# Building the Right Support: An analysis of funding flows

## Department of Health and Social Care

Report by RedQuadrant

# Contents

# Introduction

In September 2021 the Department of Health and Social Care commissioned RedQuadrant to undertake an analysis of funding flows associated with Building the Right Support (BtRS). This is part of the work that the BtRS Delivery Board is overseeing aimed at driving further progress in reducing the numbers of people with a learning disability and autistic people in mental health inpatient settings.

At the outset, 4 key questions were identified, and these formed the basis of our investigations:

1. **What is the relative cost-effectiveness of community-based and inpatient care over the short, medium and long term?**

2. **Do current funding flows allow sufficiently for higher costs (for example, immediately post discharge) and for investment in community support and crisis services?**

3. **Are there financial incentives or disincentives that impact on both admission rates and the discharge of patients from inpatient settings?**

4. **Is the additional money that has been invested sufficient, and is it being used or directed to the best effect?**

We also took account of the report and recommendations of the Parliamentary Health and Social Care Select Committee published their report on the treatment of autistic people and people with learning disabilities, particularly those relating to the need to build more community support to avoid the need for inpatient care.

Our methodology is set out in detail in Appendix A. In summary, our investigations included:

- collection and analysis of available activity and financial data including analysis of a sample of 5 Transforming Care Partnerships' (TCPs') financial data (data tool in Appendix B)
- modelling carried out by RedQuadrant and NHS England and NHS Improvement (NHSEI) (methodologies in Appendices C and E)
- a survey to councils via the Local Government association (the LGA) and Association of Directors of Adult Social Services (ADASS) (results provided in Appendix D)
- interviews with a broad range of stakeholders (detailed in Appendix F)
- alongside a literature review (references in Appendix H)

For the purposes of our report, we refer to Transforming Care Partnerships (TCPs), as the bodies originally tasked with delivery of BtRS. We acknowledge that there has been a move to Integrated Care Systems (ICSs) and that, at the time of writing, all partnerships apart from 3 now operate on the ICS footprint.

## Scope and context: 'Not just a matter of funding flows'

We have also listened to the views of people with lived experience – those who have personally experienced what they felt were inappropriate admissions or lengths of stays, and their families – by liaising with the BtRS Advisory Group. We have heard a strong view that to focus solely on funding flows risks missing what are seen to be fundamental problems within the whole system – including a perceived failure to engage and work with families to ensure that the right levels of support are available at the right time to support people with a learning disability and autistic people to have fulfilled and safe lives without the risk of inappropriate admissions. We have heard the need for a change in culture amongst professionals – clinicians, social workers, commissioners, and providers – and the need to put the person at the centre of everything.

We have heard calls for funding to follow the person, and for greater control on how funding is used – again with the person and their families having far greater control. Some of the areas for consideration include ones which would encourage a more flexible flow of funding direct to people with a learning disability and autistic people and their families.

We are also aware that the BtRS Delivery Board has a number of workstreams which will all feed into the development of an action plan and that this piece of work is just one element of that action plan. We hope that our focus on funding will contribute, together with the work of the other workstreams – including that being led by the advisory group on 'what good looks like' in relation to support, preventative and crisis services, - to support that change in culture and better lives ensuring the funding flows and incentives are aligned to support the BtRS objectives including ensuring challenges of the past aren't replicated in the future.

## Recognising the success achieved so far and the work still to be done

We acknowledge that Transforming Care and Building the Right Support have made progress. Since 2015, there have been 14,325 discharges of people with a learning disability and autistic people from hospital (although this will include some people who have been discharged more than once) and there has been a net reduction of people in hospital of more than 30%. This has resulted in many more people being supported to live in their own home with care and support.

We appreciate that there are challenges to making further progress, and we are aware that there is a strong will across all partners, led by the Minister for Care and Mental Health who chairs the delivery board, to make further progress. We understand from conversations with

the new NHSEI Director of Learning Disability and Autism that not only have Safe and Well Being reviews been undertaken of all people with a learning disability and autistic people in mental health hospitals over recent months, but that there is work underway to drive progress in 3 key areas – reducing the numbers still to be discharged, improving quality of care for people who are in inpatient services and reducing admissions by enhancing the development of preventative services in the community.

We hope that our report will help in this work.

## Summary findings and conclusions

There has been a long-term objective within UK health and social care policy to reduce the numbers of people with a learning disability and autistic people who are long-stay patients in mental health hospitals. Pursuit of this policy led to the closure of many long-stay hospitals and the transfer of their former patients to care in the community during the latter years of the last century and into this.

In 2015, NHS England and NHS Improvement (NHSEI), the Local Government Association (the LGA) and the Association of Directors of Adult Social Services (ADASS) published Building the Right Support, a national plan to develop community services and close inpatient facilities for people with a learning disability and autistic people. It required Transforming Care Partnerships (TCPs) to publish robust plans by 2016 and envisaged a 3-year period to deliver those plans.

The financial model for the BtRS national plan is based on releasing savings from a reduction in inpatient care and using those savings to fund:

- accommodation with care and support for those discharged from inpatient beds
- community support services which would better support people in their homes and therefore avoid the need for the volume of inpatient admissions that had hitherto been the case

In addition to savings released from discharge from hospital, Building the Right Support also required contributions from a range of other funding streams, including Council Adult Social Care budgets.

Additional funding has also been made available at various points since 2015, and these are detailed in the funding streams section below.

This report seeks to examine the funding flows, and any related financial incentives and disincentives, that a) enable people to move out of hospital into homes with care and support, and b) develop the infrastructure of community services that prevent unnecessary hospital admissions and enable people to live ordinary lives in the community.

The starting point for this work must be to acknowledge that the current policy and funding structures have resulted in a reduction in the number of adults with a learning disability and autistic people in hospital from 2,725 in March 2015 to 1,885 in November 2021. This constitutes a reduction in the rate per million adults from 62.3 to 43.1. However, the rate of reduction has not been fast enough to meet stated ambitions and it is acknowledged by most that more needs to be done.

It is also important to note that this is not a static population – people are constantly being admitted and discharged. Since 2015, 14,325 discharges from hospital and 12,835 admissions to hospital have taken place. (This will include transfers and where someone has been admitted or discharged more than once).

Reducing the number of people in inpatient settings to be below the maximum target levels (30 per million adults and 12 to15 per million children and young people) needs to continue. The number of people in inpatient settings is driven in part by the number of new admissions into inpatient settings. However, it is also due to the complexity in arranging appropriate homes with care and support in the community for people with the highest support needs. This includes people admitted via criminal justice routes, and in particular those who have been in inpatient settings the longest, and for whom community care packages in many cases seem likely (at least at first) to outweigh significantly the cost of an inpatient stay. For example, of the 2900 people who were inpatients at the start of the programme, 790 (or 27%) were in hospital in March 2021. In November 2021, 355 people had been inpatients for more than 10 years and a similar number for more than 5 years.

Throughout this project we have spoken to staff across the NHS, councils and other organisations who are committed to supporting people with a learning disability and autistic people to live in homes in the community, through the provision of the right care and support. During our investigation, many of the NHS staff we spoke to were also supporting activities related to the COVID-19 (coronavirus) pandemic and were under particularly intense pressure and we appreciate the level of engagement made with this project.

## Summary findings

At the outset of our work, we looked for detailed financial information on the following in relation to BtRS:

- the sources of funding
- the allocation of that funding by area and category of expenditure
- information on how funds had been spent over the course of the programme

We hoped to be able to access financial data which could give an insight into the money that had been released through the reduction in inpatient beds, and the money that had been invested in accommodation with care and support for individuals as well as developing community support, including preventative and crisis services. We hoped to be able to compare the costs of community services with inpatient care and the impact of investment in different services and at varying rates at a local, regional and national level.

The financial data we that was shared with us was more limited than we had hoped. We were provided with the following financial data at a national level:

- funding transfer agreements (FTAs) (where funding was transferred from NHSEI specialised commissioning to local NHS systems after net discharges achieved from any adult in a bed commissioned by NHS England, primarily low or medium secure beds) are recorded nationally through quarterly reporting from CCGs to NHSEI and this information is available at a local level. We have not seen evidence of how this spend is recorded at a local level
- in this same way, NHSEI collect the total expenditure on services relating to people with a learning disability and autistic people via the regular collection of total clinical commissioning groups (CCGs) spend on learning disability and autism
- NHSEI also allocates service development funding directly to regions and systems to support transformation of services for people with a learning disability and autistic people and collects regular data on how much of this has been spent. We have not seen evidence of how this spend is recorded at a local or regional level and data was not available to us for this review
- councils submit annual returns to NHS Digital via the adult social care activity and finance report incorporating adult social care finance return (ASC-FR) and short and long term (SALT) - learning disability support

Some of this national data was provided to us after the completion of our investigations. We have therefore made reference to them but have not had the opportunity to fully interrogate them. With the exception of FTAs, this information does not enable extraction of data on expenditure specific to BtRS (as in, expenditure specifically spent on people with a learning disability or autistic people who have been or who may be at risk of admission to an inpatient setting) we do not believe further interrogation would have significantly affected our conclusions.

At a local level, information relating specifically to people within the scope of BtRS – as in, people with a learning disability and autistic people who are still inpatients, are at risk of being admitted to a mental health inpatient setting or have been discharged from an inpatient setting into a home with care and support - can be identified by looking at spend for a particular person who is either an inpatient or has been discharged. 2 TCPs with whom we engaged also demonstrated that they identify people when they are at risk of admission, and record levels of investment in related services. However, we have not seen a national or regional mechanism to extract information on either TCP or council investment and or expenditure related to BtRS.

NHSE&I have subsequently informed us that regions are able to identify how much has been allocated via Funding Transfer Agreement and community Service Delivery funding and how these two pots of money have been spent.

We believe that the limited ability to analyse financial data in this way to provide a national perspective is a significant barrier to the effective oversight and management of the BtRS programme overall. In our view, this limits the ability of those responsible for reporting on progress of this programme to be able to do so. We believe analysis of financial data at a national level could provide:

- the ability to identify areas of good practice, for example: commissioning impactful preventative services or appropriate homes and care and support service
- early warning where funding flows for discharges appear to be impeded
- early warning where there may be insufficient funding via savings from inpatient settings through greater understanding of the costs of accommodation with care and support and the level of actual savings that is able to be released
- assurance that areas commit appropriate levels of investment in preventative services, and that they can evidence their positive impact

Given the system's limited ability to extract national or regional financial reporting around BtRS, we have based our findings from data made available to us, including:

- Assuring Transformation dataset (published by NHS Digital) which provides national data around the numbers of people relating to BtRS in inpatient settings
- stakeholder interviews with over 50 people across the system, including those with lived experience via the BtRS Advisory Group
- in-depth interviews with 12 Transforming Care Partnerships (TCP) and financial information from 5 of those 12 TCPs
- community accommodation with care and support costings from 5 TCP commissioners, (via both NHS and council commissioners) from one private sector and 2 not-for-profit community sector providers, and inpatient costings from 2 TCP commissioners, NHSEI specialised commissioning and one private provider
- hearing from 28 councils via an online survey, including council contributions to costs for people post-discharge

Whilst data was only able to be accessed from 5 TCPs which may impact on its statistical significance, the picture was sufficiently consistent to suggest that this is likely to be reflective of the national picture. These 5 TCP areas are in 4 NHS regions and included areas which are achieving the target for inpatient numbers and those that are not. Comprehensive comparative financial data at a TCP, regional and national level would allow greater assurance of the overall success of the programme, including highlighting potential contributing factors for under-performance.

Our primary recommendation is therefore around the need for comprehensive financial monitoring which covers 2 broad areas: 1) costs relating to all people who are admitted to inpatient care, those within inpatient care and costs of post-discharge care – this should include the total costs of care and support packages over time, and the share of funding between NHS and councils, and 2) the investment levels in preventative and crisis services, again capturing both NHS and council spend where practicable. Further thought will need to be given around standard definitions to ensure consistency of reporting throughout local systems. It is also acknowledged that this will need to be applicable across both NHS and social care systems.

A summary of our key findings is provided below. More explanation on each point along with our evidence is provided in detailed sections below.

### Financial reporting and programme oversight

Responsibility for the delivery of the programme's aims has rested with TCPs (moving to ICSs) which are composed of CCGs and their local council partners. There has been limited regional or national oversight of expenditure and investment of either councils or NHS system spend on the people for whom BtRS is relevant.

TCPs have reported BtRS performance information, but this did not include financial information. The discontinuation of the requirement for CCGs and TCPs to provide a financial return to NHSEI, set against their BtRS plans, removed a potentially vital planning and monitoring tool that could have assisted in ensuring that funds were flowing in the most effective directions.

There is no national mechanism for measuring the extent to which the TCPs and councils have invested in the range of preventative and crisis support services as set out within the Building the Right Support service framework.

### Relationship between the savings released from a reduction in inpatient beds and the cost of funding community-based solutions

When exceptionally high-cost arrangements for accommodation with care and support are excluded from averages, the cost of funding community-based solutions can be less or similar to the equivalent inpatient costs.

Some community support packages are extremely high cost at the point of discharge – around 10 times the average cost of a placement with care and support, and around 8 times greater than the average cost of inpatient settings.

There is evidence that in some cases at least, the cost of care and support does reduce over time.

Due to the existing pressure on budgets, there is a risk that if savings released from inpatient beds are insufficient to fund accommodation with care and support, this could become a disincentive to discharging people with high support needs.

We were told that characteristics of the group of people relevant to BtRS have changed since the programme started as the proportion of inpatients with high support needs has increased. We explored these changes but have not been able to evidence that these changes have caused increased costs for accommodation with care and support for those being discharged.

Only discharges from low and medium secure hospitals attract FTA funding, meaning that 50% of inpatients at January 2022 must be funded from mainstream health and social care budgets.

### Practicalities of securing a community placement on discharge (a home with care and support)

Developing bespoke and personalised homes, alongside care and support solutions for people who may have been institutionalised over many years, needs funded lead-in time. This includes the need to prepare a home (as in, to build or adapt accommodation), recruit and train staff, and to settle the person into their new home. The introduction of the Community Discharge Grant is designed to address double running costs so should impact on this issue.

The availability and cost of suitable accommodation and access to the capital required to purchase and adapt properties can be a significant inhibitor to achieving discharges. Some capital funding rules limit the ability to develop a range and pipeline of accommodation.

Recruitment and retention of an appropriately skilled workforce is an increasing difficulty for providers of community-based accommodation with care and support.

Complexities around funding responsibilities between CCGs and councils can cause difficulties. Strong partnerships, pooled budgets, and joint commissioning arrangements significantly improve performance on achieving discharges for people.

Rigid approaches to commissioning can inhibit achieving discharges of people with high support needs. For example, local policies and practice around personal budgets – both health and social care – may impede the ability to achieve economies of scale around core support costs, for example where 3 of 4 people live in a cluster of flats or share some facilities within a scheme.

Active market development to increase the number and capacity of providers is an important element to achieving discharge of people with high support needs. This involves encouraging new providers into areas, and developing partnership approaches with trusted providers.

### Investment in community-based preventative and crisis services

Since 2015, the number of admissions has remained fairly consistent, which impacts on progress being made on reducing the overall number of people in inpatient settings.

The BtRS model service specification gave guidance to commissioners on the need for, and the scale of some aspects of community preventative services – such as intensive community support, crisis services and community forensic teams. However, we have seen no evidence that this has been translated into a service requirement for each TCP area which could be measured. Implementation of these service specifications appear not to have been mandated.

Hence, there are varying levels of investment and development of preventative and support services in TCPs across the country.

From the example of one high performing TCP, which has reduced the number of inpatients faster than its trajectory and achieved large reductions in admissions, there appears to be a connection between investing in the development of preventative and community crisis support services and reducing admission rates.

We consistently heard from stakeholders, particularly those with lived experience, that there is a growing demand for greater access to flexible resources by autistic people and their families which can be used to support people to maintain healthy lives and to avert crises from developing which may progress to avoidable hospital admissions.

The introduction of dynamic support registers (DSRs) could be a way of identifying people for whom early access to flexible support may reduce the risk of crises and potential inpatient admissions. However, some people with lived experience and their families raised concerns that access was not flexible enough. The advisory group may well have more to add on this point.

## Out of area[1] and private sector inpatient provision

Out of area inpatients typically have a longer length of stay and are more likely to be recorded as 'inappropriately placed' than people treated in a local facility. This results in increased costs and greater difficulties in achieving discharge.

Stakeholders consistently told us that discharge planning for people placed out of area is more complicated, with changes in clinical oversight of treatment plans, less consistent care management and attendance at review meetings for people in out of area inpatient settings.

There is an uneven distribution of inpatient or ATU facilities across the country. The lack of a suitable inpatient facility in a locality leads to an over-reliance on out of area admissions.

Stakeholders consistently said that where out of area placements were needed due to lack of local availability, people would be placed in independent sector hospitals.

The number of people in independent sector hospitals has reduced from 1,230 in March 2016 to 845 in November 2021 with the proportion of inpatients in an independent sector hospital falling from 48 to 43%.

[1] Out of area is defined by NHS England as where a patient is placed in a hospital which is outside of their originating ICS or TCP (i.e. the ICS or TCP of their GP (or usual residence)).
There are some cases where a patient can be placed 'out of area' appropriately. These include where:
- the patient requires a specialist bed which is not available in the local area or all parts of the country. For adults this is defined as those in high secure, neuro-psychiatry acquired brain injury beds, adult personality disorder and adult deaf. For under 18s it includes low and medium secure beds, mental health services for the deaf and severe obsessive-compulsive disorder and body dysmorphic disorder adolescent beds).
- the placement is closer to family or carer(s)
- a child or young person is admitted from out of area school placement
- there are safeguarding reasons for the placement
- there are offending restrictions
- it is patient or family choice
The number of inappropriate out of area placements excludes those patients where the placement was appropriate for one of more of the reasons stated above. '

### Particular impact for children and young people transitioning to adulthood

There has been some reduction in the numbers of children and young people under 18 within inpatient units during the course of the BtRS programme since 2017 when we understand that data on inpatient numbers is more reliable.

There is a lack of appropriate NHS inpatient beds for children and young people with a learning disability and autistic children and young people in many parts of the country. Stakeholders reported that this leads to excessive levels of children and young people in out of area inpatient settings in private sector hospitals.

There is less evidence of widespread partnership working around planning for post-discharge care and support of children and young people than for adults.

There is a perceived 'cliff edge' of support for young people – particularly autistic young people – at the point of transition to adulthood (age 18) where personal social care may not be appropriate, but other support is needed. This all too often results in crises developing without early intervention and support, with the prospect of escalation to the point where crisis admissions to hospital or an ATU is the result.

Stakeholders have told us about the Department for Education funded 'high needs funding pot' specifically to meet the educational needs of high needs children but have pointed to the absence of a similar source of funding available to be called upon to support additional health-related needs for children on discharge from inpatient care. Although access to continuing health care funding is available for specific qualifying cases.

We consistently heard from stakeholders, especially from families of those with lived experience, that there are insufficient levels of local and flexible services and or support available to families with autistic children that can be made available at times of crisis to avert the risk of hospital admission.

# Conclusions

This research highlights the problems arising from the inability to access national comparative data to provide comprehensive financial information, which would enable financial performance monitoring and the ability to identify trends and initiate corrective actions relating to BtRS. We have identified that for areas where data was shared:

- the average cost of a home with care and support is close to the cost of inpatient beds
- there are frequent examples of people for whom a home with care and support is significantly more expensive than indicative inpatient settings
- there is inconsistency in investment in preventative and crisis services across TCPs

In summary, our judgement is that:

- the moral case for change remains overwhelming – people need to move out of inpatient settings and have the right to live an ordinary life
- savings generated by inpatient bed reductions are unlikely to be sufficient to meet the costs of many people still to be discharged from inpatient care. Careful consideration needs to be given to how Integrated Care Boards (ICBs) can be supported and incentivised to enable as many people as possible to be discharged to live ordinary lives in the community
- similarly, continued high admission rates (particularly of autistic people) need to be addressed, and greater focus placed on investing in support that is available at an early stage with greater control for people and their families to find solutions that do not rely on inpatient stays, especially through transition

Returning to the original questions at the outset of our investigations

### What is the relative cost-effectiveness of community-based and inpatient care over the short, medium and long term?

The lack of consistent and readily available financial data demonstrating how resources have been allocated, committed and spent limits the ability of the national system to be able to determine the cost-effectiveness of the programme.

There are examples of accommodation with care and support arrangements that cost significantly more than the savings associated with their inpatient care. We heard from stakeholders that this is increasingly the case. This contributes to the average costs of accommodation with care and support being close to, or higher than, the cost of inpatient care

in the 4 of the 5 TCP areas for which we had financial data. If costs rise, this will inevitably increase pressure on already strained budgets.

### Do current funding flows allow sufficiently for higher costs (for example, immediately post-discharge) and for investment in community support and crisis services?

We have seen no evidence to suggest that funding has not been available to fund higher costs post-discharge. We are unable to ascertain how consistent the practice is of reviewing, both upwards and downwards, the costs of care and support once people have settled into the new arrangements.

We saw 2 examples (2 out of 66) of exceptionally high-cost arrangements, which were around 8 times the average cost of inpatient care. We saw examples where costs of care and support reduced over time reflecting a change in their needs. More analysis is needed to understand how common exceptionally high costs arrangement are and whether these costs are able to reduce significantly over time.

We are concerned that the double running costs associated with forensic patients on Section 17 Leave, and therefore requiring an acute bed as well as a home with care and support for extended periods, could have a significant impact on health system budgets if progress is to be improved on discharging patients with a forensic history.

An absence of a reliable source of information to determine the current levels of investment in preventative services has hampered our ability to answer this question. However, from the evidence that we have been able to examine, it is apparent that there is a wide difference between the levels of funding that systems have invested in community services. Reasons for this are varied but include the pressures on funding from high numbers of inpatients requiring discharge, existing services within an area, underdeveloped partnership working and joint commissioning between councils and CCGs. The increased cost of community accommodation with care and support and the numbers where costs exceed inpatient cost is further reducing the funds available for such services.

While further work will be required to determine the level and distribution or allocation of such funds, we consider that a ring-fenced fund is required to assure appropriate levels of investment separate from savings released from inpatient care. Allocation of this fund should take account of historic service levels and forecasted investment; the aim should be that all areas have a sufficient level of development to reduce admissions sustainably. It will be important that the fund can be demonstrably seen as leading to new and expanded preventative and crisis services by NHS and council partners and is not able to substitute for existing areas of spend.

### Are there financial incentives or disincentives that impact on both admission rates and the discharge of patients from inpatient settings?

While we have seen no evidence that funding has been the deciding factor in someone not being discharged, we did hear that for some CCGs the cost of arranging appropriate homes with care and support for people being discharged was becoming a particular strain on their budgets. Councils too cited mounting budget pressures. The further comparisons of cost of accommodation with care and support against savings released we suggest below would provide greater assurance on whether this is relevant to more areas.

We have not been able to identify any specific financial incentives and disincentives impacting discharges. We have heard of the 'commercial imperative' to admit to inpatient facilities in the private sector, but we have not seen data that would substantiate a widely recited claim that private sector providers are incentivised by profit to extend lengths of stay.

### Is the additional money that has been invested sufficient, and is it being used or directed to the best effect?

Without the accurate recording of budgets allocated, committed and spent on the programme, and without performance information that is designed to measure the return for investment, it is not possible to answer this question categorically.

We have heard from stakeholders that the flow of funding available for the level of investment required to provide services that will be better able to make further and meaningful reductions in inpatient admissions has been insufficient in some TCP areas. This may be due to differing levels of existing services within an area, and the numbers and costs of discharges still to be achieved impacting on the level of funding available.

Similarly, we consider that from the evidence we have seen and the data available to us, achieving successful discharges of many of the remaining inpatients, particularly those with longer lengths of stay, is likely to exceed the levels of funding released by reduced inpatient use. Some form of additional funding stream is likely to be required to ensure that the impact of the creation of significant deficits on local health and adult social care system budgets does not begin to act as a disincentive to discharge those with higher levels of need.

Reducing the numbers of long-stay inpatients, though a critical part of the BtRS programme, is not the only area where additional funding streams may be required. We have also highlighted the critical importance of funding for preventative and crisis services which have an impact on reducing the numbers of admissions.

In order to gain a greater understanding of funding flows to support stronger performance and financial oversight of BtRS, we suggest the following:

1. Consider mandating collation of financial data points to enable a direct comparison of inpatient and community costs
    - use this data to target additional funding, if needed, in addition to savings released from discharges to ensure appropriate community accommodation with care and support
2. Consider mandating collation of financial data to identify forecasted spend on preventative services, looking for areas of underinvestment or where expenditure is out of line with expectations
    - ring-fenced funding should be prioritised for these areas
3. Consider carrying out funding flow reviews of all inpatients with excessive lengths of stay, beginning with people with stays of over 10 years, to determine whether funding flows have impeded securing an appropriate solution
    - prioritise additional funding or take action to enable funding to flow appropriately to enable discharges for these people

# Background to the Building the Right Support programme

There has been a long-term objective within UK health and social care policy to reduce the numbers of people with a learning disability and autistic people who are long-stay patients in hospitals. Pursuit of this policy led to the closure of many long-stay hospitals and the transfer of their former patients to care in the community during the latter years of the last century and into this. However, by 2010 there remained more than 3,500 people for whom out-of-hospital care options had not been seen as achievable, or whose community-based care had broken down[2]. These patients resided in both NHS and private sector specialist hospitals and Assessment and Treatment Units (ATUs).

