Creativity Reduces Costs

People with learning disabilities who are labelled as ‘challenging’ are often placed in services costing up to £100,000 a year and all PCT’s will have a some people costing double that or more. Despite this expenditure, outcomes are poor. Many people are placed in remote establishments, having little contact with friends and family, minimal meaningful activity and almost no prospect of the situation improving – so the cost to commissioners will continue. This arguably breaches Human Rights and Equalities legislation and certainly contradicts government policy (the Mansell Report) which calls for local, individualised services rather than block ‘containment’ solutions.

New DH funded guidance, just published by the National Development Team for Inclusion (NDTi), aims to help. By studying places that have made progress, specific commissioning actions are proposed¹.

Box 1. Seven Areas for NHS Commissioner Action

- **Vision and Values.** A commitment to the principles of ‘an ordinary life’. Know the evidence base. Accept there may not be quick results and support providers and families through difficult times.

- **Leadership.** Be actively involved in service development. Work with enlightened clinical leadership and social care partners. Champion and support leaders who take planned risks.

- **Relationships.** Work in partnership with the local authority. Develop a ‘no-blame’ culture between organisations. Place people and families at the centre of decision-making.

- **The Service Model.** Use person centred approaches. Separate out housing and support. Accept high costs in the early stages of a service.

- **Skilled Providers and Staff.** Choose providers must really want to work with people who challenge, have ‘in touch’ senior managers, invest in staff and look outwards to local communities.

- **An Evidence Base.** Develop an outcomes framework and costing analysis with providers to evidence progress people were making and cost.

- **Specific Commissioning Actions.** Provide up front investment; find flexible ways of choosing providers; use CH criteria creatively; openly aiming for reduced costs over time – based on evidenced improvements in people’s lives.

Where progress has been made, the starting point for improving quality and reducing costs has been a creative, open organisational culture. Commissioners worked alongside families to develop a medium-term change strategy, involving shared financial risk with the local authority. Simplistic continuing care arguments about who was responsible for individuals were consigned to history.

Strategies were outcome focused and rights-based. Organisations undertook to reject short-term actions that compromised these principles which helped to generate genuine confidence and trust between partners. This was particularly important in the relationship between commissioners and providers with agreement that when things went wrong (and they inevitably do), there were no attempts to apportion blame and revert to institutional provision. Rather people learnt together about what had not worked and thus developed strategies to prevent a repetition elsewhere in the system.

Progress involved behaviour that is all too rare in some commissioning environments. For example, commissioners encouraged and supported innovative provider leaders to take risks. Clinicians and social care providers were expected to work as close partners with clinical advice being followed and NHS training to social care staff was part of NHS contracts. Most crucially, learning disabled people and families were genuinely at the centre of decision making about their services.

Commissioners had concluded that conventional tendering systems to select providers did not work. Instead, having initially attracted organisations to the locality based on their attitudes as much as traditional 'technical' skills, providers were awarded new contracts on the basis of their past performance in working with partners and achieving outcomes with people. A small number of trusted, long-term partnerships appears to be the key.

Commissioning for people who challenge is too often reactive rather than planned. A crisis occurs, it is assumed that the service is failing, and an expensive remote placement is contracted. The skilled, individualised services that are shown by the evidence to produce better outcomes can initially be expensive - but if done properly can lead to significant savings. In Birmingham for example, the Supported Living and Outreach Team (SLOT) has been in place for a number of years. The £450,000 annual cost of that team has for some time been reaping savings of twice that amount – as defined by current service costs, compared to those when the individuals were previously placed in traditional 'challenging behaviour' services.

Systems to generate information on desired outcomes and costs are thus crucial. Effective commissioning includes a commitment to achieve cost savings over time - but only when the outcome evidence shows the person's life is improving and their challenges reducing. If applied before that, the service will collapse and expenditure increase.

The CSR identified £1billion of NHS funding to be used to achieve linked benefit with social care. The approaches outlined in this good practice guidance are shown to improve outcomes and reduce costs and so could be a highly effective use of that all-too-scarce resource over the coming months and years.

Rob Greig

Chief Executive: National Development Team for Inclusion

For the full good practice guidance and a two page summary, go to www.ndti.org.uk/publications/insights