector provision. We have seen staff demonstrate a degree of commitment and willingness to 'go the extra mile' in difficult times that is highly impressive. We are also clear that many staff would prefer to be seeking to deliver services in a different type of setting – but history and economics mean they are sometimes still working in large hospital institutional settings. It is also clear that many people with learning disabilities are currently living in private hospital provision because the 'traditional' service system of local authority led commissioning, supported by NHS commissioned clinical input, with a combination of local authority and third sector support provision, has failed to adequately address the challenges presented by people. The result is placement in a private sector hospital, usually by NHS commissioners, that is constrained by a 'containment' approach that often frustrates the staff as much as commissioners and policy makers.

51. What exists is a sub-system of the learning disability health and social care system that is at odds with evidence and policy but which continues to operate because no-one with power has the incentive to change it. It suits the providers of the hospitals because it meets their corporate financial needs. It suits many commissioners because it provides a fall back position (often one of 'out of sight out of mind') when poor commissioning of services for people who challenge has led to service breakdown. It suits many families because, following years of their relative being passed between services that did not work, they at least experience a degree of continuity and security within the institutional hospital setting. The only people it does not suit are the people with learning disabilities themselves, who are not supported to live a decent quality of life, in their communities, with support to address their unique needs – but their voice has little or no power within the system.

52. It is clear that there are limited levers to change the system and achieve a reduction (and indeed cessation of growth) of private hospital places or to encourage private sector models that deliver policy aims. The ideal situation is that the managers and owners of the hospitals set down their own vision for an alternative approach based upon the evidence that better outcomes can be achieved through alternative, individualised service models. This kind of provider driven change exists in only limited circumstances. The reality is that delivering national policy just because that is the expressed wish of the government is unlikely to have 'traction' in the private sector –

though we urge that this should not mean an end of action to try to persuade the private sector to 'buy in' to the policy vision.

53. The major hurdles to be overcome are those of finance and profitability. If the private hospitals are to be encouraged (as opposed to required) to change, then the owners and managers need to be offered an alternative role in the service system that is commercially attractive and enables them to continue to add value (in financial terms) to the company. Even if that is successfully done, there may be a reluctance to risk significant change because of financial uncertainty – a reluctance that may increase during times of economic recession, given the way in which most private providers are financed.

54. This places commissioners, NHS and local authority working together, in the position of key agents for change. Commissioners need to clearly articulate their own vision and commissioning intentions in line with national policy in a way that leaves no room for misunderstanding by private (and indeed voluntary sector) providers[4], and then support this with outcomes based contracting and payment by results models. The message should be clear that commissioners wish to develop new models of supporting people who challenge in line with the Mansell Report and that, once those are in place, they will no longer be purchasing places in large hospitals. Such a statement should include a wish to engage with private hospital providers to develop service models in partnership, using the very skills and expertise that the private sector can bring. If done positively, with the right kind of support, and with forward-looking leadership from the provider, this could act as a model for what can be achieved.

55. If national government is concerned about the growth of private sector hospitals that appear to be delivering services that are contrary to national policy in relation to people who challenge, the key rests in local commissioning and outcomes based procurement and contracting. The majority of private hospital beds are commissioned by the NHS, and a crucial question will be how to create the knowledge, energy, commitment and priority within the new GP commissioning consortia that will result in the adoption of the cost-effective approaches described in Valuing People and the Mansell Report - along with real improvements in people's lives.

56. This report has sought to describe the work undertaken in this initiative and the issues that were raised through that work. It intentionally does not go on to discuss possible actions in response to those issues, as these will be the subject of subsequent papers from the NDTi.

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4 NDTi (for DH). Guide for Commissioners of Services for People with Learning Disabilities who Challenge Services. (2010)