This report seeks to examine the funding flows associated with the delivery of the BtRS programme that 1) enable people to move out of hospital, into homes with care and support, and 2) develop the infrastructure of community services that prevent unnecessary hospital admissions and enable people to live ordinary lives in the community. Before we set out our findings and recommendations, this background section will introduce the topic with the following sections:

1. Context for the programme and performance targets
2. Performance against those targets
3. Funding system information

### Context for the programme and performance targets

Originally entitled Transforming Care, the Building the Right Support (BtRS) programme was a response to public concern following the exposure of the abuse of patients with a learning disability within specialist hospitals.

While the focus of Transforming Care was largely on reducing the numbers of people in inpatient care through discharging people into the community, Building the Right Support added the additional focus on developing the preventative services that would help to reduce

[2] Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales, (CQC) (p4) reports 3642 inpatients with Learning Disability

the number of people admitted to hospital. BtRS also highlighted the importance of ensuring that, for those who needed inpatient care, the quality of that care could be assured.

In May 2011, the BBC's Panorama programme revealed criminal abuse of patients at a private hospital for people with a learning disability, Winterbourne View near Bristol. The shock generated by the evidence of abuse at Winterbourne View led to these commitments from the government:

- an end to all inappropriate placements by 2014 – so that every person with challenging behaviour gets the right care in the right place
- any adult who is in a specialist autism or learning disability hospital setting will have their care reviewed by 1st June 2013
- if they would be better supported in the community then they should be moved out of hospital as quickly as possible, and no later than 1st June 2014

The original Transforming Care report found there to be

> 'an estimated 3,400 people in NHS-funded learning disability inpatient beds of which around 1,200 are ATUs in December 2012. Of this, it was estimated that 200 were young people under 18 meaning that 3,200, or 72 adults per million in England were in these units'.

In 2015, an inquest found that neglect had contributed to the death in 2013 of Connor Sparrowhawk, an 18-year-old autistic man with a learning disability and epilepsy, in an ATU run by Southern Health NHS Foundation Trust, raising further concerns regarding the safety of people with a learning disability and autistic people in inpatient facilities.

In 2015, NHSEI together with the Local Government Association (the LGA) and the Association of Directors of Adult Social Services (ADASS) published Building the Right Support, a national plan to develop community services and close inpatient facilities for people with a learning disability and autistic people. It required Transforming Care Partnerships (TCPs) to publish robust plans by 2016, and envisaged a 3-year period to deliver those plans.

BtRS established a target to reduce the number of inpatients with a learning disability and autism by March 2019 to:

- 10 to 15 inpatients in beds commissioned by Clinical Commissioning Groups (CCGs), such as those in assessment and treatment units, per million population
- 20 to 25 inpatients in NHSEI-commissioned beds (such as those in low-, medium- or high-secure units) per million population

In 2019, another case of criminal abuse of people with a learning disability in a private hospital - Whorlton Hall in County Durham – was reported by BBC Panorama. This led to a sector wide recommitment to delivering the outcomes set out in Building the Right Support.

2019 saw the publication of the NHS Long Term Plan which modified the targets, providing clarity on both targets for adults and children as follows:

- a maximum of 30 adult inpatients per million population (all commissioners)
- a maximum of 12 to 15 inpatients who are children or adolescents per million population (all commissioners)

These targets were to be met by March 2024.

> 'More people with high support needs will be supported to live fulfilling lives at home rather than in hospital, while thousands will be offered a personal health budget, giving them choice over the type of support they need to live the life they choose.'

In 2021, a Safeguarding Adults Review into the deaths of 3 people at Cawston Park, a private hospital in Norfolk, was published and concluded that there were 'major failures of governance, commissioning, oversight, planning for individuals and professional practice', contributing to these deaths which occurred between 2018 and 2020. The report asserted that:

> 'Unless this hospital and similar units cease to receive public money, such lethal outcomes will persist'.

In July 2021, the Parliamentary Health and Social Care Select Committee published their report on the treatment of autistic people and people with learning disabilities in which they highlighted the continuing high numbers of people still in hospitals and ATUs, high rates of admission and low levels of investment in community services. They called upon the government to prioritise action to address the shortfall.

This report forms part of the work that the BtRS Delivery Board has commissioned to respond to those concerns.

### Performance against maximum inpatient number targets

Transforming Care Partnerships – CCGs and councils – across the country have made significant progress over the years in reducing the numbers of people with a learning disability and autistic people within inpatient settings. The net reduction of 840 people between March 2015 and November 2021 does not account for the total number of people discharged, given the continued admissions and some readmissions during the same period.

However, the net reduction has not been as great as had been hoped.

### Adult inpatients

In November 2021, NHS Digital data showed a range of 15 to 69 adult inpatients per million of the adult population across 42 local system areas (39 ICSs, 3 TCPs). The average across all England regions was 43 adult patients per million population – significantly above the 2020 interim target of 37 per million.

- 7 areas were achieving the target (having 15 to 30 adult inpatients per million)
- 8 areas were meeting the expected 2020 trajectory towards the target (having 31 to 37 adult inpatients per million)
- 27 areas had more than 37 adult inpatients per million, of whom 12 areas had rates of 50 or more

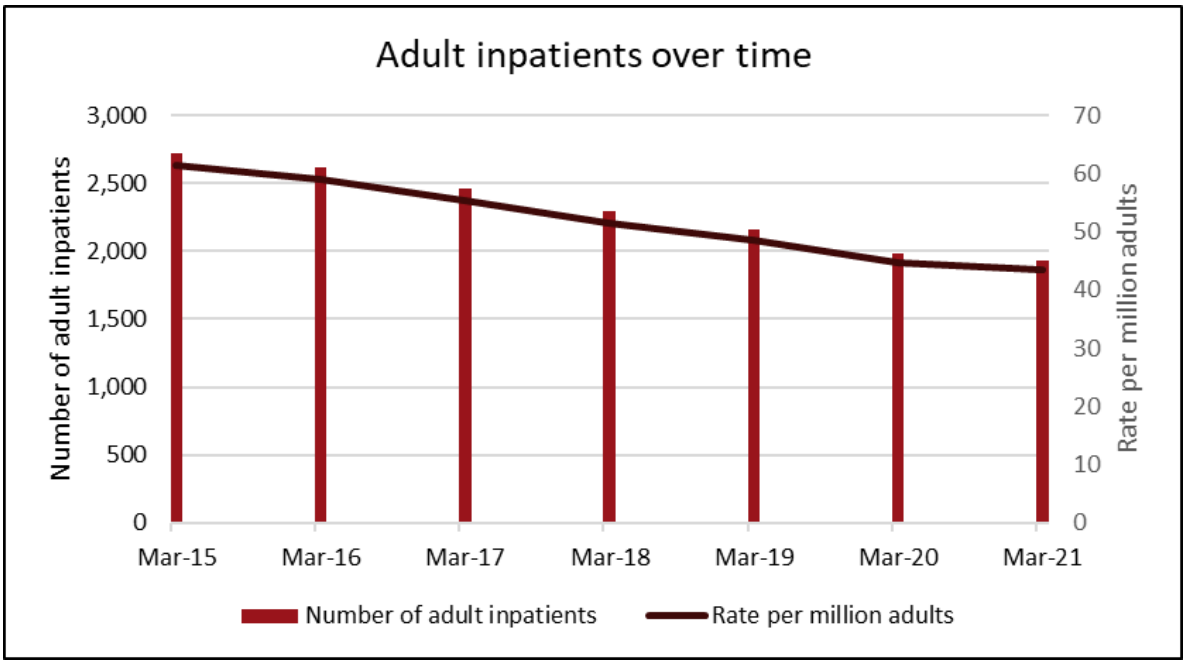


**Figure 1:** Number of adult inpatients and rate per million adults 2015 to 2021
**Source**: Assuring Transformation dataset (published by NHS Digital), November 2021, tables 2.1 and 5.2, applying ONS data on England population of adults 2020. Analysis by RedQuadrant

| Measure | March 2015 | March 2016 | March 2017 | March 2018 | March 2019 | March 2020 | March 2021 | November 2021 |
|---|---|---|---|---|---|---|---|---|
| Number of adult inpatients | 2,725 | 2,620 | 2,465 | 2,290 | 2,160 | 1,985 | 1,930 | 1,885 |
| Rate per million adults | 61.3 | 58.9 | 55.4 | 51.5 | 48.6 | 44.7 | 43.4 | 42.4 |

**Figure 2:** Number of adult inpatients and rate per million adults 2015 to 2021
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021, tables 2.1 and 5.2, applying ONS data on England population of adults 2020. Analysis by RedQuadrant

### Children and young people

200 young people aged under 18 out of a population of 12.1 million were in hospital in England in November 2021. Unlike for adults, the number of children inpatients over time has not been consistently decreasing and was higher in 2021 than in 2015.

However, we were told that data prior to March 2017 may not have consistently included autistic children and that March 2017 is a more useful benchmark against which to measure progress.

Taking this into account following an increase in numbers between March 2017 and March 2019, there has been a 20% reduction from 2017 to 2021. This equates to a current level of 16.5 children and young people in hospital per million, which is approaching the target rate of 12 to 15 patients per million.

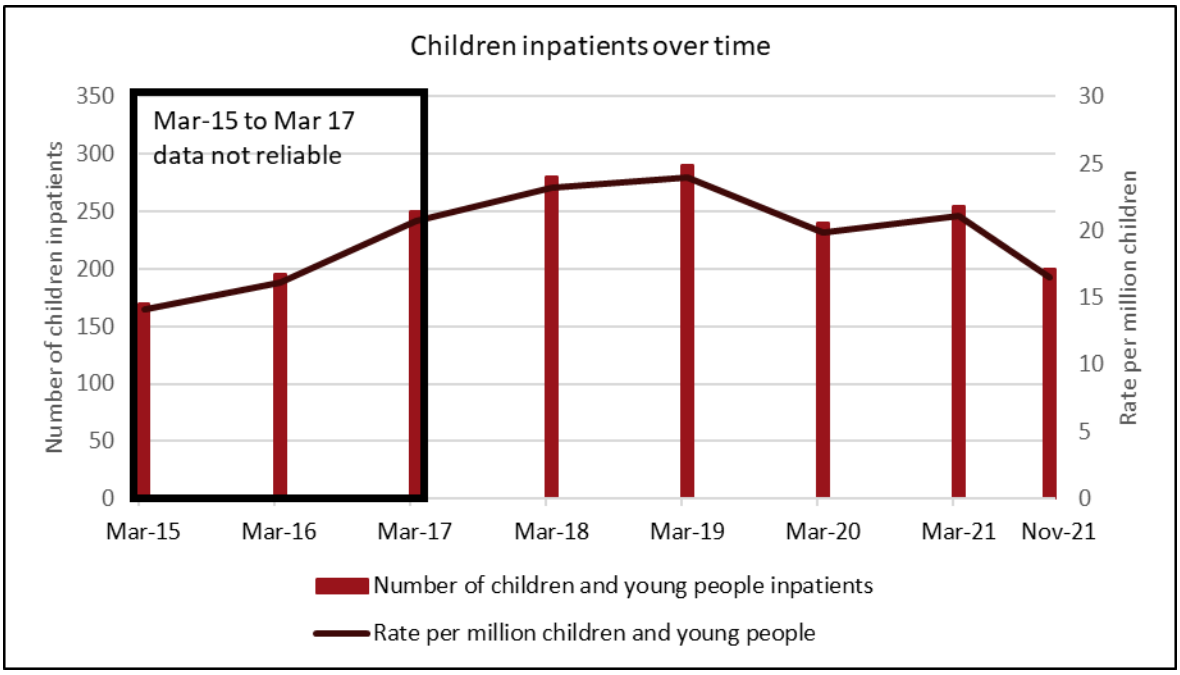


**Figure 3:** Number of children inpatients and rate per million children 2015 to 2021
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021, tables 2.1 and 5.2 and applying ONS data on England population of children 2020. Analysis by RedQuadrant

| Measure | March 2015 | March 2016 | March 2017 | March 2018 | March 2019 | March 2020 | March 2021 | November 2021 |
|---|---|---|---|---|---|---|---|---|
| Number of children and young people inpatients | 170 | 195 | 250 | 280 | 290 | 240 | 255 | 200 |
| Rate per million children and young people | 14.1 | 16.1 | 20.7 | 23.2 | 24.0 | 19.9 | 21.1 | 16.5 |

**Figure 4:** Number of children and young people inpatients and rate per million children and young people 2015 to 2021
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021, table 2.1, and ONS table SAPE23DT6a: Mid-2020 Population Estimates for 2021 Clinical Commissioning Groups in England by Single Year of Age and Sex. Analysis by RedQuadrant.

## Funding system information

### Funding flows

The financial model for the BtRS national plan is primarily based on releasing savings from a reduction in inpatient care and using those savings to fund:

- accommodation with care and support for those discharged from inpatient beds
- community support services which would better support people in their homes and therefore avoid the need for the volume of inpatient admissions that had hitherto been the case.

In addition to savings released from discharge from hospital, Building the Right Support also required contributions from a range of other funding streams, including Council Adult Social Care budgets.

The following diagram from an LGA/ADASS/NHSEI 'frequently asked questions' document from 2016, put it simply:

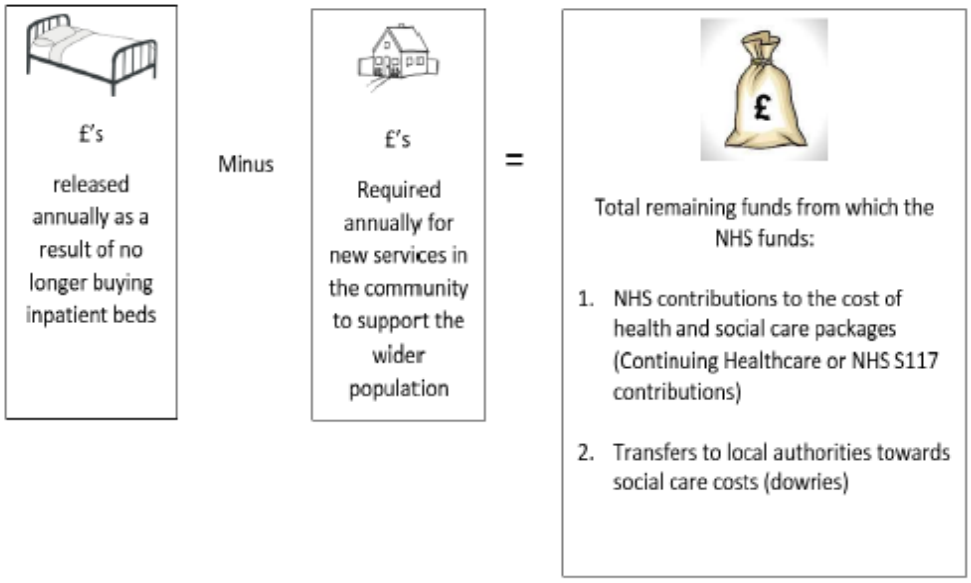


**Figure 5:** Funding model for BtRS
**Source:** Diagram extracted from Building the right support – Frequently Asked Questions (Finance) Dated 21st September 2016 (LGA, ADASS, NHSEI)

The high-level funding flows for BtRS can be summarised are shown below.

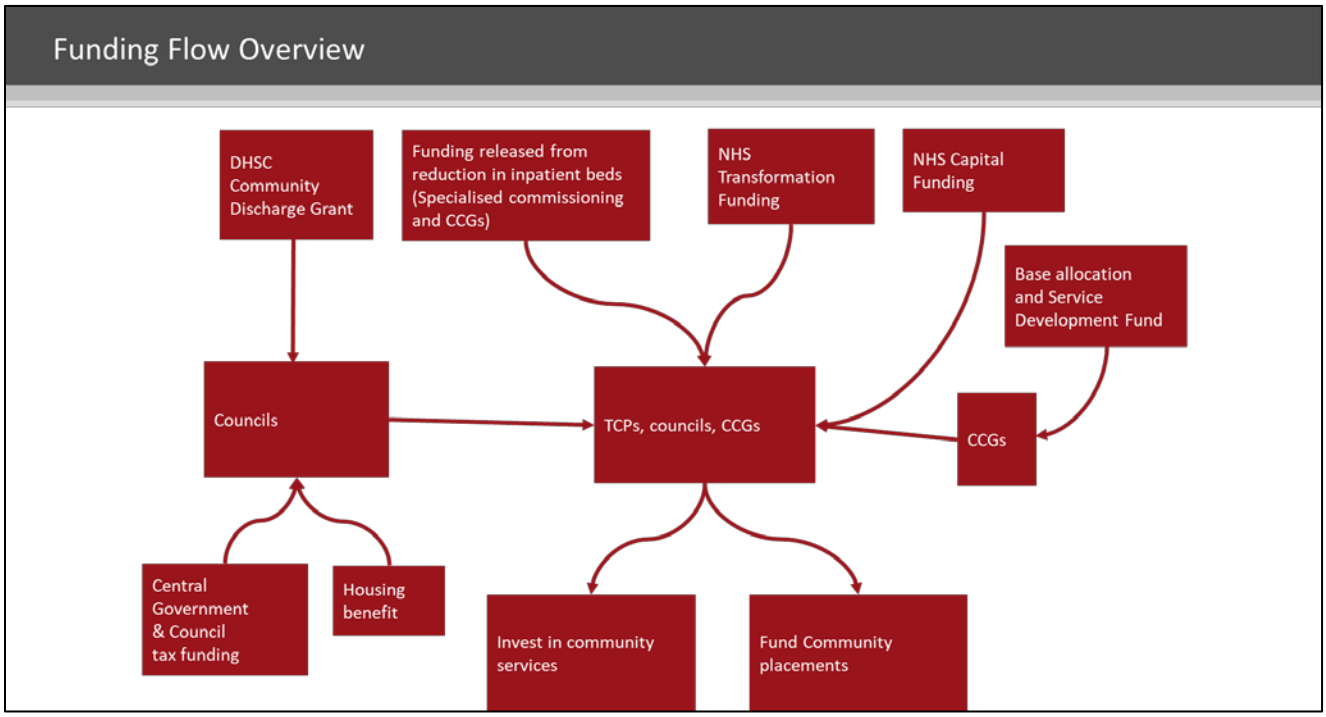


**Figure 6**: High-level funding flows for BtRS
**Source**: RedQuadrant

## Funding streams

Funding for BtRS is complex and multi-layered. It can be grouped into 3 broad categories:

1. Assumed or actual savings from reduced use of inpatient beds
2. Additional funding from NHSEI or DHSC to supplement those savings
3. Existing NHS, CCG and council budgets

The diagram below sets out funding that has been available to the programme since 2016

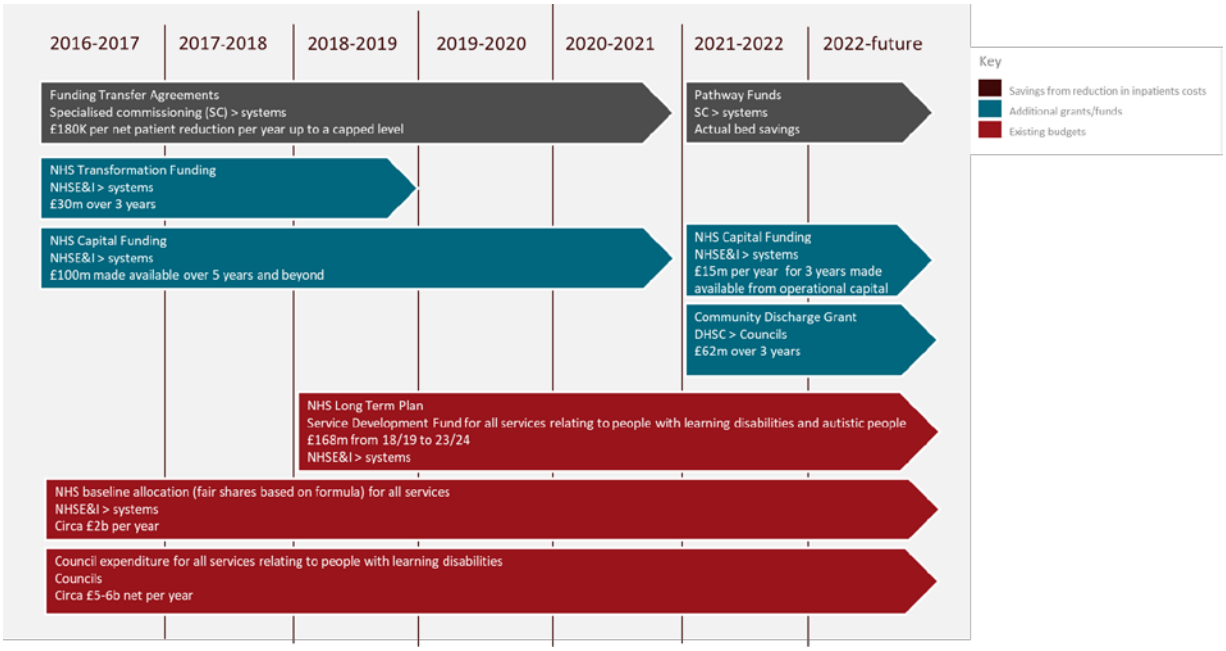


**Figure 7:** Diagram representing funding streams for BtRS from 2016
**Source**: RedQuadrant

## Savings from reduction in inpatient costs

Funding transfer agreements (FTAs) were set up to allow money to flow from NHS specialised commissioning inpatient services to local health and care systems, via the TCP to fund accommodation with care and support for people as they were discharged from an adult specialist mental health bed which was commissioned by NHSEI. This was primarily people coming from secure inpatient settings. A sum of £180,000 per net patient reduction per year was paid quarterly to CCGs, up to a capped level based on an agreed trajectory. However, TCPs were able to fund above and beyond this cap. The net reduction was against a 31st March 2016 baseline and the £180,000 was the average annual cost of a specialised inpatient bed at that time. This funding was intended to be used both to fund individual placement costs of people discharged and to develop community services aimed at reducing future admissions.

FTA has been the major source of funding for people discharged from secure impatient settings, including those eligible for a 100% dowry - people who had been an inpatient for five or more years at a qualifying date of 1st April 2016.

These funds were in many instances passed across to the relevant council who then commissioned the appropriate care package, meeting their share of Section 117 aftercare costs out of the existing resources. Since 2020 funds have also been available from the Community

Discharge Grant, although this was specifically intended to cover double running costs associated with discharge rather than meeting on-going Section 117 responsibilities.

From April 2021, 15 new NHS-led provider collaboratives (PCs) were set up as part of the local integrated care system (ICS) structure. The scope of these PCs includes the commissioning of low and medium secure beds for adults with a learning disability and autistic people with a budget delegated from the NHSEI specialised commissioning service.

In April 2021, FTAs were replaced by pathway funds, including the £84 million recurrent legacy FTA funding. The pathway fund still has the same purpose as FTAs – to allow funding to flow from specialised inpatient services (secure) to community provision but are based on actual savings released, rather than an agreed formula. The guidance explains how they are intended to provide more scope for local ambition as any savings released can be widened to include investment in community services, including for children[3]. The guidance also includes a requirement for some 'experts by experience' (people with a learning disability and autistic people, and their carers and families) and voluntary sector representation should be included on the pathway panels[4].

It is also currently within the rules that provider collaboratives can request from pathway panels that funds be held back for future demand for inpatient care, which could impact on the amount of money available to fund discharges: 'Should the Lead Provider conclude that some of the costs released will need to be retained, this should also be presented to the panel for consideration'. [5] While unlikely, this option is currently within the guidance.

### Additional grants/funds

NHS transformation funding was made available to TCPs in 2016 with the intention of kick-starting the programme and to help cover the double running costs, as discharges were to commence in advance of significant amounts of inpatient costs being released. Transformation funds allocated to an area had to be match funded by the receiving CCG.

CCGs also have access to service development funds. These are national NHS funding for all Long Term Plan (LTP) commitments including those which relate to BtRS – they encompass all

[3] Guidance on the implementation and operation of the Learning Disability and Autism Pathway Fund, Dec 2021, NHS England, NHS Improvement p.7

[4] Ibid, p.18

[5] ibid, p.9

national funding for learning disability and autism programme. These are recurrent funds available to support developments in services, including to support service developments in line with the BtRS service model. There is no specific line item for BtRS, but some line items are relevant, such as Community SDF, key working, Care (Education) and Treatment Reviews and community respite care.

£100 million of NHS capital funding was made available over the 5 years up to 2020 to 2021 for housing support. Taking into account learning from the first 5 years about the amount of funds which could be re-cycled into the scheme from receipts from sales of properties, £15 million per year for 3 years, has been made available from operational capital from 2021 to 2022 onwards.

The Community Discharge Grant introduced in 2020, provides £62 million over 3 years. The grant is a Section 31 non-ring-fenced grant to councils given to accelerate discharging of patients with a learning disability and autistic people from hospitals into the community.

In addition, in 2021 the national autism strategy outlines a number of requirements for improving services for autistic people around diagnosis, prevention of mental health crisis and supporting people back into the community. This is linked to existing funding in the NHS Long Term Plan and the councils Community Discharge Grant.

### Existing budgets

Discharges of people who have not been in secure beds are not eligible for FTA funding support and are a call upon existing funding streams.

CCGs have annual budget allocations which include funds to cover health care requirements of people with a learning disability and autistic people within their areas. Their budgets include spend on both inpatient and post-discharge care and support, including continuing health care and Section 117 aftercare funding.

Councils with social care responsibilities spend significant proportions of their Adult Social Care budgets on support for people with a learning disability and autistic people. This includes care and support in residential care, supported living and independent living environments. It also includes funding for day care, respite care and through direct payments to provide person-centred support to people with a learning disability, autistic people and their families.

