Commissioning services for people with learning disabilities who challenge services

Who should read this?

Local authority and NHS learning disability commissioners. It will also be of interest to providers and clinicians working with people labelled as ‘challenging’, and commissioners and providers in the mental health field.

Background

People with learning disabilities who are also labelled as ‘challenging’ services continue to get poor quality services and outcomes across most of the country. A few locations have succeeded in making progress in implementing the Mansell Report and these have been studied to learn the lessons of how to commission services more effectively.

Purpose of Report

Produced to help commissioners implement the Mansell Report (“Services for People with Learning Disabilities and Challenging Behaviour and/or Mental Health Needs - revised edition”). This is the Government’s policy on how to support people described as ‘challenging services’.

Plain English summary

A Guide has been written to help people who plan and pay for services (commissioners) improve services for people with learning disabilities who are said to be ‘challenging’ – which means that services find it very difficult to get things right for them.

It is based on information about what has worked well in five areas around the country and gives examples and advice to follow.

Main findings

The NDTi studied local areas that appeared to be making progress in implementing the Mansell Report, to understand what they had done that had helped them make progress. The report identifies and describes seven important areas of good practice - along with specific advice on actions that will improve commissioning and outcomes.

The examples studied showed that commissioning high quality, cost effective services for people with learning disabilities who challenge services is very achievable – but it requires skill, attention and ‘up front’ investment. This will result in financial savings. Without this, commissioners will continue to face significant bills for poor quality services that deliver outcomes that fall well short of the expectations of policy and human rights legislation.

Where progress was being made, the following was happening:

- **Vision and Values.** Commissioners started from a commitment to the principles of ‘an ordinary life’. They ensured they understood the evidence base around services to people who challenge and worked in partnership with people and families to deliver that vision.

- **Leadership.** Commissioners were actively involved in service development, championed new ways of working and supported leaders
from all organisations who were innovators and took planned risks. Strong clinical leadership existed that was committed to the vision in the Mansell Report and worked in partnership with 'social care'.

- **Relationships.** Strong relationships and a 'no-blame' culture between organisations were important. People and families were at the centre of decision-making. Local authority and NHS commissioners shared responsibility, used resources jointly and had strong relationships with providers – getting beyond simplistic tendering processes when choosing providers. Providers and clinicians worked closely together - using each other's expertise with trust and respect.

- **The Service Model.** Using person centred approaches, services were jointly designed by all partners – including the person, their family and future providers. Clinical leadership was consistently available and non-aversive techniques drove staff practice. Other good indicators of success included separating out housing and support and commissioners accepting high costs in the early stages of a service in order to create the framework for future progress.

- **Skilled Providers and Staff.** Skilled providers and support staff were essential, with positive, enabling approaches that looked outwards to the local community. Providers were selected because they actively wanted to work in partnership with people and families and had a demonstrable willingness to keep going in difficult times. They could also demonstrate genuine senior management involvement in service delivery, responsiveness to clinical advice and no use of casual, agency staff.

- **An Evidence Base.** Commissioners had developed, with providers, an outcomes framework and a costing analysis to help them understand and evidence what progress people were making at what financial cost.

- **Specific Commissioning Actions.** Other important commissioner actions that were identified included: up front investment to ensure skills and resources were in place at an early stage; flexible ways of choosing providers; flexible contracting systems that could respond quickly to changes in people's needs; creative use of continuing healthcare criteria; shared financial risk between commissioners and openly aiming for reduced costs over time – but only based on evidenced improvements in people's lives.