# Detailed findings

There are 6 main themes to our findings:

1. The limitations in national financial reporting to support national oversight of the programme – the difficulty in comparing spend and return on investment across local areas
2. Relationship between the savings released from a reduction in inpatient beds and the cost of funding community-based solutions – the risk that savings released may be insufficient to fund community-based services
3. The practicalities of arranging homes and appropriate care and support – exploring a number of factors which restrict the ability for funding to flow effectively
4. Investment in community-based preventative and crisis services – which considers the level of consistency of investment across the country
5. Out of area and private sector inpatient provision – highlighting the impact on costs of variable availability of appropriate inpatient and ATU beds
6. Children and young people, in particular as they transition into adulthood – we find that there is limited shared funding to support post discharge support

The findings and areas for consideration in this report represent the summation of the intelligence gathered and analysed in the discovery phase of the project. It is acknowledged that the evidence we have been able to gather has not been as comprehensive as we would have hoped, due to issues which we have outlined elsewhere. However, we did gather enough evidence to draw conclusions in several important aspects of the programme: we believe that these findings and areas for consideration are important and can indicate areas where improvements could be made to funding flows.

Our methodology is set out in Appendix A, a list of the organisations with which we engaged is provided in Appendix F, and detail of data-gathering and modelling methods are provided in Appendices B to E.

# Financial reporting and programme oversight

In this section, we explore how financial reporting and oversight support the BtRS programme.

### Findings

Our findings relating to this theme are outlined below:

1. Responsibility for the delivery of the programme's aims has rested with TCPs which are composed of CCGs and their local council partners. There has been limited regional or national oversight of expenditure and investment of either councils or NHS system spend on BtRS specifically.

   (We have noted that going forward responsibilities will rest with integrated care systems (boards and partnerships) but will still be composed of both NHS and council partners)

2. TCPs have reported BtRS performance information, but this did not include financial information. The discontinuation of the requirement for CCGs and TCPs to provide a financial return to NHSEI against their BtRS plans has removed a potentially vital planning and monitoring tool that could have assisted in ensuring that funds were flowing in the most effective directions.

3. There is no national mechanism for measuring the extent to which the TCPs and councils have invested in the range of preventative and crisis support services as set out within the Building the Right Support service framework.

### Evidence for findings

We sought to examine whether the BtRS funding sources were delivering the outcomes of the programme, and whether there were impediments in funding flows, or blockages which were restricting progress towards achievement of the programme outcomes. We were also asked to look at whether there were any financial incentives or disincentives within the funding system.

We looked for detailed financial information on the following:

- the sources of funding
- the allocation of that funding by area and category of expenditure
- information on how funds had been spent over the course of the programme

We hoped to be able to access financial data which could give an insight into the money that had been released through the reduction in inpatient beds, and the money that had been

invested in accommodation with care and support for individuals as well as developing community support, including preventative and crisis services. We hoped to be able to compare the costs of community services with inpatient care and the impact of investment in different services and at varying rates at a local, regional and national level.

### National and regional oversight of expenditure

We will discuss each of the types of funding streams in turn:

1. Assumed or actual savings from reduced use of inpatient beds
2. Additional funding from NHSEI or DHSC to supplement those savings
3. Existing NHS, CCG and council budgets

### Assumed or actual savings from reduced use of inpatient beds

Funding transfer agreements (FTAs) amount to a recurrent £84 million per year at closure of the scheme (31st March 2021), and we saw the FTA allocation for each CCG. We have not seen evidence of how money from FTAs has been spent at a local level.

As a new scheme, full information on the use of pathway funds is not yet available. We note 4 points from the guidance notes:

- pathway funds are linked to actual savings released as the reliance on inpatient care is reduced, and capacity is withdrawn[6]
- the lead provider will be able to present a case to the pathway panel if they conclude that some of the costs due to be released need to be retained[7]
- the requirement for an annual pathway feedback report including 'a summary of what has been committed by pathway panel members, what has been spent and what has been delivered'
- 'In addition, the panel must also ensure its members report what the legacy FTA and national programme funds have been spent on, irrespective of whether they are part of

[6] Guidance on the implementation and operation of the Learning Disability and Autism Pathway Fund, Dec 2021, NHS England, NHS Improvement p.7

[7] *ibid* p.9

the pathway fund**.** This is a new requirement, reflecting the need for greater transparency on how money has been spent'[8]

We welcome the introduction of the feedback report and the acknowledgement of a greater need for transparency.

The impact of the link to actual savings, and the potential impact of those savings not to be released is discussed in Section 2 below.

### Additional funding from NHSEI or DHSC to supplement those savings

We saw very limited information around the allocation and use of this additional funding and therefore were not able to draw any conclusions around its impact.

We have not seen evidence of how NHS transformation funding (2016-2019) was allocated or how it, along with the match funding, was spent by CCGs.

We have recently been provided with information around how NHS service development funds have been allocated. However, we have not been able to access data to show how this money has been spent.

NHS capital funding provided for over 100 properties from 2017 to 2021 to enable people to move out of long-term inpatient settings. We have not seen any further detail of the use of this funding.

From 2021 to 2022 councils will report on the use of the Community Discharge Grant (CDG) to DHSC via their data reporting tool which is aimed at tracking the use of the fund and its effectiveness.

[8] *ibid* p.11

An extract from the LGA guide to CDG is set out below:

**How is this year's grant different from last year's grant?**

- To ensure oversight of local authority CDG expenditure the Department of Health and Social Care are introducing a new light touch data recording tool for the 2021/22 financial year.
- DHSC have developed the CDG data recording tool in conjunction with local government, with an aim to collate data to demonstrate the effectiveness of the grant. This evidence base will help to inform the Government's understanding of how the grant has been utilised and how effective it has been, ultimately informing future decision making.
- The **DHSC CDG data recording tool** has three sections
  - Section 1 – LA plans for CDG expenditure which was due on 29 November 2021
  - Section 2 – progress report due 31 January 2022.
  - Section 3 – post financial year reporting due 13 April 2022.
- Lead local authorities for each ICS and TCP have signed a Memorandum of Understanding agreeing to the intended use of the grant, in line with the stated objective.
- The Community Discharge Grant is a non-ring-fenced section 31 grant.

**Figure 8:** Information on recording tool for CDG
**Source:** LGA guide to Community Discharge Grant

There was ad-hoc reporting of data for 2020 to 2021 but due to the pandemic we are told that this was limited. We have seen the breakdown of grant by areas, but as the requirement for reporting was only introduced for this year, detail of how it has been spent was not available for us to view. We note that councils' plans for CDG expenditure (2021 to 2022) were due to be received by DHSC on 29th November 2021 but we have not seen this information.

### Existing budgets

We sought to understand the spend on BtRS via existing budgets. A difficulty arose in that, while individual CCGs and councils have comprehensive information on their budget allocations and spend, there is limited financial data collected and collated at either a regional or national level specifically for BtRS apart from the spend on inpatient care, .i.e. people with a learning disability and autistic people who are either at risk of being admitted to an inpatient setting or have been discharged.

#### TCPs

We found that while TCPs do report BtRS performance information and this is collated regionally and nationally, this does not include financial information.

All TCPs were required to have robust implementation plans - using a standard template - in place by 1st April 2016, in line with the national service model, to be delivered over 3 years

(2016 to 2017, to -2018 to 2019). These were submitted to NHSEI for approval of funding. The delivery period was subsequently extended to 4 years.

The returns for these implementation plans originally included a specific finance section that required information on how resources were being spent, and the flow of funds from inpatient provision into the community. This return would have provided an audit trail of how funds were invested and a ready data source to examine costs and resource allocation. It may have helped answer the question as to whether placement costs in the community are more expensive in the short, medium and longer term. However, the finance template was discontinued after 2016 to 2017. We heard from stakeholders that this was due to variable data quality and note also ADASS referenced issues in relation to the difficulty in consistent and full completion.

Some TCPs showed us their 2021 to 2022, to 2023 to 2024 plans. These contain information including commissioning intentions regarding different types of services. However, beyond these being submitted to the regional NHS office, as part of the process of drawing down funds, we saw no evidence of a process for reviewing and collating information and trends from these plans. In addition, plans do not include individual care and support package costs, nor how ongoing packages of care are funded.

We therefore sought to gather data from a sample of 12 individual TCP areas with a bespoke data collection tool.

This proved challenging, given the numbers of CCGs involved, the pressures on staff within CCGs from other competing demands, and the lack of a pre-existing reporting framework that could be used to collect financial information. We received data returns from 5 TCP areas.

**Councils**

While councils report total net spend on services for people with a learning disability within the council's area, they do not have a method to record council investment in the BtRS programme specifically, other than expenditure using the CDG (see above). Neither is spend on services to support autistic people collected or reported by councils. We therefore requested information from councils via an online survey supported by ADASS and the LGA. We received responses from 28 councils.

Given the system's limited ability to extract national or regional financial reporting around BtRS, we have based our findings from available data, including:

- Assuring Transformation dataset which provides national data around the numbers of people relating to BtRS in inpatient settings

- stakeholder interviews with over 50 people across the system, including those with lived experience via the BtRS Advisory Group
- in-depth interviews with 12 Transforming Care Partnerships (TCPs) and financial information from 5 of those 12 TCPs
- community accommodation with care and support costings from 5 TCP commissioners, from one private sector and 2 not-for-profit community sector providers and inpatient costings from 2 TCP commissioners, NHSEI specialised commissioning and one private provider
- hearing from 28 councils via an online survey; including council contribution to costs for people post-discharge

## Conclusion

We suggest that the limited ability to analyse financial data to provide a national perspective is a weakness in the effective oversight and management of the BtRS programme overall. In our view, it limits the ability of the BtRS Delivery Board, NHSEI, DHSC, and other partners to be fully assured that 1) resources are being allocated and spent in the most effective way and that 2) where differences in levels of investment are occurring and to identify the resultant impact.

Our findings in this report suggest the need for additional funding streams to support the high costs of care and support placements for many people with long lengths of stay where the cost of their care and support substantially exceeds the cost of their former inpatient bed, and for targeted investment in preventative and crises services aimed at reducing admissions.

We acknowledge that these costs are the responsibility of both the NHS and of local government, and that the balance of contribution between NHS Long Term Plan funding and section 31 targeted funding for councils will need careful consideration. This should not deflect though on the need to identify funds which can be accessed to meet these challenges.

While we believe we have seen sufficient evidence to justify these proposals, we believe that this should be linked to a clear mechanism for monitoring the allocation, spend and return for that investment – as in, demonstrating that any additional flow of funding is appropriately targeted and is having measurable impact.

## Areas for consideration

| Area for consideration | Potential benefits |
|---|---|
| Consider mandating collation of financial data points to enable a direct comparison of inpatient and community costs | Target additional funding, if needed, in addition to savings released from discharges to ensure appropriate community accommodation with care and support |
| Consider mandating collation of financial data to identify forecasted spend on preventative services looking for areas of underinvestment or where expenditure is out-of-line with expectations | Provide ability to prioritise ring-fenced funding for areas where there is underinvestment or where expenditure is out-of-line with expectations |
| Consider developing a forecasting model which incorporates analyses of effects of demand, prevention activity and inpatient length of stay | Provide insights into effective action to promote better outcomes and value for money |

# Relationship between the savings released from a reduction in inpatient beds and the cost of funding community-based solutions

In this section, we explore whether the flow of funding from savings associated with reductions in inpatient beds was sufficient to fund accommodation with care and support for people discharged.

Stakeholders told us that the needs of people who had been inpatients for a considerable number of years were significant. People were often admitted because of the absence of appropriate levels of care and support in the community. Changing from a system reliant on inpatient care when things went wrong to one where the expectation is that care and support would be provided in someone's own home requires significant cultural, financial, and practical change. We heard that for many people who had been in inpatient facilities for extended periods, existing service models had proven unsuitable for them. Successful discharges require a personalised approach and the development of services designed around individual needs and circumstances.

### Our findings relating to this theme are outlined below:

When exceptionally high-cost arrangements for accommodation with care and support are excluded from averages, the cost of fencing community-based solutions can be less or similar to the equivalent inpatient costs.

1. When exceptionally high-cost arrangements for accommodation with care and support are excluded from averages, the cost of funding community-based solutions can be less or similar to the equivalent inpatient costs.
2. Some community support packages are extremely high cost at the point of discharge – around 10 times the average cost of a placement with care and support, and around 8 times greater than the average cost of inpatient settings.
3. There is evidence that in some cases at least, the cost of care and support does reduce over time.
4. Due to the existing pressure on budgets, there is a risk that if savings released from inpatient beds are insufficient to fund accommodation with care and support, this could become a disincentive to discharging people with high support needs.
5. We were told that characteristics of the group of people relevant to BtRS have changed since the programme started as the proportion of inpatients with high support needs has

increased. We explored these changes but have not been able to evidence that these changes have caused increased costs for accommodation with care and support for those being discharged.

6. Only discharges from low and medium secure hospitals attract FTA funding, meaning that 50% of inpatients at January 2022 must be funded from mainstream health and social care budgets.

### Evidence of findings

Stakeholders consistently told us that in the early years of the BtRS programme, commissioning accommodation with care and support for those people discharged was less expensive than the cost of inpatient care. This was because people being discharged, on average, had lower support needs than many of those who remain to be discharged, and they therefore required lower levels of care and support once discharged.

We were told that as the programme has developed, the proportion of people with high support needs being discharged has increased, with the associated additional costs involved.

Savings released being insufficient to fund accommodation with care and support was identified some years ago from stakeholder interviews for the University of Birmingham et al's evaluation of Building the Right Support: phase 2 case study findings report, (July 2018) which stated 'That cost of packages can exceed the funding transfer agreement amount was born out in all TCP areas in which we have investigated costs.'

As there is no national financial dataset that enables a full comparison between the costs of inpatient care and community solutions, we based our analysis on costs data from NHSEI specialised commissioning and a sample of 5 TCPs who shared their placement cost data with us.

### Inpatient bed costs

NHSEI provided us with these bed costs which vary between £551 and £653 per day depending on the person's care needs.

NHSEI specialist commissioning bed costs 2020 to 2021:

| Cost per inpatient bed | NHS low secure learning disability | NHS low secure autism | NHS medium secure learning disability | NHS medium secure autism |
|---|---|---|---|---|
| Day cost £ | 525 | 571 | 564 | 612 |
| Annual cost £ | 191,625 | 208,415 | 205,860 | 223,380 |

**Average day cost: £207,3201** [1]

**Figure 9:** Table of NHS inpatient bed costs

**Source**: NHSEI Specialised Commissioning

[1] Average here is the mean across these day costs, not weighted on usage

Another breakdown is available, showing variations in costs between NHS and independent sector inpatient beds for different categories of patients, as shown below.

Taking account of day costs for non-NHS beds, the range is between £494 and £711 per day.

| Cost per inpatient bed | Non-NHS low secure learning disability | Non-NHS low secure autism | Non-NHS medium secure learning disability | Non-NHS medium secure autism |
|---|---|---|---|---|
| Day cost £ | 494 | 650 | 558 | 711 |
| Annual cost £ | 180,310 | 237,250 | 203,670 | 259,515 |

**Average day cost: £220,816** [1]

**Figure 10:** Table of non-NHS inpatient bed costs

**Source**: NHSEI Specialised Commissioning

[1] Average here is the mean across these day costs, not weighted on usage

We also sought to collate CCG-commissioned bed costs, but only received information from 2 TCPs, therefore we have not included this information in our comparison.

### Community care and support costs

The table below provides the average costs of accommodation with care and support (for brevity, we will call accommodation with care and support arrangements 'community placements' in this section). These costs are for 2020 to 2021 for the 5 TCPs that responded to our finance information request.

Consistent with the overall policy recommendations of Building the Right Support, for the majority of those discharged, there will be a separation between housing and care costs. The figures in the table below do not include housing costs – i.e. rents associated with a tenancy – as these are covered by housing benefit, which although remain a call on public finances, do not impact on NHS or Council care budgets.

Although this was a small sample, it included areas that have reduced their number of inpatients below 30 per million adults and those that still have some way to go; geographically, the 5 areas are spread across 4 NHS regions. While it is possible that other TCP areas may be experiencing different placement cost, the fact that all areas we analysed had costs in a similar range gave us a level of confidence of this as an indicative comparator.

| TCP | Number of placements 2020 to 2021 | Average cost per annum (2020 to 2021) £ | Average cost per annum (excluding highest cost placement) £ | Exceptionally high cost placement £ | One-off costs (excluding capital) |
|---|---|---|---|---|---|
| TCP 1 | 23 | 219,164 | 157,455 | 1,576,774 | Not provided |
| TCP 2 | 32 | 187,338 | 187,338 | Not provided | Not provided |
| TCP 3 | Not provided | 133,013 | 133,013 | Not provided | Not provided |
| TCP 4 | 9 | 377,193 | 185,271 | 1,912,569 | 217,000 |
| TCP 5 | 2 | 161,000 | 161,000 | Not provided | Not provided |
| **Weighted average excluding TCP 3** | **223,520** | **175,984** | **1,744,672** | **N/A** | **N/A** |

**Figure 11:** Table of TCP community placement costs
**Source**: 5 TCPs via RedQuadrant data tool

In summary our data shows that, average community placement costs for a TCP area range from £133,013 to £377,193 (or £185,271 excluding high-cost placements) per year.

### Community placement costs in detail for one TCP area

One TCP provided the cost of all their 23 community placements. In this example:

- 14 out of 23 community placements were less than £180,000 per year, ranging from £25,000 to £168,000 per year
- 6 placements were between £180,000 and £250,000 per year
- 3 highest cost placements: around £350,000, £480,000 and over £1,500,000 per year

More data is needed to understand how representative these 5 TCPs are and therefore whether this is a consistent picture across all TCP areas.

### Examples of high-cost placements

Out of a sample of 66 placements (from TCPs 1, 2, 4 and 5), 2 (or 3%) of the community placements are considerably higher than the average community placement cost – around 10 times more expensive. This is around 8 times the cost of an inpatient bed.

Details of these community placements are given below:

- TCP 1 – predicted annual cost of £1,576,774: this placement had to be agreed at short notice and an interim care package was agreed at £29,700 per week. As seen in 3.1 below, some care packages do reduce over time but this is usually achieved gradually and we have made the assumption that this cost will remain at this level for at least one year.
- TCP 4 - annual cost of £1,912,569: this person was placed in bespoke accommodation funded by an £875,000 capital grant. A staff ratio of 5:1 support with 24/7 care, plus a specialist nurse covering a 12-hour shift and a full-time manager was required. The package costs £36,680 per week. In addition, £185,000 was agreed for transitional support and £32,000 for a positive behaviour support worker to help manage the plan.
- We were also made aware of 2 further high-cost placements currently being considered at a cost of £653,000 each per year, although commissioners are exploring other options to try and reduce these care packages.

## Comparing costs

Comparing all of the various data points, we can then compare annual costs of inpatient beds with community placements.

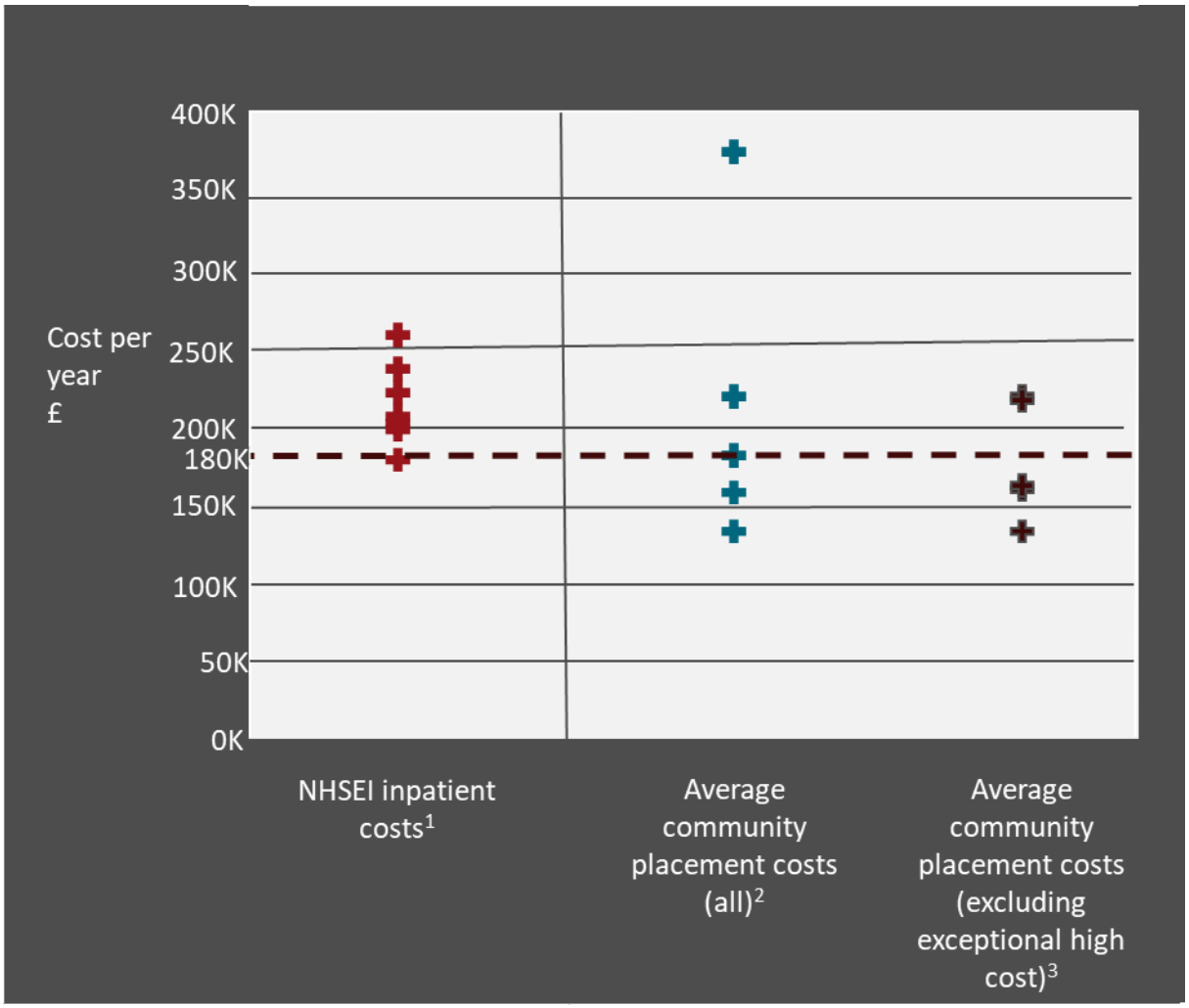


**Figure 12:** A pictorial representation to compare costs of community placements and inpatient provision
**Sources:** NHSEI specialised commissioning and 5 TCPs via RedQuadrant data tool

[1] NHSEI national data – 8 costs by patient type
[2] Average community placement costs for 5 TCPs
[3] Average community placement costs, excluding exceptionally high-cost placements, for 5 TCPs

When exceptionally high-cost placements are excluded in community placement average costs, these costs (£133,013 to £185,271) are less than or similar to inpatient costs (£180,310 to £259,515).

When exceptionally high-cost placements are included in community placement average costs, the picture is less clear and suggests that average community placement costs (£133,013 to £377,193) may be broadly similar to the equivalent averages of inpatient costs (£180,000 to £259,000).

Since the financial model for the BtRS national plan is based in no small measure on releasing savings from a reduction in inpatient care and using those savings to fund not only community placements but also investing in preventative services, high community placement costs will impact on an area's ability both to discharge people and to invest in the necessary preventative services.

### Costs reducing over time

We heard from some stakeholders that the costs of some care packages, though high at the point of discharge, may reduce over time, as the impact of people living in an institutional setting for a long time diminishes and as the care and support provided succeeds to build the capacity for greater degrees of independence and self-care. We have found some evidence of this.

We were unable to gain data on this from TCPs, so requested data from a not-for-profit provider which specialises in supporting people to live in the community, especially those who have particularly high support needs. For this reason, we have described these costs as examples of high placement costs.

Looking at the data provided by this provider, we can see that for half of the examples provided, costs do reduce over time as the person's needs change. The table includes the cost of placements at point of discharge and then how over a period of time, some costs are reduced. Sometimes this can be achieved relatively quickly as in person A, whose care package reduced from 2:1 support to 1:1 support within the first year. However, as with person D, sometimes this can take much longer and for this person it has taken 4 years before any changes could be made to the care plan.

| Identifier | Cost per year on discharge £ | Notes | Long term cost per year £ |
|---|---|---|---|
| Person A | 168,888 | Initially 2:1 support plus waking night support, moved to 1:1 plus waking night support within one year. | 106,109 |
| Person B | 239,623 | No change | 239,623 |
| Person C | 261,732 | No change | 261,732 |
| Person D | 276,196 | At discharge, person had 3:1 support day and 2:1 night. After 4 years moved to 2:1 | 150,638 |
| Person E | 318,379 | No change | 318,379 |
| Person F | 343,511 | No change | 343,511 |
| Person G | 367,914 | 2:1 support at all times, reduced to 1.1 | 186,773 |
| Person H | 505,777 | 5:1 support initially, reduced to 3:1 and aiming for 2:1 (change made over 7 year period) | 411,922 |

**Figure 13:** Examples of high cost of community placements over time
**Source:** 2 non-profit community support providers

Regular reviews of care and support packages should ensure that the appropriate levels of care and support are provided and adjustments are made over time. We were told that there is potential to improve consistency of these reviews in some areas.

### Reasons for delayed discharges

NHSEI collate information on 'mental health delayed discharges' and the reasons for them. NHSEI shared a summary of their analysis for BtRS inpatients in September 2021. 'Funding' or 'funding flows' is not available explicitly as a reason for delayed discharge. The results are further segmented by those for people with a learning disability and those for autistic people in the table below.

| Reasons for delayed discharge (patients in hospital as of September 21) | Learning disability | Learning disability and autism | Autism | All |
|---|---|---|---|---|
| Social care reasons | 40% | 60% | 60% | 55% |
| Housing reasons | 30% | 60% | 30% | 43% |
| Health reasons | 20% | 20% | 20% | 20% |
| Patient or family reasons | Data suppressed for 5 or less people | 10% | 20% | 9% |
| Education and children's services reasons | Data suppressed for 5 or less people | Data suppressed for 5 or less people | 10% | 4% |
| Criminal justice reasons | 10% | Data suppressed for 5 or less people | Data suppressed for 5 or less people | 4% |
| Legal issues | 10% | Data suppressed for 5 or less people | Data suppressed for 5 or less people | 4% |
| Other | 40% | 30% | 30% | 38% |

**Figure 14:** Reasons for delayed discharges

**Source:** Assuring Transformation dataset (published by NHS Digital). Analysis by NHSEI

It is possible that many of the reasons cited above have a funding element to them, but no further information was provided to us. Using this analysis, we cannot say whether funding flow issues have impeded discharge. It seems reasonable to assume though that the top 2 reasons, that of social care reasons and housing reasons may relate to practicalities around identifying or adapting a home and arranging appropriate care and support. Further interrogation of detail behind this data, including the further breakdown by codes if available, could serve to provide useful insight into delayed discharges.

In addition, the Assuring Transformation dataset (published by NHS Digital) Table 3.3, also records "Reasons for delayed discharge" and records that in January 2022 there were 10 people whose discharge was delayed due to lack of agreed social care funding and further 10 where there was a lack of agreed NHS funding – making a total of 11% of those where their discharge was delayed.

## Disincentives

### Funding cap on funding transfer agreements

We heard from one TCP area – which had achieved a higher rate of discharges than their trajectory - that there was a clear financial disincentive within the FTA process to achieving this higher rate of discharges:

An area may be expected to achieve a net discharge of 5 people during a given year and therefore expect FTA funding of 5 x £180,000 to support those discharges. However, if they overperform and have a net discharge of 8 people then their FTA income remains at £900,000, while their costs will have increased to as much as £1,440,000. In one high performing TCP area, the CCG was carrying a deficit of £1.2m in a year as a consequence of 'overperformance' of discharges.

We have been assured that this cap no longer applies within the pathway fund arrangements as the fund is based on actual savings released as opposed to a notional sum related to net reductions against a trajectory of expected performance.

We consider it important that pathway fund guidance is examined carefully to ensure that there are no other disincentives of a similar type.

### Insufficient funding released from savings

Even with the limited data outlined above, it is clear that in not all cases where people are discharged into the community will their care and support costs be less than their former inpatient care costs. This is further supported by the view of one private sector provider who provides both inpatient and small-scale residential care in the south of England. They told us that their rate for most inpatients was in the region of £550 per day, but that the costs for someone discharged into one of their residential units was likely to be at least £1,000 per day.

Stakeholders consistently told us that a growing proportion of those still requiring to be discharged had high support needs, and that this is having an impact on their overall CCG budgets. We heard from councils that there is a lack of funding to expand community teams, and that there are budgetary challenges in funding community packages. We have heard that budget deficits in relation to this programme are increasing and it would seem inevitable that unless actions are taken to address the shortfall between savings released and new placement costs, there could well be significant disincentives to secure discharges, particularly of those with the highest support needs. With the guidance given regarding the pathway fund that funding for placements should reflect actual savings made, this could become an increasingly powerful disincentive. It is though important to acknowledge that the pathway fund is not the

sole source of funding for post discharge care and that councils will continue to have responsibility for funding their share of Section 117 aftercare costs.

In addition, it must also be considered that only those people discharged from secure hospital beds attracted FTA funding. For those placed within non-secure (e.g. ATUs) there has been no additional funding available to the TCP and these have relied upon CCG and council mainstream funding, supplemented by Service Development Funds and Community Discharge Grant. We can see from the Assuring Transformation dataset (published by NHS Digital), that of the 2,030 inpatients remaining in November 2021, 1,080 were not in secure beds. 150 had lengths of stay of more than 10 years and a further 110 for between 5 and 10 years. These discharges will continue to have a significant impact on local NHS and council budgets without the benefit of pathway funding.

### Has the change in characteristics of people remaining to be discharged had an impact on costs?

Commissioners, especially those who attended our problem and solution mapping workshops, told us that there has been a significant change in the make-up of the people included within the programme over time and that this has impacted on the ability of TCPs to meet targets and at costs containable within their budgets.

#### Lengths of stay

We consistently heard from stakeholders that those with shorter stays in hospital were more likely to have been discharged in the early years of the programme. Consequently, people with longer lengths of stay (who require higher levels of post-discharge care) constitute an increasing proportion of those people remaining in inpatient beds. Stakeholders told us that for people with short lengths of stay, the cost of post discharge care is less than for those whose stays are longer, and significantly less than inpatient care. It is also the case that a higher proportion of those with longer lengths of stay are forensic patients where additional reasons for extended stays may apply.

**Original people identified under BtRS**

The table below indicates progress at discharging the original people identified under BtRS. Of 2,900 inpatients in March 2015, 1,670 (54%) were not in hospital in 2018, By 2021, the number of the original group of people still in hospital had reduced to 790, meaning that 73% had been discharged successfully.

| Date | People with a learning disability | Autistic people | Autistic people with a learning disability | Not-known | Total original BtRS cohort in inpatient setting |
|---|---|---|---|---|---|
| March 2015 | 1630 | 445 | 665 | 165 | 2900 |
| March 2018 (number) | 795 | 200 | 295 | 40 | 1330 |
| March 2018 (% remaining) | 49% | 45% | 44% | 24% | 46% |
| March 2021 (number) | 495 | 110 | 165 | 20 | 790 |
| March 2021 (% remaining) | 30% | 25% | 25% | 12% | 27% |

**Figure 15:** Number of people and proportion of people from the original BtRS cohort remaining in an inpatient setting over time**.**

N.B these figures will include some people who have been discharged and readmitted during this period.

**Source:** Assuring Transformation Dataset (published by NHS Digital). Analysis by NHSEI

It should also be acknowledged that the total number of people discharged over the period far exceeds the net reduction in inpatient numbers. Since 2015, 14,325 discharges from hospital and 12,835 admissions to hospital have taken place. (This will include transfers and where someone has been admitted or discharged more than once). This is presented in the chart showing discharges and admission per month since March 2015 below:

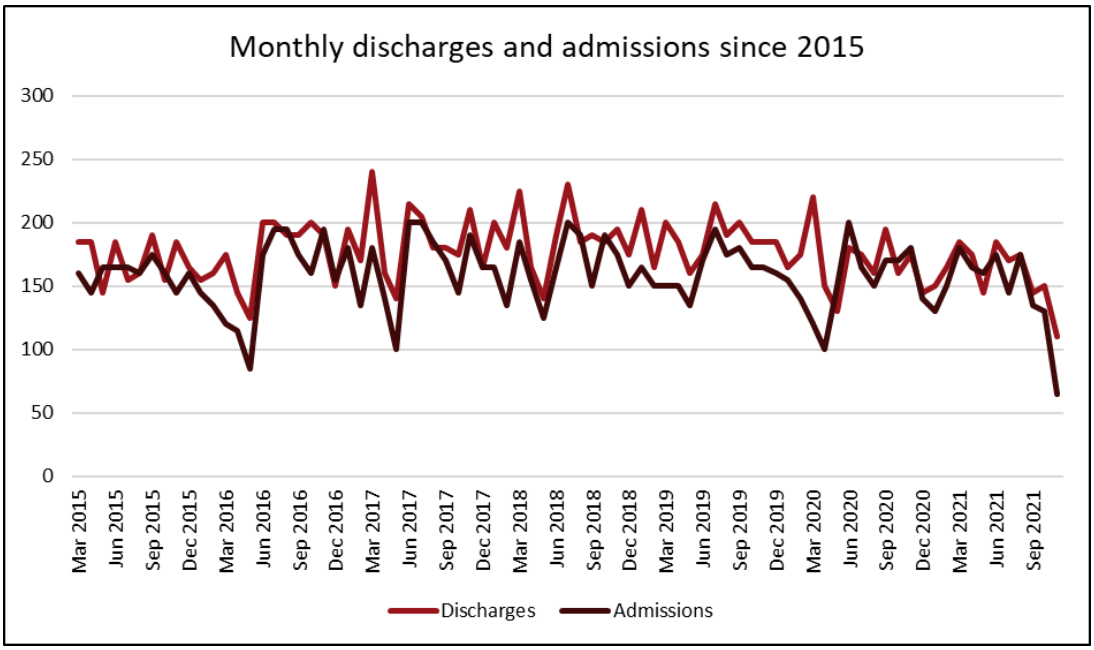


**Figure 16**: Monthly admissions and discharges since March 2015

**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021. Analysis by RedQuadrant

**All adult BtRS inpatients length of stay**

The table below shows information on length of stay for adult inpatients throughout the period since BtRS began.

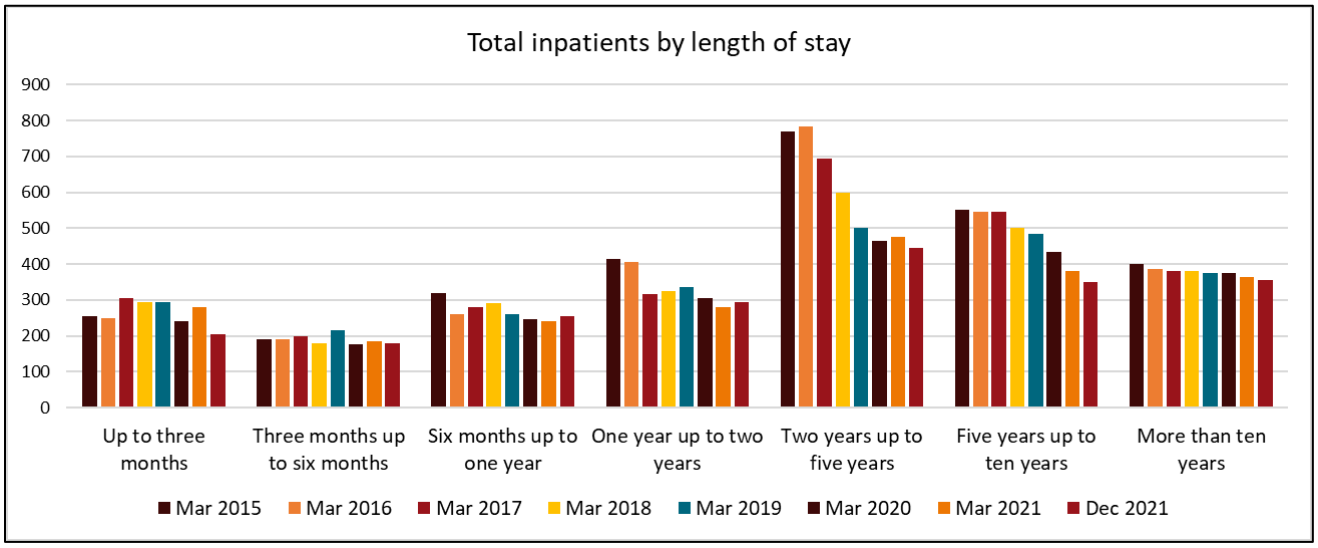


**Figure 17:** Total BtRS inpatients over time by length of stay
**Source:** Assuring Transformation dataset (published by NHS Digital), December 2021. Analysis by RedQuadrant

Our analysis of lengths of stay of the inpatient population since the commencement of BtRS shows:

- progress has been made in reducing the number of people whose stay is between one and 10 years. This suggests that the system has become more successful at discharging people more quickly.
- less progress in reducing the numbers of people with lengths of stay over 10 years. This reduced from 400 in March 2015 to 355 in December 2021. This results in a proportionate increase from 14% to 17% over the same period.

**Length of stay by admission date**

We also considered length of stay for people admitted at 3 points in time to see whether progress was being made around discharging people more quickly. We looked at the following periods: April 2015 to March 2016, at the beginning of BtRS, April 2017 to March 2018 and January 2019 to December 2019.

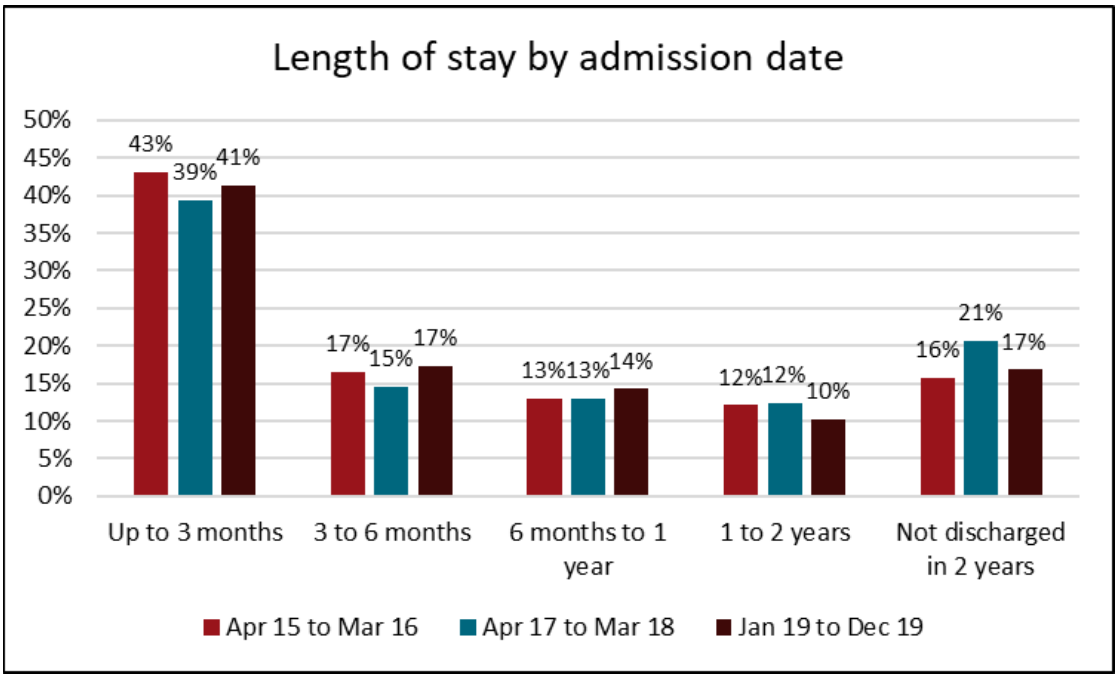


**Figure 18:** Length of stay by admission date
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021. Analysis by RedQuadrant

Analysis of length of stay by admission date shows that the proportion of people who have not been discharged after 2 years has increased since BtRS began. This suggests a risk that BtRS has not yet managed to reduce the number of people beginning long stays.

The prevalence of discharges after a short stay appears to be consistent with the purpose of ATUs – that is where people have a short stay, focused on assessment and treatment.

### Forensic patients

We consistently heard from stakeholders that the proportion of people in hospital with a forensic background has increased since the start of BtRS. Analysis of inpatient data does not support this view.

Forensic patients come into the remit of the BtRS programme through a number of routes:

- transfer from high secure hospitals to low or medium secure facilities – patients subject to Section 31 (hospital orders) and Section 41 restrictions
- admission on conviction on a Section 31 hospital order to a low or medium secure unit
- from prison on Section 47 ‘prison transfer order‘ as in need of treatment

- admitted under Section 3 from the community – although such admissions are more likely to be to a locked learning disability (for example, an ATU) or mental health facility rather than a secure unit.

Reviewing the number of inpatients subject to the Mental Health Act 1983 MHA Part III (with and without restrictions) over time, we see that the actual number has reduced in line with overall reductions, meaning that the proportion of inpatients subject to MHA Part III has remained stable at between 38% and 40%.

| Period | March 2015 | March 2016 | March 2017 | March 2018 | March 2019 | March 2020 | March 2021 | November 2021 |
|---|---|---|---|---|---|---|---|---|
| Number of people | 1130 | 1120 | 1045 | 1000 | 950 | 880 | 860 | 800 |
| Proportion of inpatients | 39% | 40% | 39% | 39% | 39% | 39% | 39% | 38% |

**Figure 19:** Inpatients subject to the Mental Health Act 1983 MHA Part III

**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021. Analysis by RedQuadrant

Although the proportion has not increased, we acknowledge the difficulties raised by commissioners in relation to discharge-planning for people with a forensic background. We heard that for many people, it involves complex arrangements and significant periods of double running costs as tribunals require lengthy trial periods before a final discharge can be agreed.

This is because patients require approval by the Mental Health Act tribunal (and in some instances the parole board) before a final discharge can be realised. Such approval invariably requires the tribunal (or parole board) to be satisfied those arrangements being put in place are sufficient to manage risk, and that the person concerned is seen to be compliant with those arrangements during the trial period. There may be requirements imposed in relation to the skills and qualifications of staff who will be part of the care team, and regarding the type and location of the property.

During trial periods the person remains a secure inpatient, on Section 17 leave, able to be returned to hospital if their supervising clinician deems it necessary. During these periods – which we have been told can last between 3 and 12 months or more – the costs of the inpatient bed remain, as does the costs of the community care placement and package. This means that no savings can be released at that time to fund accommodation with care and support.

A person on Section 17 leave has no access to benefits, either personal or housing benefits, meaning that the local NHS system must cover even greater costs including those which might otherwise have been covered through access to benefits.

Since pathway funds are reliant on the release of actual savings, these double running costs and additional costs associated with forensic discharges are likely to put additional pressures on local budgets. Although as previously mentioned, it is important to note that pathway funds are not the sole source of funding to support post discharge care and support.

Regression analysis carried out by NHSEI at our request found that:

- ward security is an important factor, with those in non-secure hospital settings more likely to have a lower length of stay than those in secure settings
- Mental Health Act status is a factor impacting length of stay. Inpatient spells relating to patients not subject to the Mental Health Act are likely to be shorter. Inpatient spells for those on Part III Mental Health Act sections (restricted and non restricted) are likely to be longer.

Further detail of methodology and the fit of the model are provided in Appendix E.

### Increasing numbers of autistic people within the programme:

Many stakeholders told us that there are greater numbers of autistic people coming into the system and needing appropriate discharge.

It is clear from the chart below that the number of people identified as autistic who were admitted (and also discharged) has been increasing since 2015.

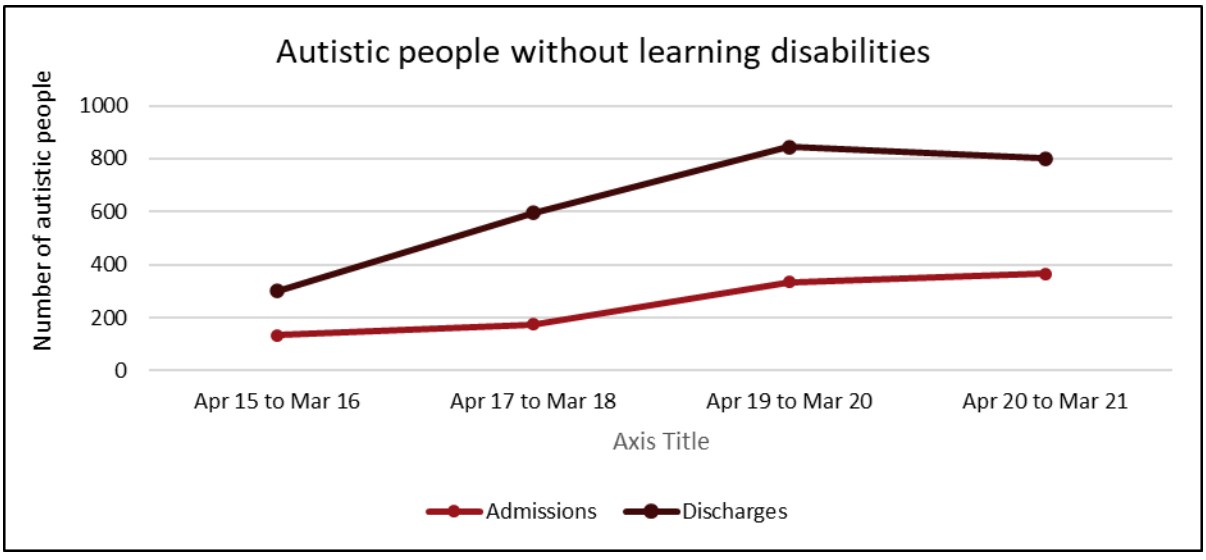


**Figure 20:** Admissions and discharges of autistic people without a learning disability
**Source**: Assuring Transformation dataset (published by NHS Digital). Data extracted by NHSEI in February 2022. Analysis by RedQuadrant

Some stakeholders suggested that autistic people are an addition to the BtRS programme. However, we believe that this is not the case since both Transforming Care: a national response to Winterbourne View hospital and Building the Right Support model service specifications: supporting implementation of the service model made explicit reference to the programme covering the needs of people with a learning disability and autistic people.

What may have changed over the years is that improved diagnosis and identification of autistic people may have resulted in more patients being directed at a time of crisis into specialist hospitals and ATUs rather than to mainstream mental health services.

We heard that admissions of autistic people tended to be of shorter duration and that autistic people were not a significant part of the group whose discharge had proved complicated or more costly than inpatient care. Assuring Transformation dataset (published by NHS Digital), confirms that autistic people without a learning disability are more likely to be discharged in less than 3 or 6 months than those with a learning disability.

Therefore, although there may have been some changes to the characteristics of the people within BtRS, we have seen no evidence that this has directly influenced increasing costs post discharge.

### Conclusion

Savings generated by inpatient bed reductions are unlikely to be sufficient to meet the costs of many people still to be discharged from inpatient care. Careful consideration needs to be given to how ICBs can be supported and incentivised to enable as many people as possible to be discharged and enabled to live ordinary lives in community. It is important that the social care contribution to post-discharge funding costs is fully considered and that ICBs work with council partners to ensure that this is the case.

There are examples of accommodation with care and support arrangements that cost significantly more than the savings associated with their inpatient care. We heard from stakeholders that this is increasingly the case. This contributes to the average costs of accommodation with care and support being close to, or higher than, the cost of inpatient care in the 5 TCP areas we had financial data for. If costs rise, this will inevitably increase pressure on already strained budgets.

The potential impact of the change from FTA to pathway funds, whereby only actual savings are released for reinvestment, may create additional pressure on budgets.

While we have seen no evidence that funding has been the deciding factor in someone not being discharged, we heard that for some CCGs the cost of arranging appropriate homes with

care and support for people being discharged was becoming a particular strain on their budgets. Councils too cited mounting budget pressures.

Contrary to what we heard from many stakeholders, the data does not show either significant increases in the number of people being discharged with lengths of stay greater than one year, or any increases in the number of people in inpatient settings with a forensic history. Neither did we see evidence that demonstrated that the increase in autistic people without a learning disability had added a particular additional strain funding.

## Areas for consideration

| Area for consideration | Potential benefits |
|---|---|
| Consider whether there is a need for a supplementary funding pot or regional pooled budget which can be drawn on for cases which are substantially more expensive to support within the community than within inpatient care and where funding of that discharge is beyond the capacity of NHS and council partners to manage within their resources. Such funding could draw from both NHS LTP/SDF funding and local government section 31 ringfenced grant, with performance measured and reported to the board annually. | Reduce the likelihood that people are not discharged or their discharge is delayed due to lack of available funding.<br><br>Facilitate an acceleration of discharges of those with longest lengths of stay |
| Consider reviewing the potential financial impact of the change from FTAs to pathway funds, in particular the level of actual savings from reducing inpatient care that are transferred. | Understand what impact the change from FTAs to pathway funds has had on local system financial stability and ability to invest into services aimed at providing early intervention and support to people with a learning disability, autistic people and their families. |
| Consider further investigating the financial issues surrounding the planning for discharge of forensic patients, including how double running costs during periods of Section 17 leave can be managed. | Clearer understanding around the financial impacts of the discharge process for forensic patients may support their discharges and limit the potential adverse impact on funds to support other discharges. |
| Consider carrying out funding flow reviews of all inpatients with excessive lengths of stay, beginning with people with stays of over 10 years, to determine whether funding flows have impeded securing an appropriate solution. | Prioritise additional funding or take action to enable funding to flow appropriately to enable discharges for these people. |

# Practicalities of securing a community placement on discharge (a home with care and support)

In this section, we explore examples of arrangements that have enhanced how funding flowed in relation to commissioning homes with care and support, and whether there are particular impediments to the flow of funding.

### Findings

Our findings relating to this theme are outlined below:

1. Developing bespoke and personalised homes, alongside care and support solutions for people who may have been institutionalised over many years, needs funded lead-in time. This includes the need to prepare a home (as in, to build or adapt accommodation), recruit and train staff, and to settle the person into their new home. The introduction of the Community Discharge Grant is designed to address double running costs so should impact on this issue.
2. The availability and cost of suitable accommodation and access to the capital required to purchase and adapt properties can be a significant inhibitor to achieving discharges. Some capital funding rules limit the ability to develop a range and pipeline of accommodation.
3. Recruitment and retention of an appropriately skilled workforce is an increasing difficulty for providers of community-based accommodation with care and support.
4. Complexities around funding responsibilities between CCGs and councils can cause difficulties. Strong partnerships, pooled budgets, and joint commissioning arrangements significantly improve performance on achieving discharges for people.
5. Rigid approaches to commissioning can inhibit achieving discharges of people with high support needs. For example, local policies and practice around personal budgets – both health and social care – may impede the ability to achieve economies of scale around core support costs, for example where 3 of 4 people live in a cluster of flats or share some facilities within a scheme.
6. Active market development to increase the number and capacity of providers is an important element to achieving discharge of people with high support needs. This involves encouraging new providers into areas, and developing partnership approaches with trusted providers.

## Evidence for findings

### Ability to provide community packages of support

We asked councils whether they are able to provide appropriate community packages of support for everyone ready for discharge, with the following results:

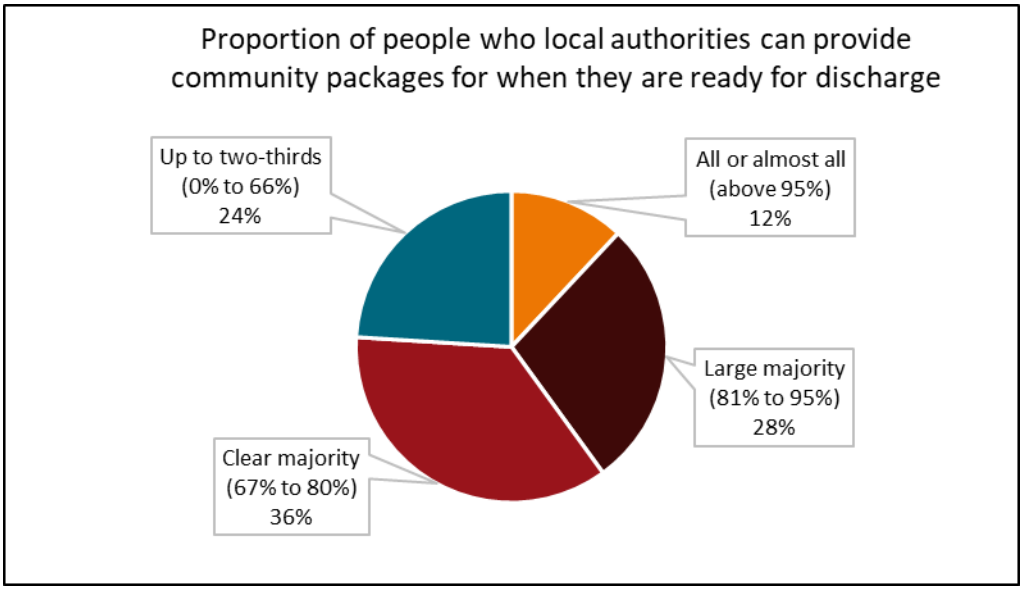


**Figure 21:** Council survey respondents on ability to provide community packages when they are ready for discharge
**Source:** ADASS/LGA council survey for RedQuadrant 2022

While 40% of councils who responded say that they can provide packages for all or almost all people, 24% said they were only able to provide packages for up to 2-thirds of people.

80% of our council survey respondents reported that high placement costs were of great concern. Other elements that were reported as being of concern were:

- increased demand for support (77%)
- scarce housing for people being discharged (74%)
- the scarcity of community providers (67%)

### Access to capital

While each council will have its own capital programme, there is the Disabled Facilities Grant and Homes England make capital grants available to housing associations to support the development of social housing, the NHSEI capital fund is the only dedicated fund available to the programme. Therefore, for this section, we are focusing discussion on the capital

mechanism that has been specifically created to support people related to BtRS. NHSE&I have told us that this relatively small pot of money is available to provide for a small but significant group of people where there may be no alternative capital finding options available.

Our insights into the use of capital funds come from interviews with the NHSEI, with TCP or ICS representatives, a housing provider, CCG data returns and our survey of councils.

£100 million of NHS capital funding was made available over the 5 years up to 2020 to 2021 for housing support. Taking into account learning from the first 5 years about the amount of funds which could be re-cycled into the scheme from receipts from sales of properties, £15 million per year has been made available from operational capital from 2021 to 2022 for 3 years.

We have been told that this NHS capital funding has provided for somewhere in the region of 100 properties from 2017 to 2021 – ranging from new build, refurbishments and purchase and adaptation of properties, to enable people to move out of long-term inpatient settings. We have not seen any further detail of the use of this funding.

The following issues have been highlighted:

### Capital grant mechanisms are considered to be overly complex

Whilst we were only able to talk directly to one housing association, we heard from them and from commissioners that that funding approval could take a long time (a year was cited as the typical time), was seen as overly bureaucratic and that allocations, once made, were inappropriately time-limited in relation to draw-down.

We were told that capital grants favoured single service solutions, and whilst these are the preferred model consistent with the ethos of Building the Right Support, there are cases where a cluster scheme may be the best practical solution and NHSE capital has funded a number of these. We heard that the amount available in each grant was often insufficient to support the development of cluster schemes.

There were less concerns for schemes that involved the refurbishment of an existing property with these reportedly being approved in a timelier fashion.

### Complexities for housing associations

Whilst we only had limited direct contact with housing associations during our investigation, we were told of some issues which would warrant further investigation as they were seen as inhibiting full engagement with the programme.  They were:

- Housing and care providers are often not involved in discharge planning early enough.[33]
- The bespoke nature of accommodation required make these schemes more complicated. They take longer to complete and committing to more than one or two schemes in a year may impact on an Association meeting its development targets.
- The grant approval process is complex with multiple stages: Local (CCG), Regional and National NHSE&I. This can take many months, often with additional information required at each stage.
- A concern when Homes England Affordable Housing grant and NHS capital grant is used on a single scheme: NHSE&I are required to put a legal charge on property purchased. This results in complexities with legal documents and a risk that should a scheme no longer be needed; the property value may be adversely affected and disposal made more complicated.

### Workforce issues

Many stakeholders, commissioners from both the NHS and councils, as well as care providers reported that a scarcity of an appropriately trained workforce was a major factor in the availability of support packages, especially for people with high care and support needs. Social care providers are currently reporting high vacancy rates and there are pressures to increase salaries of the social care workforce.

Typically, stakeholders highlighted the following issues related to when a person was ready for discharge and had high support needs, requiring intensive support in a community setting with high levels of staffing (perhaps as much as a 3:1 ratio):

- providers are asking for higher rates to enable them to pay salaries that will attract staff. One commissioner felt that this influenced the balance of power between purchaser and provider, meaning that commissioners had to accept higher costs to secure a placement
- rapid turnover in the workforce compounds the difficulties of maintaining quality and consistency in individual placements. Staff retention appeared to be linked to higher paid alternative employment opportunities available to the social care workforce in other sectors and industries for less challenging work
- staff with experience of working with people with high support needs are in short supply. This is especially true for staff who have worked with people coming from a forensic background and subject to hospital orders. We heard that tribunals are more likely to agree to discharge people when they are assured of the qualifications and

experience of staff in whose care they are to be discharged. This is likely to add to the overall cost of a placement for someone discharged from a hospital order

### Funding complexities and commissioning competence

We have heard from some stakeholders that a factor that could influence the varying success rates of achieving discharges relates to the relative strength of commissioning in different areas, as this is a complex funding landscape and commissioning environment.

#### Flexibility

We heard that in some areas commissioning practice made it more possible for contracted costs to vary to 1) recognise that there may be additional costs early on in a placement, and 2) while costs may be expected to be reduced over time, there may be instances where needs increase and additional resources are needed. In one area we heard of a creative mechanism that commissioners had put in place to make approval of additional sums of money to assist a provider over a difficult period where a person was experiencing a crisis threatening placement disruption. This was effective and was one of the factors which had contributed to a reduction in their admission or readmission rates.

We heard from one not-for-profit provider who withdrew from contracting with a council where commissioners refused to consider pooling any of the costs within a shared or cluster scheme, which would have resulted in the scheme being unviable. This put at risk the future care of those people for who the scheme had been planned.

#### Commissioning across areas

Several interviewees stated that there were additional complexities with commissioning services at an appropriate scale (typically accommodation-based services) when potential people came from a number of adjacent council or CCG areas. Commissioners considered that even though care needed to be personalised to meet the needs of each person, there were opportunities to consider pooling some of the care and support elements within a shared or 'cluster' accommodation (for example, 3 or 4 flats in a single building) to achieve efficiencies and value for money.

BtRS rightly aims to find solutions for each person, personalised and right for them, geared towards each person leading as a full and independent a life as possible. However, commissioners also need to have regard to strategic aims of developing a supply of accommodation within the resources available, and where appropriate, and having full regard to CQC registration requirements and best practice around personalisation, looking for economies of scale and value for money.

### Lack of forward-planning

Lack of forward planning by commissioners was an issue raised by not-for-profit providers of placements who reported that they are often approached to place individuals within 3 months of them being ready for discharge, leaving insufficient time for providers to recruit staff with the relevant skills to their team.

### Joint funding arrangements

We have seen evidence (that is stronger results in reducing admissions and net inpatient numbers) that where there is collaborative commissioning and long-standing partnership working between CCG and council partners, there is a greater likelihood of success. In such areas the relative strengths of NHS and council commissioning are brought together and work in concert rather than in competition. In these instances, it is also more common to see pooling of budgets which also assists in the commissioning processes

While those eligible for a dowry or continuing health care funding are fully funded by the CCG – often historically from funds released through the FTA – a large proportion of people within the programme will have both health and social care needs, and will require funding from both the NHS and the council.

Councils are required to fund the social care elements for people being discharged, both those who have been formally detained under the mental health act or informal patients. For the majority of those discharged, who will have been admitted under Parts 2 or 3 of the 1983 Mental Health Act, Section 117 will apply. Local agreements between CCGs and councils set out the local arrangements governing the share of funding. In some areas case-by-case negotiation and calculation is undertaken, aimed at ensuring a council is not at risk of ultra vires spending by contributing to meeting health needs. We have not been able to establish the proportion of people in each category from the available data although we were concerned to hear that in one area there is no agreement in place around sharing of Section 117 aftercare costs.

We heard from councils that disputes about funding (with local NHS systems) are a barrier to discharge as they take valuable practitioner and commissioner time to resolve. 81% of our council respondents felt that strong encouragement for pooled budgets would result in a great or moderate improvement in discharge arrangements.

We are aware that there are differing approaches taken by councils towards the programme. These range from:

- TCPs with jointly appointed lead officers and commissioning teams, where pooled budgets and section 75 agreements and clear mechanisms for sharing Section 117 funding are in place and working well, to
- areas where the council remains partly disengaged from the process and no agreements on section 117 funding or of jointly commissioning care for discharged patients

It is evident that those areas which are performing best and achieving the largest number of discharges and reducing incidences of admissions are those where strong partnership working exists. Conversely, the absence of a strong partnership approach and joint funding mechanisms are a feature of the worst performing areas.

We were able to identify a number of factors which were relevant to ensuring the success of joint funding arrangement, namely:

- good leadership and a commitment to partnership working and risk-sharing within the TCP and between NHS and LA partners
- a written policy in respect of s117 to provide an objective basis for agreeing joint arrangements and the value of each party's respective contributions
- an escalation system can provide efficient means of either resolving or avoiding problems with complex funding decisions. We heard of one TCP SRO (a senior council officer) who chaired a fortnightly virtual ward round where issues could be identified and solutions brokered
- good communication between the respective decision-making teams, with access to comprehensive information sharing
- an agreement on management of annual inflationary uplifts for joint funded packages. Some councils commented on difficulties in securing agreement for uplifts from their CCG partners

We believe that there is a case for stronger encouragement in areas where there remains a reluctance to engage effectively and where this is impacting on performance and the outcomes achieved for people awaiting discharge.

### Market development

The success of the BtRS programme and the continued achievement of effective discharges into the community relies on a healthy market of providers. In many TCPs, there are a range of experienced and skilled providers – many in the charitable and not-for-profit sector – who have developed strong reputations for high quality care and support, and whose aims are promoting independence and fulfilled lives for their service users.

They are facing significant challenges (see section on workforce above) and are constrained by the rates that commissioners pay in determining the salaries that they can pay their staff. Unlike the private hospital sector, we hear from the not-for-profit provider sector that they operate on very fine margins and face significant financial risks should a placement breakdown or end prematurely.

Almost all our council survey respondents (93%) felt that a scarcity of appropriately skilled community providers was a problem. Not all areas are equally served by local providers and work needs to be prioritised to develop the market, through growing partnership arrangements with existing providers and by encouraging new entrants into the local market.

### Conclusion

While acknowledging that the NHS is not the only source of capital to support this programme, there is a need to review the arrangements for the flow of NHS capital funding to support BtRS. While there will be limitations to what is permitted under – for example – Treasury rules, the widespread concerns expressed around accessing NHS capital need to be examined closely.

There are significant challenges being faced by commissioners in CCGs and councils, but the overriding conclusion is that these are better managed, and the flow of funding more successfully directed, where strong partnership arrangements are in place, with joint commissioning teams and agreements in place around funding shares. Poor partnership working reduces the ability to make the best out of the available funding.

We believe that improving commissioning competence and skills is key: we have heard from Skills for Care of the work that they have been doing, as part of the overall BtRS Delivery Board programme of work to develop a bespoke training programme in commissioning for learning disability and autism services and a commissioning qualification. We have included a consideration below further to promote these useful programmes.

## Areas for consideration

| Area for consideration | Potential benefits |
|---|---|
| Consider how access to appropriate capital for the development or adaptation of homes for people being discharged can be further facilitated | Minimise the likelihood of lack of an appropriate home being a barrier to discharge |
| Consider strongly promoting, via a good practice guide, the best use of personal budgets, personal health budgets, funding of core costs outside of personal budget allocations | Minimise hurdles relating to financial mechanisms |
| Consider what steps can be taken to identify and support those councils that are not engaging effectively within the BtRS programme including those where a lack of funding agreements is impacting on achieving discharges | Enable greater consistency of performance in relation to BtRS. All council partners are contributing appropriately to meeting social care costs of people discharged. |
| Consider promoting active development of the local provider market for care and support, including establishing partnerships with not-for-profit providers which provide some security in relation to the upfront costs required in developing bespoke services | Minimise the likelihood of lack of appropriate care and support being a barrier to discharge |
| Consider further promoting the uptake of the Skills for Care training for learning disabilities and autism commissioning and their commissioning qualification for NHS and council commissioners. It is likely that the best value of this training would be achieved where both NHS and council commissioners engage in the programme on a team basis | Increase consistency in commissioning competence |

# Investment in community-based preventative and crisis services

The Parliamentary Health and Social Care Select Committee report published in July 2021 said:

> 'Autistic people and people with learning disabilities have the right to live independent, free and fulfilled lives in the community and it is an unacceptable violation of their human rights to deny them the chance to do so. It is also more expensive to detain autistic people and people with learning disabilities in inpatient settings and this takes up resources that are not then available for more humane community care. We are therefore deeply concerned that community support and provision for autistic people and people with learning disabilities, and financial investment in those services, is significantly below the level required to meet the needs of those individuals and to provide adequate support for them in the community. Fixing this must be a greater priority for both the Department of Health and Social Care and NHS England and Improvement.'

Reducing admissions and developing a range of preventative and crisis services is fundamental to BtRS. It is separate from – though linked to – the aim of achieving discharges of inpatients into the community but relies on the same sources of funding.

In this section we test whether sufficient funding is flowing into the development of preventative and crisis support services, and what are the most significant factors inhibiting investment. We also explore whether investment in such services had a measurable impact on the admission rates into inpatient care.

### Findings

Our findings relating to this theme are outlined below:

1. Since 2015, the number of admissions has remained fairly consistent, which impacts on progress being made on reducing the overall number of people in inpatient settings.
2. While the BtRS model service specification gave guidance to commissioners around intensive community support, crisis services and community forensic teams, there is no standard that sets out the minimum requirements for community-based support services for people with a learning disability and autistic people.
3. There are varying levels of investment and development of preventative and support services in TCPs across the country.

4. From the example of one high performing TCP, which has reduced the number of inpatients faster than its trajectory and achieved large reductions in admissions, there appears to be a connection between investing in the development of preventative and community crisis support services and reducing admission rates.
5. We consistently heard from stakeholders, particularly those with lived experience, that there is a growing demand for greater access to flexible resources by autistic people and their families which can be used to support people to maintain healthy lives and to avert crises from developing which may progress to hospital admissions.
6. The introduction of dynamic support registers (DSRs) could be a way of identifying people for whom early access to flexible support may reduce the risk of crises and potential inpatient admissions. However, some people with lived experience and their families raised concerns that access was not flexible enough. The Advisory Group may well have more to add on this point.

### Evidence for findings

We have heard from a range of stakeholders that the success of BtRS is reliant on a change to the levels of support available to people with a learning disability and autistic people and their families at an early stage. The availability of flexible early support can make the difference between people dealing with stresses associated with managing life with a learning disability or as an autistic person, and a deterioration that might lead to an admission to an inpatient bed. A good example was given by the author of the Cawston Park SAR who related the need for some additional input from a voluntary sector support worker when a young man's principal carer – his mother – became ill. This was not able to be accessed which is said was one of the major factors which lead to this person's mounting difficulties, his subsequent admission into Cawston Park where he remained for 5 years until he died.

### Rates of admissions

Throughout the course of the BtRS programme, admissions into inpatient and ATU facilities has continued at a significant rate. The chart below, which shows admissions and discharges during the month of March for the years since BtRS began, demonstrates that overall reductions in inpatient numbers have been the result of discharges exceeding admissions, often by quite modest numbers.

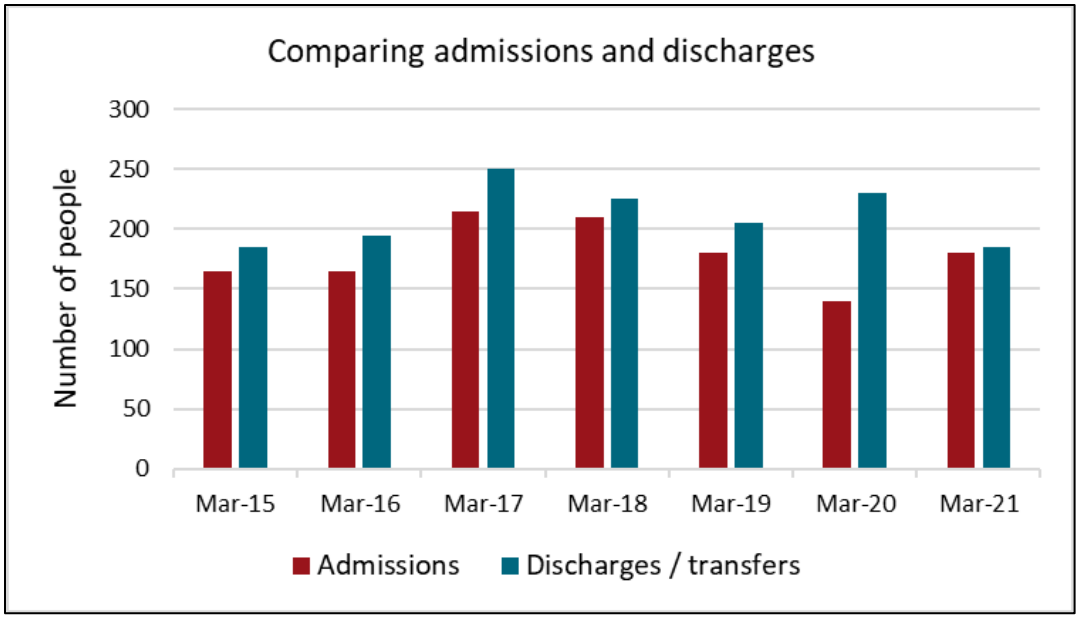


**Figure 22:** Admissions and discharges/transfers for adults since 2015
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021. Analysis by RedQuadrant

## Readmissions

Looking at a month each year since 2015, between 12% and 22% of admissions are people who were discharged within past year. This stresses the importance of preventative services to also support people to live in their home with care and support after they have been discharged.

| Number of admissions and readmissions | March 15 | March 16 | March 17 | March 18 | March 19 | March 20 | March 21 | November 21 |
|---|---|---|---|---|---|---|---|---|
| All admissions (in stated month) | 165 | 165 | 215 | 210 | 180 | 140 | 180 | 65 |
| Readmissions (in stated month) of patients discharged within past year | 20 | 25 | 40 | 30 | 40 | 15 | 30 | 10 |
| Readmissions of patients discharged within past year as % all admissions | 12.1% | 15.2% | 18.6% | 14.3% | 22.2% | 10.7% | 16.7% | 15.4% |

**Figure 23:** Readmissions since 2015
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021. Analysis by RedQuadrant

## Preventative and crisis support models and guidelines

The BtRS service model, published in 2015 set out a framework for the range of services that should be in place. This is based on the 9 principles of the care navigator model which is shown below.

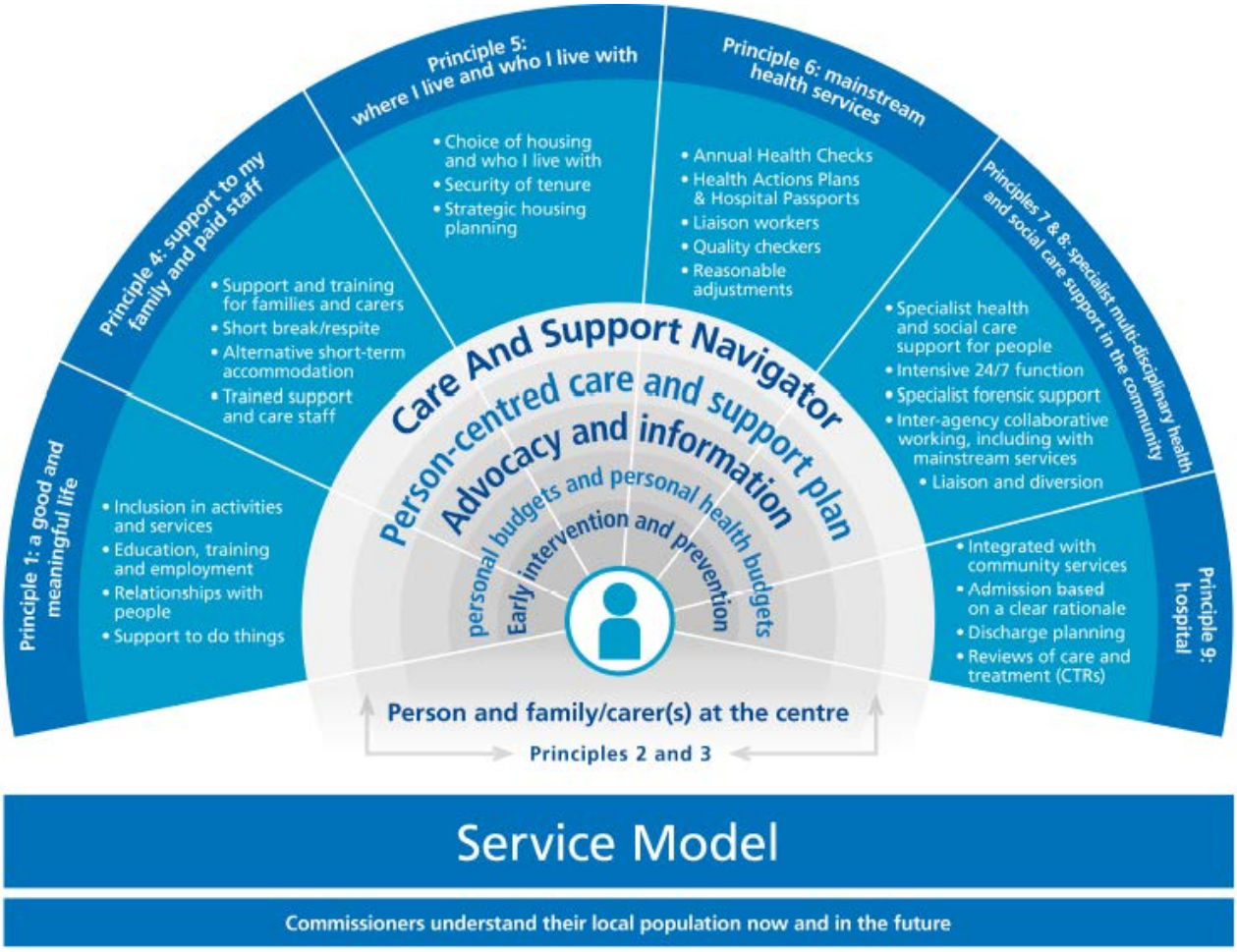


**Figure 24:** Diagram of BtRS Service Model
**Source:** BtRS Service Model

This includes access to respite and short breaks, alternative short-term accommodation, specialist health and care support, intensive 24/7 support function, specialist forensic support, access to advocacy, and personal budgets including personal health budgets.

A set of service specifications – guides for commissioners – was also published in 2015. These included a section on enhanced and intensive community support, crisis services and community forensic services.

The NHS Long Term Plan published in January 2019 also set out elements of services that should be in place across the NHS:

> "3.35. Increased investment in intensive, crisis and forensic community support will also enable more people to receive personalised care in the community, closer to home, and reduce preventable admissions to inpatient services. Every local health system will be expected to use some of this growing community health services investment to have a 7-day specialist multi-disciplinary service and crisis care"

We are aware that the BtRS Advisory Group is leading on a workstream charged with defining 'what good looks like' with respect to the support that should be available to people with a learning disability and autistic people. We understand from information shared with us by the Advisory Group that this will emphasise the importance of easy access to flexible resources, rather than just an expansion of traditional services.

### Monitoring investment on preventative and crisis support

There appears to have been limited monitoring or mechanisms for ascertaining compliance with the service model although we understand that NHSEI undertook a baselining exercise in 2021, to which we have not had access. The Assuring Transformation dataset (published by NHS Digital) and Mental Health Services single data set is used to monitor the reduction of inpatient numbers and can identify if TCPs are not meeting their trajectories. In such cases we are told that a recovery plan can be required of a TCP with the potential for financial assistance. However, there is no similar mechanism in relation to investment in preventative and crisis services.

We note that there is a comprehensive system in place in relation to increasing the level of investment into adult mental health services in the Mental Health Investment Standards (MHIS).

Recent guidance drawn up by NHSEI on how pathway funds will operate outlines a new requirement to report an annual summary including what has been committed by panel members, what has been spent, and what has been delivered [9]. If this is collated at a national level, this could begin to provide a level of financial oversight and the transparency that we believe is vital to the success of this programme in relation to investment in preventative

[9] Guidance on the implementation and operation of the Learning Disability and Autism Pathway Fund , NHS England and NHS Improvement, 4.4. Reporting The annual Pathway Feedback Report (Section 5.2)

services. In addition, the guidance notes that the panel must also ensure its members report what the legacy FTA and national programme funds have been spent on, irrespective of whether they are part of the pathway fund. This is described as 'a new requirement, reflecting the need for greater transparency on how money has been spent'.

### Inconsistent levels of service of community support

Stakeholders told us that historically there was an inconsistent level of service across the country. In some areas, particularly in parts of the north of England, there was greater reliance on inpatient care, and an underinvestment in community support and less effective access to mainstream services for people with a learning disability and for autistic people. In other areas, the reverse was true, with a lesser reliance on inpatient care and a greater likelihood that people's needs could be met within the community, even during a crisis.

We spoke to commissioners in a high performing TCP where there had been a significant and sustained reduction in new admissions. They attributed this in large part to their investment in preventative services.

We also noted that in areas with an historic over-reliance on inpatient care, and a low baseline of community-based services, admission rates remained high. Coupled with continued high inpatients rates overall, there has been a slower shift to invest in preventative services.

Our investigations show that there is a wide variation in the development of preventative services and despite the BtRS service specifications setting out aspects of preventative services, there remains no clear minimum standard of what people with a learning disability and autistic people and their families can expect to be provided in their area.

### Current service levels

The recent report of the NHS benchmarking network into learning disability and autism improvement standards reported the following:

- 90% of staff say their trust has in recent years developed effective new ways to support people with a learning disability and autistic people to live successfully in the community
- 75% of trusts provide intensive support services. This includes crisis support for 83% of these (as in, 62% of trusts provide crisis support)
- 67% of trusts provide community-based support for people with a learning disability and autistic people who have forensic needs
- 40% of intensive support services do not operate 7 days a week

- 76% of trusts say they operated a dynamic risk or support register for people with a learning disability and autistic people living in the community who are at risk of admission to hospital

This variable provision of preventative services is also reflected in the response received from councils when we asked them about the availability of preventative services:

### Council perspective

We asked councils about their ability to provide support to avoid admission by those with a learning disability and autistic people into inpatient care.

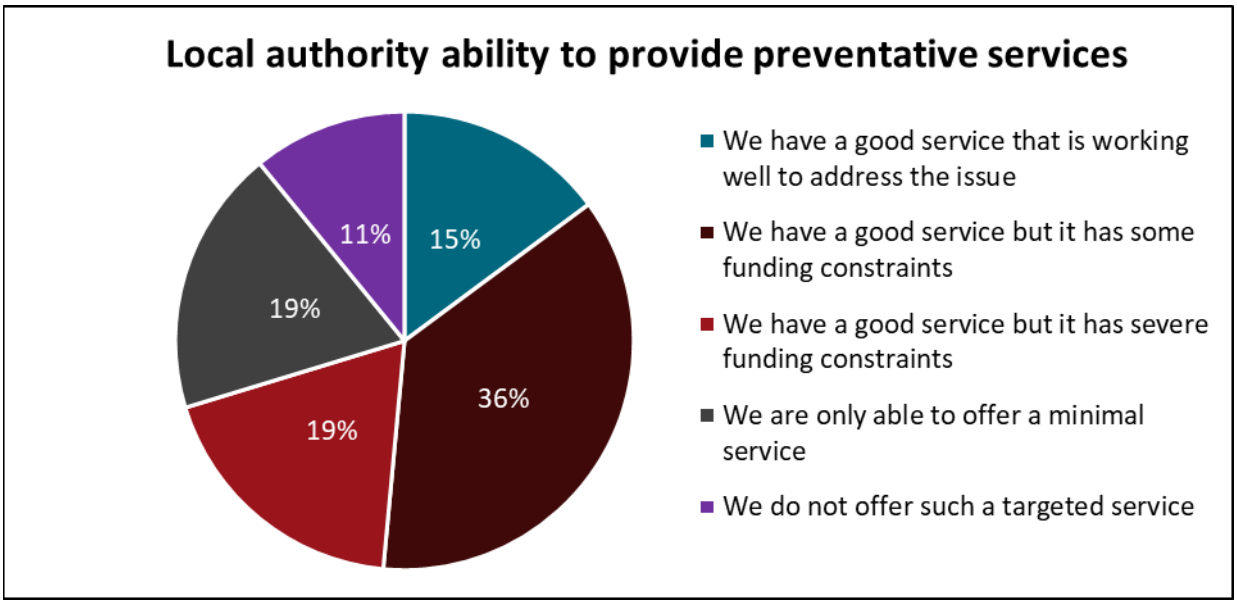


**Figure 25:** Council survey respondents on ability to provide preventative services
**Source:** ADASS/LGA council survey for RedQuadrant 2022

### Funding provision for preventative services

It was hoped that the funding to develop preventative services could be gained as savings were achieved from the reduced number of inpatients. Transformation grants for NHS local systems, and more recently the Community Discharge Grant for councils – although CDG is primarily aimed at covering double running costs associated with discharges - have been available to assist in this investment.

We were not able to gain an understanding of the expenditure on preventative and or crisis services for TCP areas. We heard from councils that they were more likely to have increased their spend on crisis services than preventative services:

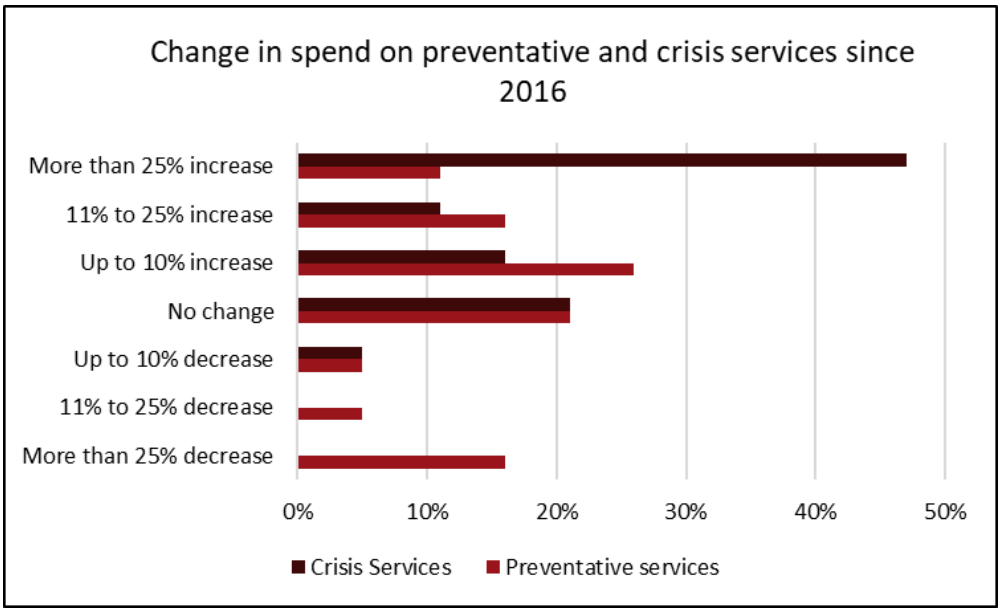


**Figure 26:** Comparing the predicted change in spend on preventative and crisis services
**Source:** ADASS/LGA council survey for RedQuadrant 2022

We asked councils what might support them to provide more preventative services:

| Likely effect of … | Great improvement | Moderate improvement | Small effect |
|---|---|---|---|
| Level of funding for adult social care services as a whole increased, including this area | 81% | 15% | 0% |
| Improved flexibility and reduced bureaucracy entailed with NHSEI funding and DHSC grants | 74% | 11% | 15% |
| Value of grants available for addressing learning and disability generally increased | 73% | 15% | 8% |
| Specific grant made available for addressing the issue for young adults (aged 18 to 24) | 72% | 20% | 4% |
| Specific grant made available for addressing the issue in relation to adults | 52% | 37% | 11% |
| Stronger encouragement for pooled budgets | 46% | 35% | 15% |

**Figure 27:** Helping factors for preventative services
**Source:** ADASS/LGA council survey for RedQuadrant 2022

As can be seen, councils cite an increase in funding for adult social care overall and improved flexibility for grant funds as factors that would likely have the greatest improvement on their ability to provide preventative services. In addition, one council told us that they would like to prototype new ways of working for prevention but did not have any budget for this.

We also heard from some councils of a scepticism around 'doing prevention' and that it can be difficult to convince their elected members of the beneficial impact of increasing spending on preventative services as results are often hard to evidence.

### NHS dynamic support registers

A number of stakeholders raised with us the importance of early identification of people who may be susceptible to developing difficulties within their lives that could result in admissions to inpatient care. Many people with lived experience talk about the importance of help being offered and appropriate adjustments being made at the early stages of life – starting in the primary classroom. Our study does not extend to consider interventions at that level, but it is evident that the earlier that problems or potential challenges are identified, the more likely it is that help and support can be provided.

We understand that the development of local dynamic support registers (DSRs) is geared towards ensuring that people are identified, and that support can be made available prior to crises occurring. Recent NHS data indicates that many TCP areas are now making use of DSRs. However, there is still not universal coverage of DSRs – in fact, a recent NHS benchmarking network report into learning disability improvement standards found that only 76% of NHS trusts operate a dynamic support register for people with a learning disability and autistic people living in the community at risk of hospital admission.

We have heard from people with lived experience their fears that the DSR could become another hurdle to cross when looking for support. It is perceived by some to be another 'barrier to negotiate' - a form of eligibility to meet or not and that the promise that DSRs would be a tool to facilitate early identification and support may not be being realised.

### Council perspective

Respondents to our survey to councils identified the following as potential ideas for improvements:

- new or expanded use of outcomes-based commissioning, with financial incentives for community providers who are facilitating people with a learning disability and autistic people to live ordinary lives in the community
- ensuring that community response teams are empowered to add-in additional support resource without needing to ask for approval, especially at weekends
- more research to demonstrate the effectiveness and cost-effectiveness of a range of preventative measures

### Modelling an increase in investment in community preventative services

To assist us in exploring the connection between investment in community preventative services and admission trends we have developed a model based on one high performing TCP area. In this area there had been a focus on investment in preventative services with a corresponding reduction in admission levels.

Explanation of our method and assumptions is provided in Appendix C. We examined expenditure in the system as a whole (inpatient care, preventative and or crisis support, and the cost of accommodation with care and support) providing estimates and or forecasts for the current year (2021 to 2022), previous years (2016 to 2017, to 2020 to 2021) and future years (2022 to 2023, to 2027 to 2028).

The model extrapolates the results from one TCP area to all TCP or ICS areas. Our estimate is that the total system expenditure on people relevant to BtRS (inpatient care, preventative and or crisis support, and accommodation with care and support) has been of the order of £740 million per year over the period 2016 to 2017, to 2021 to 2022.

Our scenario modelling of system expenditure (excluding high secure and ICU) is shown below.

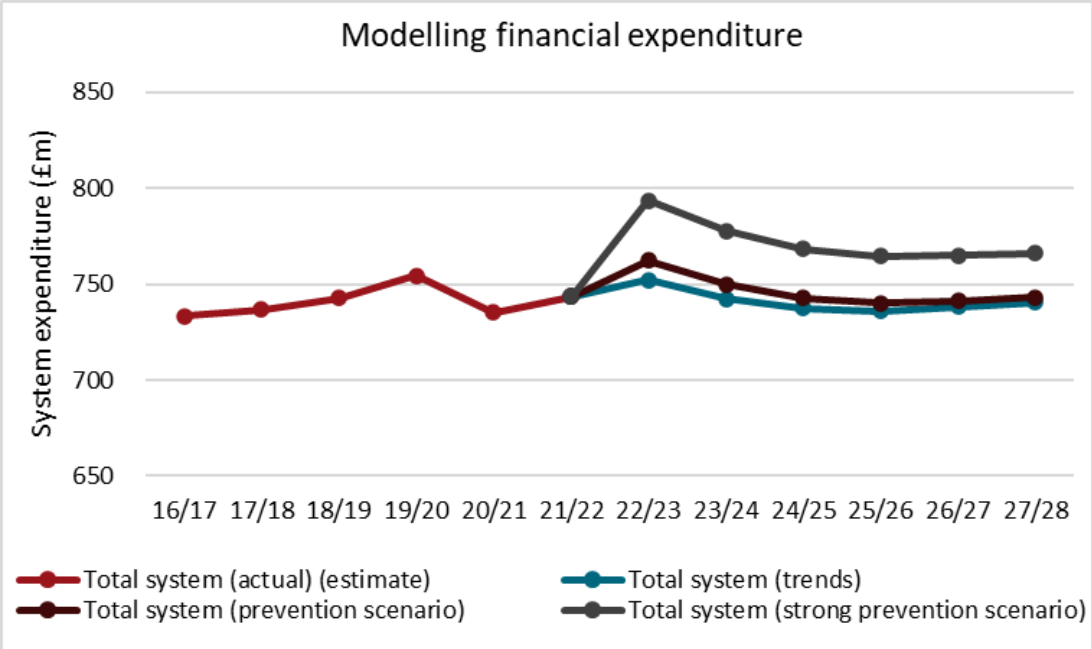


**Figure 28: Modelling the impact of preventative services: expenditure**
**Source:** RedQuadrant modelling

| Scenario | 2021 to 2022 | 2022 to 2023 (and later years) |
|---|---|---|
| Prevention and or crisis– base case | £34 million | £34 million |
| Prevention and or crisis – prevention | £34 million | £51 million |
| Prevention and or crisis– strong prevention | £34 million | £86 million |

**Figure 29:** Modelling the impact of preventative services: expenditure
**Source**: RedQuadrant modelling

The chart below demonstrates a reduction in levels of inpatients (excluding high secure and ICU) based on the level of preventative spend modelled:

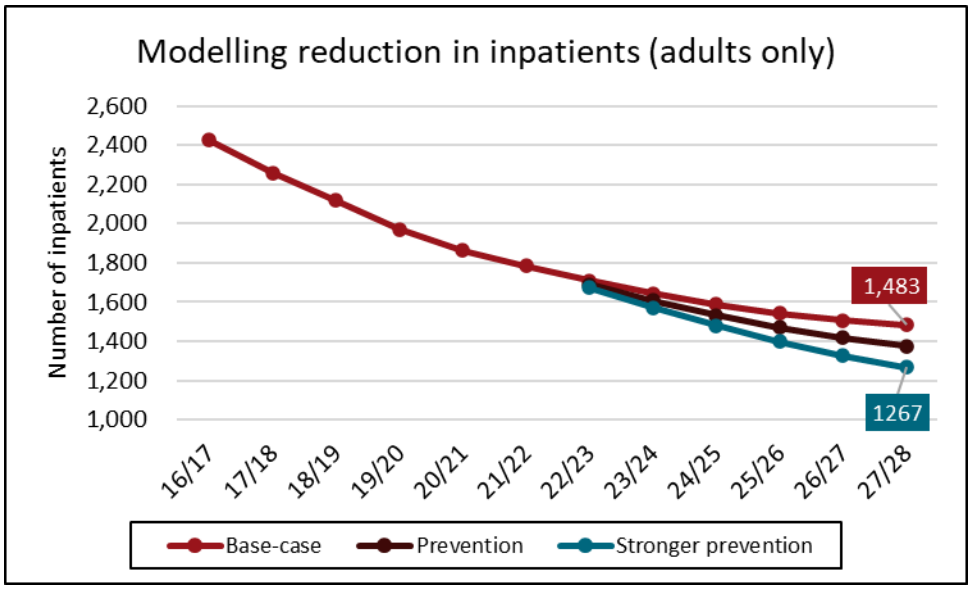


**Figure 30:** Modelling the impact of preventative services: reduction in adults only
**Source:** RedQuadrant modelling

The chart suggests that if the strong preventative model is used, because of reduced admissions, the national number of adults in inpatient settings could reduce to 1267 by 2027 to 2028, 216 fewer inpatients than the base case. This would equate to an average of 22.5 inpatients per million population, and thus exceed the BtRS target of 30 per million. Reaching such a level would, however, require an acceleration from recent trends and would be highly likely to require additional targeted investment.

From our interviews with local areas, and from our survey through ADASS, we have heard strongly that preventative spending has a strong tendency to be squeezed out by crisis needs, in spite of additional funding that has been provided through service development funds and Community Discharge Grant.

Our modelling suggests that a ring-fenced fund for preventative and crisis support, of the order of £86 million per year, could have the impact of reducing the number of adults in inpatient settings to 1267 by 2027 to 2028.

For the purposes of our modelling, this £86 million includes:

- £34 million which is already being invested from existing budgets (extrapolating from our case study area to the overall cohort for England)
- the increase of annual expenditure is therefore £52 million for the stronger prevention scenario

Areas with a lower level of current investments, would require a greater uplift in order to reach the strong prevention scenario.

Our key area for consideration in this section, outlines the collation of financial data to identify forecasted spend on preventative services, looking for areas of underinvestment or where expenditure is out of line with expectations. This could provide a form of safeguard against new funding being accessed without additional services being provided.

### Conclusion

There needs to be a greater focus placed on investing in support that is available at an early stage, with greater control for people and their families to find solutions that do not rely on inpatient stays.

The flow of funding into preventative and crisis services is inconsistent across the country as is the progress being made in reducing admissions. We saw financial data for one TCP area who has committed significant levels of investment has made good progress in reducing admissions.

Pressures on overall funding within CCGs and councils and the potential for less pathway funds being available for preventative service investment (especially as a result of high costs of placements following discharge), lead us to the conclusion that a ring-fenced funding source is required to ensure that the full benefits of investment in preventative and crisis services can be realised and admission rates significantly reduced.

## Areas for consideration

| Area for consideration | Potential benefits |
|---|---|
| Consider whether there is a need for a ring-fenced funding stream or an investment standard for local systems which is unrelated to the release of funding from inpatient reductions to fund development of preventative community support services. Such funding to be composed of both NHS LTP funding and local government section 31 ringfenced grant, with performance measured and reported to the board annually. | Enable more consistency around appropriate levels of investment in preventative community support services |
| The delivery board should give serious consideration to developing a minimum service standard for the provision of community preventative and crises services that all ICS or TCP areas should be required to deliver. This should be applicable to both NHS and council partners and performance measured and reported to the board annually. | Enable more consistency around appropriate levels of service in preventative community support services |
| Consider encouraging local systems to review their dynamic support registers with the aim of making resources available to families and individuals that can be deployed speedily and flexibly to meet changing need and so avert crises. This should follow the principle that 'funding belongs to the person, not the system'. | Potential for more flexible support which can positively impact on lives of autistic people in the community |

# Out of area and independent sector inpatient provision

In this section we discuss the impact of out of area inpatient placements, and whether funding flows were assisting or inhibiting the consistent availability of appropriate inpatient facilities across the country.

Since the majority of out of area placements are within the independent sector, we also consider whether there are any apparent financial incentives or disincentives which exist around independent sector inpatient provision and the relative cost of different provision

### Our findings relating to this theme are outlined below:

1. Out of area inpatients typically have a longer length of stay and are more likely to be recorded as 'inappropriately placed' than people treated in a local facility. This results in increased costs and greater difficulties in achieving discharge.
2. Stakeholders consistently told us that discharge planning for people placed out of area is more complicated, with changes in clinical oversight of treatment plans, less consistent care management and attendance at review meetings for people in out of area inpatient settings.
3. There is an uneven distribution of inpatient and or ATU facilities across the country. The lack of a suitable inpatient facility in a locality leads to an over-reliance on out of area admissions.
4. Stakeholders consistently said that where out of area placements were needed due to lack of local availability, people would be placed in independent sector hospitals.
5. The number of people in independent sector hospitals has reduced from 1,230 in March 2016 to 845 in November 2021 with the proportion of inpatients in an independent sector hospital falling from 48% to 43%.

### Evidence for findings

The service model recommends that inpatient care should be provided as locally as possible with inpatient services being coordinated closely with relevant community services, families and carers.

The service model supplementary document states: 'Assessment and treatment in a hospital should be part of a broader care and support pathway. Admissions should be to hospital services that are as local as possible, and inpatient services should coordinate closely with relevant community services and families and or carers (particularly in the case of children) to prepare for discharge.'

In addition, the service specification for Transforming Care published in 2017 describes the requirements for specialist inpatient facilities for people with a learning disability and autistic people in circumstances where the care cannot be provided within mainstream mental health services. This specification outlines the need for engaging in discharge planning at the point of admission and of the integration of inpatient services with mainstream community services together with the active involvement of family and carers in the inpatient episode.

It is though the case that for some very specialist services – perhaps for people with particularly complex and multiple disability, it may not be practicable to provide appropriate services in all ICS or TCP areas and provision over a broader geographic footprint may be appropriate.

## Impact of out of area placements

### Length of stay

As the table below shows, for people who are inappropriately placed out of area, there is a higher proportion who experience a longer length of stay.[10]

[10] Out of area is defined by NHS England as where a patient is placed in a hospital which is outside of their originating ICS/TCP (i.e. the ICS/TCP of their GP (or usual residence)).
There are some cases where a patient can be placed 'out of area' appropriately. These include where:
- the patient requires a specialist bed which is not available in the local area or all parts of the country. For adults this is defined as those in high secure, neuro-psychiatry acquired brain injury beds, adult personality disorder and adult deaf. For under 18s it includes low and medium secure beds, mental health services for the deaf and severe obsessive compulsive disorder and body dysmorphic disorder adolescent beds).
- the placement is closer to family or carer(s)
- a child/young person is admitted from out of area school placement
- there are safeguarding reasons for the placement
- there are offending restrictions
- it is patient / family choice
The number of Inappropriate out of area placements excludes those patients where the placement was appropriate for one of more of the reasons stated above. ‘

| Bed location | 0 to 3 months | 3 to 6 months | 6 to 12 months | 1 to 2 years | 2 to 5 years | 5 years+ | Overall |
|---|---|---|---|---|---|---|---|
| Adults - Inappropriate out of area | 24% | 33% | 40% | 59% | 62% | 59% | 54% |
| Adults - In area or appropriate out of area | 76% | 67% | 60% | 41% | 38% | 41% | 46% |
| Children - Inappropriate out of area | 51% | 44% | 52% | 61% | Data suppressed for 5 or less people | Data suppressed for 5 or less people | 51% |
| Children - In area or appropriate out of area | 49% | 56% | 48% | 39% | Data suppressed for 5 or less people | Data suppressed for 5 or less people | 49% |

**Figure 31:** Inappropriate and appropriate or out of area stays for adults and children
**Source:** Assuring Transformation dataset (published by NHS Digital), August 2021. Analysis by NHSEI.

### Discharge planning

We heard repeatedly from both independent providers and commissioners that there is greater inconsistency of contact between a commissioning area and the patient when they are placed out of area. Reviews are less consistently completed, and discharge planning is more protracted. There is also a break in the continuity of the clinical team responsible for treatment. These factors all potentially place impediments to streamlined work around discharge planning – unsurprising that lengths of stay are longer in when people are placed out of area.

Given that inpatient stays in out of area beds are likely to be longer and that discharge planning will be more complex, combined with the assumption that longer stays increase the complexity of discharge planning, we suggest that the use of out of area inpatient beds – the majority of which are provided by the independent sector – is contributing to higher costs across the system.

### Uneven distribution of inpatient facilities or ATUs

There are differences between TCPs in the historic and current level of provision of local inpatient settings. This was in part due to the impact of areas which had been over-reliant on large ATUs which as part of the Transforming Care programme were due to close.

We understand that there is no specific programme of capital investment to re-provide local inpatient and ATU facilities. We have heard that in some areas, where an NHS foundation trust is the local bed provider, access to capital was less of a problem and the development of localised ATU facilities was underway. In one of the TCP areas that is closest to the Calderstones site – which was formerly the largest NHS inpatient and or ATU facility, there is no local ATU and access to capital appears to have been more problematic. Since the system has no local ATU, it is forced to seek inpatient placements far and wide. They report that this is almost invariably within the independent sector as NHS facilities are usually full or their beds committed to other areas.

We did hear of collaborative working between NHSEI and the independent sector in the south of England. In this area, there was no local availability of specialist learning disability and autism inpatient services. Without the development of appropriate local provision, the CCGs in that area would have had to continue to seek placements on an ad hoc basis across the country. Here an arrangement was reached between NHSEI and Elysium Healthcare to build 3 specialist units, investing private capital to achieve this, with the comfort of a 'commissioning intentions letter' - providing the organisation with assurance that the beds would be commissioned once built.

### Independent sector provision and out of area

During our interviews with stakeholders from TCPs and or CCGs across the country, we found that TCPs and CCGs were placing some people at distance in independent sector hospitals and ATUs. Occasionally this was said to be for clinical reasons, because a trusted provider was the best place to meet someone's specific clinical needs. However, in other instances placements at distance in independent sector hospitals appeared to be a placement of last resort; that is a person being placed wherever a vacancy could be found. We heard from an independent sector provider that often they are asked to admit people who NHS providers have decided were too complex for their service.

## Use of independent sector beds

The proportion of inpatient beds provided by the NHS and the independent sector has remained fairly consistent over time. For example, in March 2016, 48% of beds were in independent sector hospitals, in November 2021 this was slightly lower at 43%.

| Date | March 2016 | March 2017 | March 2018 | March 2019 | March 2020 | March 2021 | November 2021 |
|---|---|---|---|---|---|---|---|
| NHS | 52.1% | 50.7% | 50.4% | 49.4% | 51.0% | 54.6% | 57.1% |
| Independent | 47.9% | 49.3% | 49.6% | 50.6% | 49.0% | 45.4% | 42.9% |
| NHS | 1,340 | 1,240 | 1,150 | 1,140 | 1,065 | 1,090 | 1,125 |
| Independent | 1,230 | 1,205 | 1,130 | 1,170 | 1,025 | 905 | 845 |
| Total | 2,570 | 2,445 | 2,280 | 2,310 | 2,090 | 1,995 | 1,970 |

**Figure 32:** Inpatient beds by provider
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021. Analysis by RedQuadrant.
**Notes**:

1. Figures for NHS and independent figures exclude patients in hospitals with between 1 and 4 patients for all years except 2019 and 2020
2. Patients for whom their hospital was not known (30 in March 2016, 15 in March 2017, 35 in March 2018) assumed to be with independent hospitals

These averages potentially hide differences across the country. Evidence shows that there is a significant variation in the use of the independent sector by TCPs, dependent on availability of NHS provision within the area.

## Length of stay

Length of stays in independent sector hospitals are longer on average than for those patients within an NHS facility – this table looks at information at one point in time: all discharges which took place in September 2021.

| Length of stay at discharge | NHS hospital | Independent sector hospital |
|---|---|---|
| 0 to 3 months | 14% | 4% |
| 3 to 6 months | 12% | 5% |
| 6 to 12 months | 13% | 10% |
| 1 to 2 years | 11% | 14% |
| 2 to 5 years | 19% | 24% |
| 5 years + | 32% | 43% |

**Figure 33:** Comparing length of stays across NHS and independent sector settings
**Source:** Assuring Transformation dataset (published by NHS Digital), September 2021. Analysis by RedQuadrant

Looking at admissions in the 2-year period between April 2019 and March 2021 only, a significantly higher proportion of those admitted to NHS hospitals had shorter lengths of stay.

| Length of stay at discharge | NHS hospital | Independent sector hospital |
|---|---|---|
| 0 to 3 months | 56% | 34% |
| 0 to 6 months | 76% | 49% |
| 0 to 12 months | 93% | 74% |

**Figure 34:** Comparing length of stays across NHS and independent sector settings 2019 to 2021
**Source:** Assuring Transformation dataset (published by NHS Digital), September 2021. Analysis by NHSEI

Regression analysis around length of stay carried out by NHSEI at our request found that:

- patient spells for those in NHS hospitals are likely to be shorter than for those in independent sector hospitals
- NHSEI note that 'Some caution should be exercised when interpreting this finding as there may be factors that it was not possible to control for in the data set that have impacted the findings'

In summary, length of stay in independent hospitals may in part be explained by differences in level of need. For example, we have heard anecdotally that there may be a disproportionate number of patients with higher support needs in independent sector hospitals. For example, the Norfolk Safeguarding Adult Review into the deaths of 3 young adults at Cawston Park found that a commissioner had contacted 39 hospitals before placing one of the adults at Cawston Park. We understand that this is something that NHSEI plan to explore further and that a key ambition for provider collaboratives is to ensure good practice across all providers in the collaborative. This would include an expectation that people with similar needs experience a similar length of stay.

### Independent sector costs

According to data from NHSEI specialised commissioning, independent sector inpatient beds are not significantly more expensive than NHS provision. There are some differences in relation to specific need categories.

| Cost per bed day (2020 to 2021) | NHS | Non NHS |
|---|---|---|
| Medium secure - learning disability | £564 | £558 |
| Medium secure - autism | £612 | £711 |
| Low secure – learning disability | £525 | £494 |
| Low secure - autism | £571 | £650 |

**Figure 35:** Costs per bed day by type
**Source:** NHSEI Specialised Commissioning

### Financial incentives

We were keen to explore whether there were financial incentives in relation to independent sector inpatient providers. A number of stakeholders had raised the issue, pointing to the longer lengths of stay within independent sector hospitals when compared to NHS Trust provided beds. Some stakeholders also made connections to a number of cases of abuse that had been publicised concerning independent sector providers where significant profits had apparently been made. At the beginning of our work, a Safeguarding Adult Review was published into the deaths of 3 people at Cawston Park – a private hospital in Norwich. The author, Margaret Flynn, who had also been the author of the similar review into abuse at Winterbourne View 10 years previously, made strong assertions around the link between abuse and the private care market, and recommended that the NHS should cease purchasing such care – and in particular ATU care – from the private sector.

However, we have found no evidence to substantiate the assertion that independent sector providers have a financial incentive to retain patients or to frustrate discharge planning.

Independent sector stakeholders we spoke to emphasise their commitment to discharge planning, and in some cases highlighted the problems that they faced in keeping the attention of CCGs and care managers especially when they were accepting patients at distance from their originating areas.

The closest we came to identifying that financial gain might act as an inappropriate incentive was in relation to admissions of people with high support needs. One provider told us that while NHS trusts can and do refuse patients that they do not wish to admit, there is a ‘commercial imperative’ on the private sector company to do so, however complex the case may be.

Independent sector stakeholders told us about poor practice from some CCG commissioners in not completing contractual arrangements, particularly if a placement has been made in an

emergency. Providers say that they welcome the principles of a clear contractual framework and good governance and told us that there is more chance of drift in placements where that contractual framework is not in place at the outset. One provider said that they had spent considerable time and effort auditing all their inpatients cases and chasing up CCGs insisting on getting contracts in place.

## Conclusion

Use of independent sector out of area inpatient facilities remain at a high rate and varies considerably across the country.

This is due to an uneven distribution of appropriate NHS inpatient facilities. There is no specific funding source identified to secure the development of inpatient facilities sufficient to meet the needs of people within an area.

While costs of independent sector beds are not significantly higher, longer lengths of stay and the disadvantages associated with managing out of area discharge planning suggest that more funding is flowing into independent sector providers than might be the case if there were a more consistent pattern of NHS provision.

We found no evidence in our investigations of financial incentives or disincentives in relation to the use of independent sector provision and found that the independent sector providers with who we engaged are intent on delivering appropriate care and working to deliver the outcomes of BtRS through supporting discharge planning.

Given the reliance on independent sector providers for just under a half of all inpatient beds, the independent sector providers are likely to remain key partners in delivering the outcomes of BtRS and are integral to the current system.

## Areas for consideration

| Area for consideration | Potential benefits |
|---|---|
| Consider availability of appropriate capacity of inpatient facilities (such as ATUs) for people with a learning disability and autistic people within each ICS or TCP area. This should take account of the target of no more than 30 inpatients per million adult population and 12 to 15 per million children population | Minimise the use of out of area inpatient placements caused by lack of availability |
| Consider mechanisms to reduce use of out of area facilities to provide inpatient care for example by introducing financial incentives aimed at returning inappropriate out of area patients closer to home either in advance or as part of their discharge planning, and disincentivising out of area placements, for example through introducing rules limiting the lengths of contracts | Minimise people being placed out of area |
| Consider carrying out a review of contracting practice and governance of independent sector placements | Increase the consistency of use of formal contracting arrangements |

# Particular impact for children and young people transitioning to adulthood

In this section we explore what additional factors in relation to the flow of funding impacted on the numbers of children and young people within inpatient facilities, as well as issues relating to the period of transition from child to adulthood and whether funding flows were effective at this time.

### Findings

Our findings relating to this theme are outlined below:

1. There has been little reduction in the numbers of children and young people under 18 within inpatient units during the course of the BtRS programme although we understand that data on inpatient numbers is more reliable from 2017, since which time there has been some progress.
2. There is a lack of appropriate NHS inpatient beds for children and young people with a learning disability and those who are autistic in many parts of the country. Stakeholders reported that this leads to excessive levels of children and young people in out of area inpatient settings in independent sector hospitals.
3. There is less evidence of widespread partnership working around planning for post-discharge care and support of children and young people than for adults.
4. There is a perceived 'cliff edge' of support for young people particularly autistic young people at the point of transition to adulthood (age 18) where personal social care may not be appropriate, but other support is needed. This all too often results in crises developing without early intervention and support with the prospect of escalation to the point where crisis admissions to hospital or an ATU is the result.
5. Stakeholders have told us about the Department for Education funded 'High Needs Funding pot' specifically to meet educational needs of high needs children but have pointed to the absence of a similar source of funding available to be called upon to support additional health-related needs for children on discharge from inpatient care. Although access to continuing health care funding is available for specific qualifying cases.
6. We consistently heard from stakeholders, especially from families of those with lived experience, that there are insufficient levels of local and flexible services and/or support available to families with autistic children that can be made available at times of crisis to avert the chance of hospital admission.

## Evidence for findings

200 young people aged under 18 out of a population of 12.1 million were in hospital in England in November 2021. Unlike for adults, the number of children inpatients over time has not been consistently decreasing and was higher in 2021 than in 2015.

However, we were told that data prior to March 2017 may not have consistently included autistic children and that March 2017 is a more useful benchmark against which to measure progress.

Taking this into account, following an increase in numbers between March 2017 and March 2019, there has been a 20% reduction from 2017 to 2021. This equates to 16.5 per million, which is approaching the target rate of 12 to 15 patients per million.

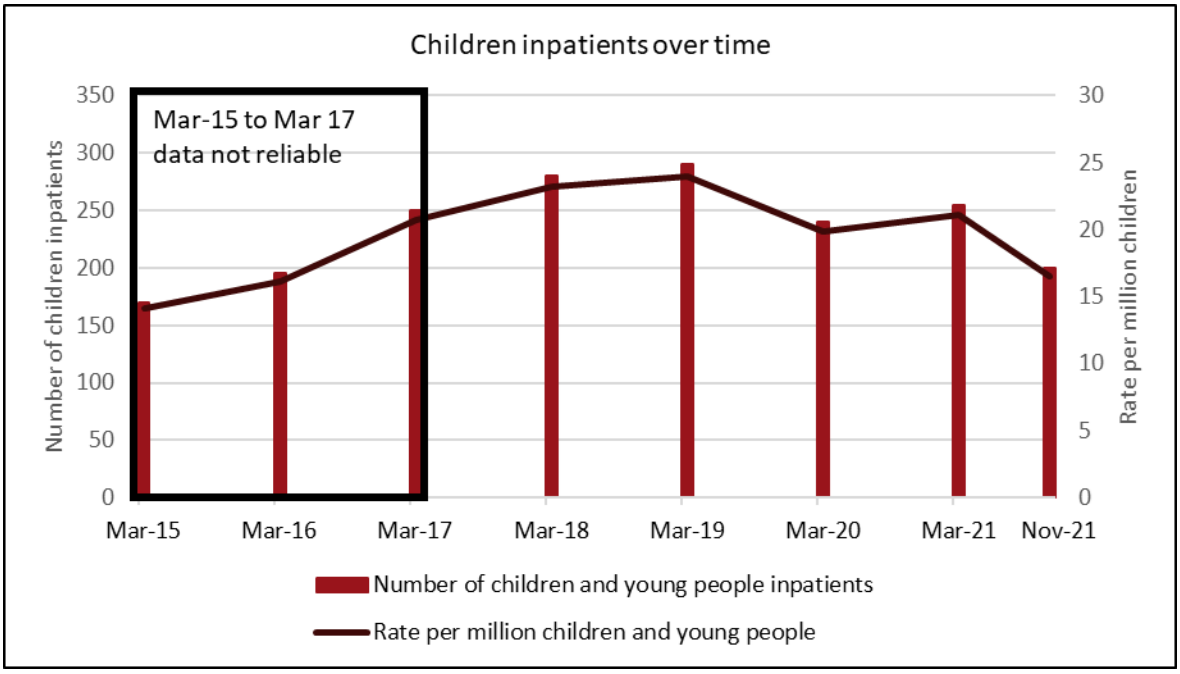


**Figure 36:** Number of children inpatients and rate per million children 2015 to 2021

**Source:** Assuring Transformation dataset (published by NHS Digital), tables 2.1 and 5.2, November 2021, applying ONS data on England population of children 2020. Analysis by RedQuadrant

| Measure | March 2015 | March 2016 | March 2017 | March 2018 | March 2019 | March 2020 | March 2021 | November 2021 |
|---|---|---|---|---|---|---|---|---|
| Number of children and young people inpatients | 170 | 195 | 250 | 280 | 290 | 240 | 255 | 200 |
| Rate per million children and young people | 14.1 | 16.1 | 20.7 | 23.2 | 24.0 | 19.9 | 21.1 | 16.5 |

**Figure 37:** Number of children and young people inpatients and rate per million children and young people 2015 to 2021
**Source:** Assuring Transformation dataset (published by NHS Digital), November 2021, table 2.1, ONS table SAPE23DT6a: Mid-2020 Population Estimates for 2021 Clinical Commissioning Groups in England by Single Year of Age and Sex. Analysis by RedQuadrant

### Admissions of 15 to 17 year olds

The level of admissions among children and young people peaks between the ages of 15 and 17, and admissions amongst this age group have increased since 2015 to 2016, although we acknowledge that there is a question over the completeness of data in 2015 to 2016.

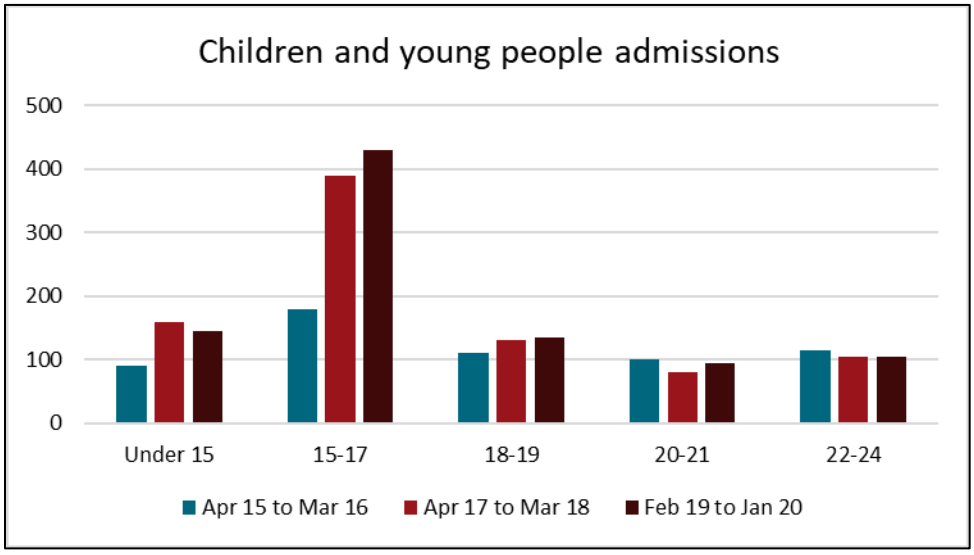


**Figure 38:** Comparing children and young people admissions over time
**Source:** Assuring Transformation dataset (published by NHS Digital). Data extracted by NHSEI in February 2022. Analysis by RedQuadrant

Although we have not had access to this data, we understand that there has been a reduction in admissions in the last 12 months.

While the number of 15 to 17 year olds admitted increased, the proportion of that age group being discharged within 3 months has increased to around 50%, the highest of all age groups studied.

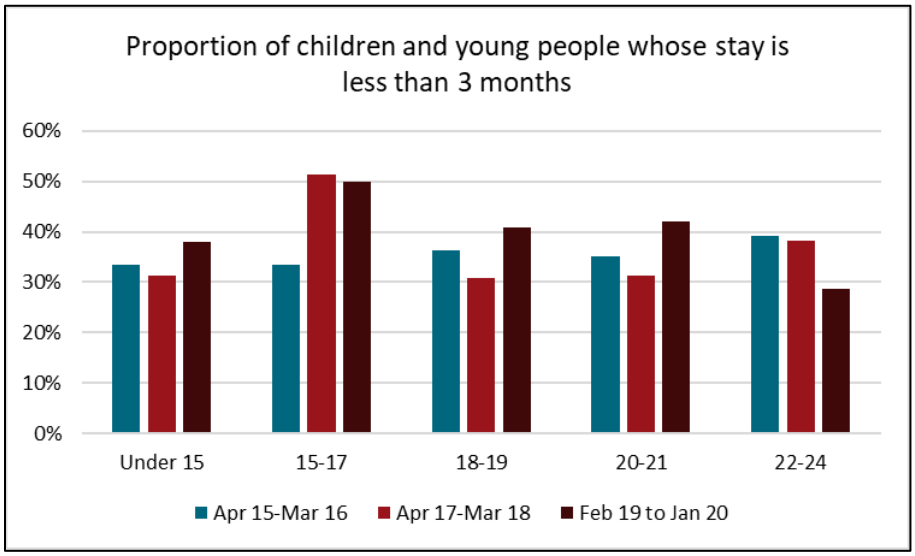


**Figure 39:** Proportion of children and young people who are discharged after a less than 3 months stay
**Source:** Assuring Transformation dataset (published by NHS Digital). Data extracted by NHSEI in February 2022. Analysis by RedQuadrant

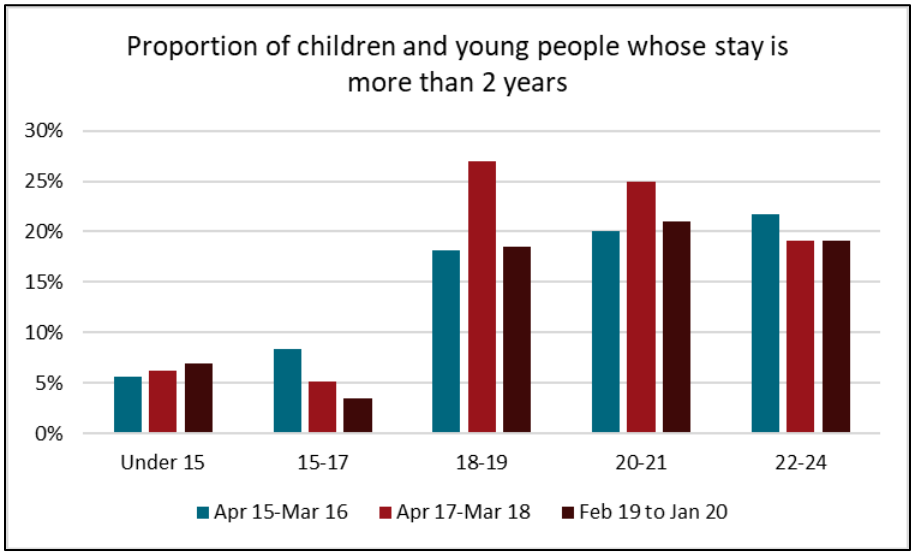


**Figure 40:** Proportion of children and young people who were not yet discharged after 2 years
**Source:** Assuring Transformation dataset (published by NHS Digital). Data extracted by NHSEI in February 2022. Analysis by RedQuadrant

## Out of area placements

Approximately half of all placements are defined as “inappropriate”. This indicates a shortage of local inpatient facilities able to meet needs.

As the table below shows, for children who are inappropriately placed out of area, this proportion increases as the length of stay increases from 6 months onwards.

| Children bed location | 0 to 3 months | 3 to 6 months | 6 to 12 months | 1 to 2 years | 2 to 5 years | 5 years + | Overall |
|---|---|---|---|---|---|---|---|
| Inappropriate out of area | 51% | 44% | 52% | 61% | Data suppressed for 5 or less people | Data suppressed for 5 or less people | 51% |
| In area or appropriate out of area | 49% | 56% | 48% | 39% | Data suppressed for 5 or less people | Data suppressed for 5 or less people | 49% |

**Figure 41:** Inappropriate and appropriate and or out of area stays for adults and children
**Source:** RESTRICTED Assuring Transformation dataset (published by NHS Digital), September 2021. Data extracted by NHSEI. Analysis by RedQuadrant I.

## Partnership working and funding arrangements

There is less evidence of widespread partnership working around planning for post-discharge care and support of children and young people than for adults. While Section 117 aftercare planning and funding can still apply to children, this only applies to those who have been admitted (sectioned) following a Mental Health Act assessment. We heard that in many instances the whole costs of post discharge support are the responsibility of the local council. Although it is accepted that accommodation and social care costs are the statutory responsibility of councils, stakeholders reported that councils were often having to find services to meet health needs – particularly health needs relating to mental health, learning disability and autism.

Stakeholders drew attention to a high needs funding pot which is available to councils in relation to covering education needs for children with high support needs. However, a similar fund in relation to high health and care needs does not exist. We note that the recently drafted guidance on pathway funds does allow for funds to be used to support the discharge and support of children with a learning disability or autistic children and young people, although there is a case for a specific funding pot to be established.

### Concerns at transition

There is a perceived 'cliff edge' of support for young people particularly autistic young people at the point of transition to adulthood (age 18). There is often an issue over eligibility for adult social care services: In many cases, traditional social care is not appropriate, and the availability of services specifically geared towards supporting autistic people in managing an independent adult lifestyle is limited. In addition, their ability to access mainstream services including health care and mental health care may be limited and those services in many instances may make access difficult. This can result in crises developing without early intervention and support with the prospect of escalation to the point where crisis admissions to hospital or an ATU is the result.

### Need for flexible, easily accessible resources

We heard from people with lived experience, that the availability of easily accessible, flexible resources and support can make a difference in terms of avoiding an inpatient admission. Further, we heard that if early identification of autism, and availability of targeted support for autistic children in schools were to be more widespread, there could be less instances of children and young people reaching crisis point requiring admission to inpatient units.

### Conclusion

There has been some progress in reducing the numbers of children and young people within inpatient units since 2017.

There is a continuing high proportion reported as being placed inappropriately out of area.

Attention should be given to how sufficient inpatient facilities might be provided closer to home, and how a flow of funding could be established to provide both preventative services and post discharge support for children and young people and their families.

The absence of specific targeted funding flows aimed at avoiding admissions and supporting post-discharge care and support needs to be urgently reviewed and a funding pot considered.

## Areas for consideration

| Area for consideration | Potential benefits |
|---|---|
| Consider strongly promoting the extended use of joint commissioning teams, pooled budgets and Section 75 agreements by ICSs and councils to facilitate streamlined commissioning particularly when considering care and support needs of children on discharge from tier 4 CAMHS services | Facilitate streamlined commissioning of homes with care and support for people being discharged, especially in relation to funding shares between all relevant parties |
| Consider establishing a high needs funding pot specifically to meet health and care needs – (similar to the existing DfE educational needs high needs funding pot) | Facilitate cost sharing of support for children discharged from inpatient care and their families, especially where there are high health related costs |
| Consider identifying funding that can be easily accessed by families of autistic children and children with a learning disability to provide access to support needed at times of stress | Minimise the likelihood of inappropriate admissions of children |

# Appendices

## Appendix A: Methodology

The methodology for this project was designed by the RedQuadrant Team, advised by Gerald Midgley - Professor of Systems Thinking in the Centre for Systems Studies at the University of Hull. The methodology aims to provide detailed, evidence-based responses to DHSC's questions, while at the same time not neglecting other factors that emerged in the course of the review, which have a significant bearing on the achievement of the objectives in relation to inpatient rates.

Investigative work was undertaken between September 2021 and February 2022.

This project had a number of parallel phases, which are detailed below:

### Literature review

Review of open-source literature, including relevant academic papers, board and equivalent papers from key organisations, and reports such as independent investigations and papers feeding into parliamentary committees. A full list of references is contained in Appendix H.

### Stakeholder interviews

Our client reference teams were from the DHSC and NHSEI. We also sought views from a wide range of relevant stakeholders to ensure that we took account of the bigger picture around the funding flows. This included all BtRS Delivery Board members and representatives from:

- 12 Transforming Care Partnerships, including both CCG and council representatives
- NHSEI learning disability and autism policy team and specialised commissioning
- NHSEI regional learning disability and autism leads
- 2 private providers of inpatient settings
- 2 not for profit providers of community placements
- the Local Government Association
- the Association of Directors of Social Services
- the Department for Levelling Up, Housing and Communities
- the Ministry of Justice
- one housing provider
- one Associate Director Housing for NHS trust

- 3 voluntary sector organisations
- Skills for Care
- those with lived experience of this subject via the BTRS Advisory Group, which has maintained close links with the project team and the project lead throughout

We also spoke with the following people:

- children and young people admission avoidance lead
- dynamic support system lead
- NHSEI engagement lead

### Data collection and analysis

Funding flows are complex, and there is no single data source that provides the full picture. For this reason, we used a mixed approach to obtaining and interrogating information to develop our findings. In summary, our data investigation included the following elements:

- open-source intelligence, for example provided by DHSC and NHSEI and publicly available
- financial data from a sample of 5 TCPs (see Appendix B) and reviewed a sample of transforming care plans and quarterly returns
- data from a survey conducted across the council membership of the Association of Directors of Adult Social Services (ADASS) with the support of the LGA (see Appendix D)
- inpatient bed costs from a range of sources including NHSEI specialised commissioning and the NHS benchmarking network
- placement costs from VCSE community providers

### Financial data from a sample of 5 TCPs

In the absence of national data explicitly detailing funding flows at a local level, and to gain a fuller understanding of the wider system of funding flows, we carried out an in-depth analysis of a sample of TCPs, TCPs being the non-statutory groupings of NHS commissioning organisations and councils originally tasked with delivering the policy objectives of BtRS. We engaged with a sample of 12 TCPs, selected to provide a range of geographical contexts and a mix of achievements in relation to the targets initially set by BtRS. Due to the intense pressures on TCP staff during this period, area selection was also driven by those who were able to actively engage with the project. Engagement with these TCPs constituted:

- semi-structured interviews with stakeholders, covering each of the questions raised by DHSC, together with matters brought to the interview by the interviewees themselves,

which they considered relevant to the matters in scope of the project. In total, over 40 interviews were conducted, and the relevant organisations are listed at Appendix F

- collating data on funding flows and spend via a bespoke reporting tool designed by the RedQuadrant team (see Appendix B)

We received data returns from 5 TCPs either directly or in one case, sufficient financial data was available via their transforming care plan. Given the pressures on TCPs at the time, we are grateful for all the engagement with this project, without which we would not have been able to draw conclusions based on evidence.

### Problem-mapping and solutions-mapping workshops with key stakeholders

Prior to holding workshops with key stakeholders, the research team examined the interview data to look for problem statements relevant to funding flows. These were gathered together and clustered into themes with the following labels:

- funding flows
- capital funding
- increasing cost of community placements for discharged people
- workforce pressures
- out of area placements
- lack of financial oversight

Within each theme, all the problem statements were then structured into a 'problem map'. Problem mapping (Midgley et al, 1997, 1998)[11] involves drawing arrows between problem statements where one problem exacerbates or worsens another problem. Thus, each problem map represents a cluster of interacting problems. A 'map of problem maps' was also constructed, giving an overview of the whole problematic situation of funding flows and other elements of the system interacting with those flows.

At this point, guidance from the DHSC was sought as to whether the team should engage stakeholders with all 7 problem maps (the 'map of maps' and the 6 themed ones listed above) or focus more narrowly on 'funding flows' and 'capital funding'. The rationale for a narrow

[11] Midgley G, Munlo I and Brown M (1997). Sharing Power: Integrating User Involvement and Multi-Agency Working to Improve Housing for Older People. Policy Press, Bristol.

Midgley G, Munlo I and Brown M (1998). The Theory and Practice of Boundary Critique: Developing Housing Services for Older People. Journal of the Operational Research Society, 49, 467-478.

focus was that stakeholders could go into more depth with just 2 problem maps, and the rationale for a wider focus was that the interactions between funding and non-funding problems matter. The DHSC advised on taking a narrow focus, partly to ensure depth of analysis on the funding issues and possible solutions, and partly because other projects had been commissioned to cover some of the non-funding concerns.

The 'funding flows' and 'capital funding' maps were therefore combined into one larger problem map (see page 33 of this report), and this was presented to stakeholders in an online workshop (held on 21st January 2022) involving distributed, remote participation using an interactive whiteboard. Stakeholders participating in this workshop included:

- DHSC
- NHSIE regional representatives
- NHSIE Specialised commissioning
- ADASS
- LGA
- TCPs
- the BtRS Advisory Group

These participants were asked to do 3 things:

- comment on the overall credibility of the problem map, highlighting any problem statements or interactions that might be mistaken (stakeholder feedback was used to revise elements of the map)
- identify anything missing from the map (a list of missing elements was generated, and subsequent analysis by the team showed that almost all were accounted for in the problem maps about non-funding issues, although a few elements about funding were added)
- identify those problems that, if solved, would generate the biggest knock-on impacts in terms of improving the system. These problems and their relationships with neighbouring problems were then subjected to more detailed scrutiny

A second workshop (held on 27th January 2022) then looked at potential solutions. The same stakeholders participated. The participants were asked to focus on 2 major transformations that, if they could be achieved, would have the most impact on the system:

- 'funding flows are transformed so they facilitate discharge'
- 'funding flows are transformed so they facilitate crisis and preventative support, leading to reduced admissions'

For each of these transformations, a BATWOVE analysis (Midgley and Reynolds, 2001, 2004[12], adapting the work of Checkland and Scholes, 1990)[13] was undertaken. This involved looking at the Beneficiaries of the transformation (who should gain), the Actors (who should make it happen), the Transformation itself (what needs to change), the Worldview that makes it meaningful (key assumptions and values), the Owners (who can stop the transformation from happening), Victims (who could be harmed) and Environmental Constraints (what has to be taken as given, such as the number of people with autism and learning disabilities). The reason for undertaking this analysis is that these are the factors that need to be considered when deciding on solutions, as solutions that don't account for these things can fail or give rise to unanticipated and unwanted side-effects (Checkland and Poulter, 2006)[14].

After the BATWOVE analyses, the participants were asked to put potential solutions onto post-it notes that would work in terms of the BATWOVEs and would deliver the 2 transformations discussed above. These solutions were then collected on a whiteboard so everyone could see everyone else's, and a discussion ensued. The full set of proposed solutions was then examined by the research team to inform the recommendations in this report.

### Final review process

Our draft report was circulated amongst key stakeholders in order to check points of accuracy before the report the final report was published.

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[12] Midgley G and Reynolds M (2001). Operational Research and Environmental Management: A New Agenda. Operational Research Society, Birmingham.

Midgley G and Reynolds M (2004). Community Operational Research and Environmental Management: A New Agenda. In, Community Operational Research: OR and Systems Thinking for Community Development. Midgley, G. and Ochoa-Arias, A.E. (eds.). Kluwer, New York.

[13] Checkland P and Scholes J (1990). *Soft Systems Methodology in Action*. Wiley, Chichester

[14] Checkland, P., and Poulter, J. (2006). Learning for Action: A Short Definitive Account of Soft Systems Methodology, and its Use for Practitioners, Teachers and Students . Chichester: Wiley.

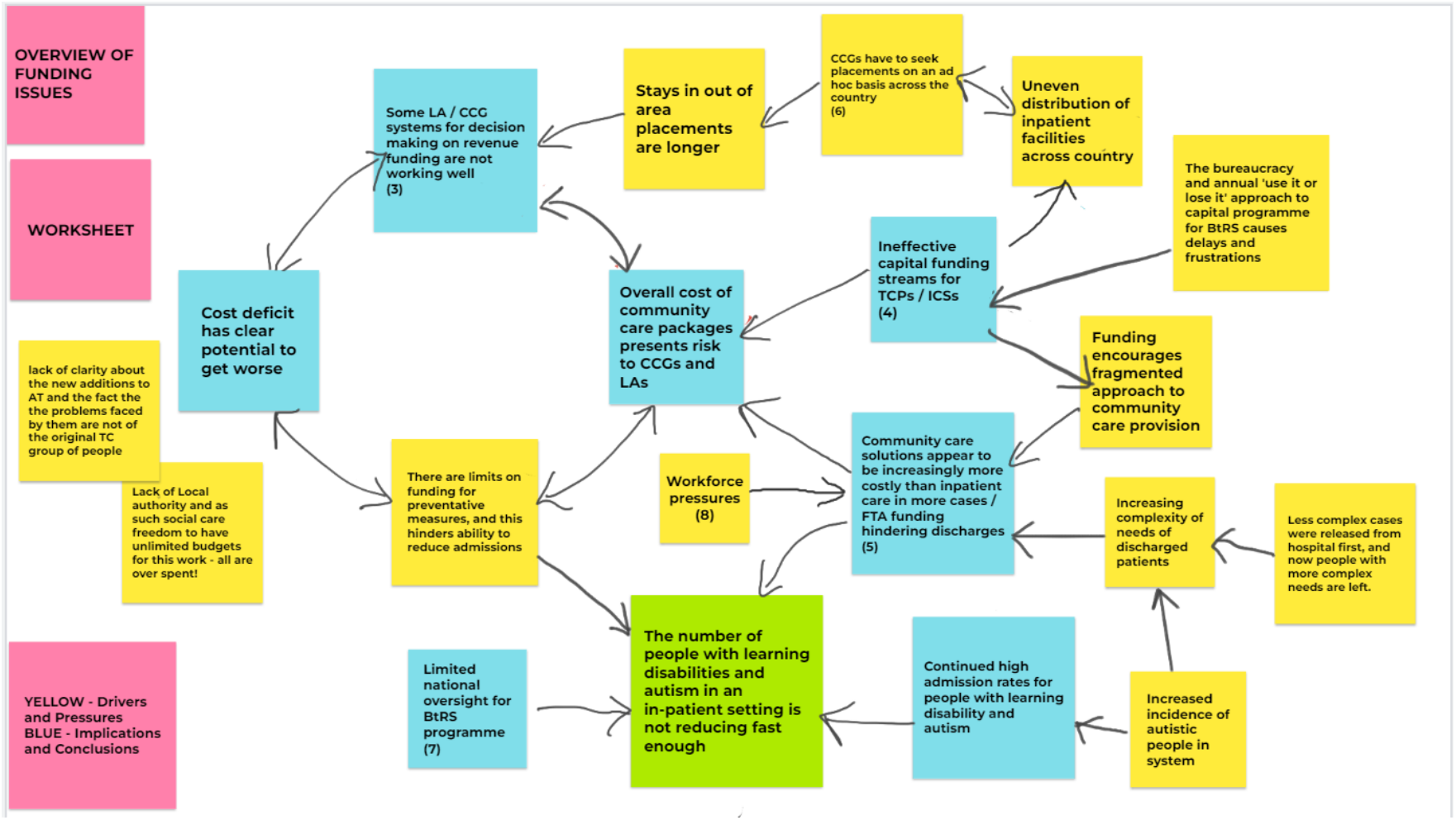


**Figure 43:** 'Problem map' as used in Workshop 1: Problem Mapping

## Appendix B: Data collection methods

### TCP bespoke data return

Our bespoke data return was designed to collect comparative data from TCPs. It incorporated costing for all of the following:

**Total inpatient cost**

| Adults | Adults 18 to 24 | Children |
|---|---|---|
| Specialised commissioning | Specialised commissioning | Specialised commissioning |
| CCG commissioning - NHS (including block contract) | CCG commissioning - NHS (including block contract) | No value |
| CCG commissioning - independent sector | CCG commissioning - independent sector | No value |
| **Totals** | Left blank for data return | Left blank for data return |

**Community provision**

| For adults and children, via any funding route | Net reduction 2016 to 2021 | Total inpatients discharged 2016 to 2021 | Total discharged receiving support 2016 to 2021 | Average cost per placement 2020 to 2021 | Total spend 2020 to 2021 |
|---|---|---|---|---|---|
| NHS funded placements for former inpatients (discharged since 2016) | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return |
| Joint funded placements for former inpatients (discharged since 2016) | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return |
| Council funded placements for former inpatients (discharged since 2016) | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return |
| **Totals** | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return | Left blank for data return |

**Other community support**

| For adults and children, via any funding route | Total patients 2020 to 2021 | Average cost per patient | Total spend 2020 to 2021 |
|---|---|---|---|
| Training and support for CCG and or LAs | Left blank for data return | Left blank for data return | Left blank for data return |
| Training and support for community providers | Left blank for data return | Left blank for data return | Left blank for data return |
| Enhanced and/or intensive support services | Left blank for data return | Left blank for data return | Left blank for data return |
| Community-based forensic support | Left blank for data return | Left blank for data return | Left blank for data return |
| Miscellaneous | Left blank for data return | Left blank for data return | Left blank for data return |
| **Totals** | Left blank for data return | Left blank for data return | Left blank for data return |

**Funding (revenue)**

| Funding type | 2020 to 2021 | 2021 to 2022 planned | 2022 to 2023 planned |
|---|---|---|---|
| Community Discharge Grant | Left blank for data return | Left blank for data return | Left blank for data return |
| Service development fund | Left blank for data return | Left blank for data return | Left blank for data return |
| Transitional funding | Left blank for data return | Left blank for data return | Left blank for data return |
| Miscellaneous | Left blank for data return | Left blank for data return | Left blank for data return |

**Capital expenditure to support community provision and or capital grants to support community provision from any routes**

We also asked for commentary around a number of subjects namely:

- out of area placements
- community support
- barriers to discharge
- savings from decommissioned beds
- risk share arrangements
- funding transfer agreement
- risks for community providers
- community support market
- bids for capital grants
- match funding

As it became increasingly obvious that this level of data was difficult for TCPs to provide within the timeline, we devised a shortened data return:

**Shortened data request**

Cost per community placement for those relevant to BtRS:

1. Average gross cost per community placement for those relevant to BtRS (latest year financial data readily available) broken down into:
    - total cost of placement including accommodation costs (if applicable) (1 provider) or
    - placement cost plus accommodation cost if care costs and accommodation costs are split
    - any capital funding that has been approved and spent as part of the discharge
    - if capital funding is applicable, what % has been funded and how has this been accounted for
2. % of average cost which is NHS
3. % of average cost which is council spend

Cost on inpatient beds for learning disability and autism [block booking]:

1. Cost per year per learning disability and autism bed (block booking) (if data readily available)

Cost of crisis support on learning disability and autism:

2. Total cost of such support per year (latest year financial data readily available)

## Appendix C: Approach for financial modelling the impact of preventative services in admissions

### Approach to analysis

The 5 categories of spend that we have considered in this analysis are:

- preventative and or crisis support
- inpatient expenditure on adults
- inpatient expenditure on children
- community placements
- high-cost top-fund fund and innovation

We have considered 3 time periods for each of these categories - previous years (2016 to 2017, to 2020 to 2021), the current financial year (2021 to 2022), and future years (2022 to 2023, to 2031 to 2032). As noted previously, we have developed 3 scenarios for future years based on insights gathered from our interviews with stakeholders.

We examine the 4 categories of spend in turn.

### Preventative and/or crisis support

According to the Assuring Transformation dataset (published by NHS Digital), average admissions (including children) are of the order of 120 per month.

The issue we consider here is the expenditure on action to reduce this level of admissions. In addressing this issue, we draw heavily on data from one ICS showing crisis spend on adults to be of the order of £0.5 million.

Adding in preventative spend, which we assume to be at a level of the same order of magnitude as for crisis spend, and scaling for population size, we derive an estimate of spend of the order of £23 million for the cohort at risk as of 2021 to 2022.

We further assume that expenditure on children for this agenda is half that of adults, based on information on project funding in our case study area's 3-year delivery plan (2021 to 2022, to2023 to 2024 NHS England Long Term Plan (LTP) commitments for people with a learning disability and autism). This suggests a level of expenditure of some £34 million on this theme in 2021 to 2022.

In assessing previous years' expenditure, we have assumed:

- a 1% year-on-year increase in preventative spend, in line with the findings of the ADASS survey which suggests only a modest increase has taken place,
- a 5% year-on-year increase in crisis spend, in line with the ADASS survey showing that major increases in spend have occurred.

| System spend (LA or ICS) | 2016 to 2017 | 2017 to 2018 | 2018 to 2019 | 2019 to 2020 | 2020 to 2021 | 2021 to 2022 |
|---|---|---|---|---|---|---|
| Prevention and or crisis (£m) (children) | 10 | 10 | 10 | 11 | 11 | 11 |
| Prevention and or crisis (£m) (adults) | 20 | 20 | 21 | 22 | 22 | 23 |
| Prevention and or crisis (£m) (total) | 30 | 31 | 31 | 32 | 33 | 34 |

In forecasting prevention and or crisis spend for future years, we draw on 3 scenarios – as noted previously these are 1) base case scenario which maintains trends up to 2021 to 2022, 2) preventative scenario which provides a heightened focus on preventative care, and 3) strong prevention scenario which further intensifies the focus on preventative care.

We assume that expenditure on prevention and crisis increases by 50% in the standard prevention scenario, and by 150% in the stronger prevention scenario (the rationale for a larger jump in spending is that instead of reaching medium-to-high risk clients, one would now be aiming for medium risk patients, of whom a larger set of clients has to be reached to achieve the same impact on hospital admissions).

| Case | 2021 to 2022 | 2022 to 2023 (and later years) |
|---|---|---|
| Prevention and or crisis (£m) (total) – base case | £34 million | £34 million |
| Prevention / crisis (£m) (total) – prevention | £34 million | £51 million |
| Prevention / crisis (£m) (total) – strong prevention | £34 million | £86 million |

### Community placement expenditure

The number of discharges to independent living, supported housing or residential care is in the order of 60 per month, or 720 per year. We would expect a multiple of this number to be supported by local authorities as support continues for more than one year, however this is counterbalanced by only a fraction requiring support. Our estimate, based on reports from ICS interviews, is that there are around 1,500 community placement packages currently being supported.

We have explored the effect of increasing preventative spend in reducing admissions, and hence discharges. We assume that a 50% increase in such spend is able to achieve an impact on admissions by adults of the order of 18 per year, or some one-6th of the level of admissions (an impact equal to improving to the 25$^{th}$ percentile in admission levels versus the 75$^{th}$ percentile).

Our starting point for assessing this expenditure is volumes and average unit costs as of 2021 to 2022.

We estimate the average community placement cost to be some £175,000 per year based on data returns made to us by a small sample of ICSs. Based on stakeholder interview assessments

that cost tends to reduce in later years of the placement, we assume that cost for years 1 and 2 is at a level 10% above this, year 3 costs at average rate, year 4 costs at a level 20% below the average level and year 5 at a rate 25% below the average. In assessing expenditure, we have multiplied the number of placements of a given duration against the unit cost for that duration, and then added together the individual components.

In reviewing expenditure over the period 2016 to 2017, to 2020 to 2021, our perspective is to take estimated spend in 2021 to 2022, and then build up in 5% annual increments. In other words, we have assumed that 2016 to 2017 community placement expenditure was 75% of 2021 to 2022 spend, 2017 to 2018 community placement spend was 80% of 2021 to 2022 spend, etc.

Our basis for the assumption is that the BtRS programme has led to a growing level of community placements over the period 2016 to 2017, with associated increase in expenditure.

| Number | 2016 to 2017 | 2017 to 2018 | 2018 to 2019 | 2019 to 2020 | 2020 to 2021 |
|---|---|---|---|---|---|
| Community placements (£m) | 175 | 187 | 199 | 211 | 222 |

In terms of future community placement costs, we need to take into account the effectiveness of increased preventative spend in reducing the inflows into hospital, and consequently the reduction in the quantity of discharges at a subsequent point. We have also taken into account a continuation of current trends which imply a continued shift from inpatient care into community support. We have modelled an increase in community placement spend associated with a fall in adult inpatient numbers of 60 in 2022 to 2023 compared to 2021 to 2022, followed by a further fall of 40 in 2023 to 2024, and additional fall of 20 in 2024 to 2025.

Our approach to assessing the impact on community placements of additional preventative action is based on insights from stakeholder interviews, as well as the findings of the ADASS survey. Both of these sources stressed that preventative support was being squeezed out to the detriment of the ability to reduce admissions; our analysis therefore draws on the experience of several ICSs that greater expenditure on prevention lessens admissions.

We have assumed that a 50% increase in preventative spend reduces community placements in future by 21 (approximately 1 person per 2 ICSs per year), and that a 100% increase in preventative spend reduces community placements in future by 31.5 (approximately 1.5 people per 2 ICSs per year).

Our calculations suggest the following levels of expenditure under the 3 scenarios.

| Case | 2021 to 2022 | 2022 to 2023 | 2023 to 2024 | 2024 to 2025 | 2025 to 2026 | 2026 to 2027 | 2027 to 2028 |
|---|---|---|---|---|---|---|---|
| Base case | £260 million | £263 million | £267 million | £273 million | £278 million | £284 million | £287 million |
| Prevention scenario | £260 million | £264 million | £272 million | £283 million | £297 million | £312 million | £325 million |
| Strong prevention | £260 million | £265 million | £275 million | £289 million | £306 million | £325 million | £343 million |

### Inpatient expenditure

Our starting point for addressing this issue is using data on numbers of patients and unit costs by year over the period 2016 to 2017, to 2021 to 2022. Our analysis has excluded patients in high secure facilities and in intensive care units.

**Expenditure over period 2016 to 2017 and 2020 to 2021**

Our analysis suggests that there has been a decrease in spend to the order of 10% over the time period. It can be seen that a fall of almost 16% in inpatient spend on adults has outweighed a 28% increase in spend on children.

| Expenditure (£m) (excludes High Secure) | 2016 to 2017 | 2017 to 2018 | 2018 to 2019 | 2019 to 2020 | 2020 to 2021 | Change (2016 to 2017 versus 2020 to 2021) |
|---|---|---|---|---|---|---|
| Adults | 450 | 425 | 409 | 403 | 380 | −15.6% |
| - of which females | 113 | 118 | 119 | 132 | 129 | 14.4% |
| - of which males | 337 | 307 | 290 | 271 | 251 | −25.6% |
| Children | 58 | 73 | 82 | 85 | 75 | 28.3% |
| Total | 508 | 498 | 490 | 488 | 455 | −10.5% |

The above shows a divergence in patterns of expenditure between adult females and males. This has largely been driven by diverging trends in prices, since while the cost of a bed for a female rose 27%, from an estimated £0.177 million per year in 2016 to 2017 to £0.224 million in 2020 to 2021, the cost of a bed for a male rose by 3%, from an estimated £0.189 million per year in 2016 to 2017 to £0.195 million per year in 2020 to 2021.

The above is based on multiplying estimated cost per bed day for a given patient category (for example, female low secure ASD) against the estimated number of patients in that category. Expenditure in relation to high secure placements is excluded.

The decrease in spend of 10% is driven by differing patterns in unit costs and volume. Though there was an increase in cost per adult bed day in the order of 9% (from an estimated £0.186

million in 2016 to 2017 to £0.203 million in 2020 to 2021), this was counteracted by the decrease in patient numbers.

Our assessment is based on a series of separate data and key assumptions:

- data on unit costs per bed day for categories of care by gender for 2016 to 2017, to 2021 (from Specialised Commissioning National Programme Lead for Learning Disability and Autism, NHSEI)
- assumption that inpatient beds are at full capacity, either in terms of being occupied or being kept open for double-running reasons
- assumption that cost of general beds is equal to cost of low secure beds
- data showing the proportion of males and females each year (Assuring Transformation dataset (published by NHS Digital), November 2021, table 2.1). We have excluded the 'not known' category from our analysis
- data showing the proportions of patients by category (learning disability, autism, learning disability and autism) each year (Assuring Transformation dataset (published by NHS Digital), November 2021, table 2.2). We have excluded the 'Other' category from our analysis
- data showing the proportions of patients by ward security level each year (Assuring Transformation dataset (published by NHS Digital), November 2021, table 2.3). We have excluded high security patients from our analysis
- assumption that, for 2020 to 2021, gender split is 50:50 female to male in relation to learning disability, and 17:83 in relation to autism (this is broadly in line with estimates from the Foundation for People with Learning Disabilities on the prevalence of autism in males compared with females)
- gender split for earlier years has been tweaked around these proportions to reflect a lower overall proportion of females in the cohort
- in relation to children, we have taken the average cost per bed day for adults for that given year, and scaled this up by a factor of 50%, reflecting data from NHS specialised commissioning (for 2016 to 2017) on the relative prices for adults and children in relation to medium secure beds

Our figures imply a cost per bed per year for adults at around £0.21 million in 2021 to 2022. It should be noted that NHS benchmarking data estimates cost per bed-day at £0.266 million, which is substantially higher.

**Expenditure on inpatient care in 2021 to 2022**

We have extrapolated the previous methodology to the current year, based on the following:

- the number of inpatients in October 2021 and or November 2021 (the mid-way point during the year) is assumed to represent the average number of inpatients for the year
- unit costs from 2020 to 2021 have been scaled up by a factor of 4.7%, which is the ONS CPI-H estimate of inflation in October and November 2021 (the mid-way point for the year)

The results are shown below.

| Expenditure (£m) (excluding high secure) | 2021 to 2022 |
|---|---|
| Adults | 381 |
| - of which females | 136 |
| - of which males | 245 |
| Children | 68 |
| Total | 449 |

**Indicative assessment of greater preventative spend on future inpatient spend**

Our modelling has examined a schematic assessment of the effect of increasing the level of preventative spend. In the prevention scenario, admissions and discharges are reduced by 21 year-on-year (0.5 per ICS) – of which 18 relates to adults, and 3 to children, and in the strong prevention scenario they are reduced by 42 (1 per ICS) – of which 36 relate to adults, and 6 to children. This is in line with considerations of the difference in system-wide admissions on a monthly basis when comparing upper-quartile and lower-quartile performance. Note that these effects are over and above the assumed trend reduction in inpatient levels occurring in 2022 to 2023, 2023 to 2024 and 2024 to 2025.

The expenditure on inpatient treatment for the 3 scenarios are shown below.

| Inpatient spend (£m) | 2021 to 2022 | 2022 to 2023 | 2023 to 2024 | 2024 to 2025 | 2025 to 2026 | 2026 to 2027 | 2027 to 2028 |
|---|---|---|---|---|---|---|---|
| Base-case | £450 million | £436 million | £426 million | £420 million | £418 million | £416 million | £415 million |
| Prevention scenario | £450 million | £428 million | £407 million | £389 million | £373 million | £359 million | £348 million |
| Strong prevention | £450 million | £423 million | £398 million | £375 million | £354 million | £335 million | £319 million |

**High-cost top-up fund and innovation**

We have added in expenditure of the order of 3% of other aspects of system expenditure to promote faster reductions in inpatient volumes.

## Appendix D: Results of ADASS and LGA survey

### Perspectives on support to avoid entry by those with a learning disability and autistic people into inpatient care

| Statement | % | Count |
|---|---|---|
| We have a good service that is working well to address the issue | 15% | 4 |
| We have a good service but it has some funding constraints | 37% | 10 |
| We have a good service but it has severe funding constraints | 19% | 5 |
| We are only able to offer a minimal service | 19% | 5 |
| We do not offer such a targeted service | 11% | 3 |
| **Total** | **100%** | **27** |

### Perspectives on potential policy levers

| Likely effect of … | Great improvement | Moderate improvement | Small effect | No effect |
|---|---|---|---|---|
| Specific grant made available for addressing the issue in relation to adults (number) | 14 | 10 | 3 | 0 |
| Specific grant made available for addressing the issue in relation to adults (%) | 52% | 37% | 11% | 0% |
| Specific grant made available for addressing the issue for young adults (aged 18 to 24) | 18 | 5 | 1 | 1 |
| Specific grant made available for addressing the issue for young adults (aged 18 to 24) (%) | 72% | 20% | 4% | 4% |
| Value of grants available for addressing learning and disability generally increased | 19 | 4 | 2 | 1 |
| Value of grants available for addressing learning and disability generally increased (%) | 73% | 15% | 8% | 4% |
| Level of funding for adult social care services as a whole increased, including this area | 22 | 4 | 0 | 1 |
| Level of funding for adult social care services as a whole increased, including this area (%) | 81% | 15% | 0% | 4% |
| Stronger encouragement for pooled budgets | 12 | 9 | 4 | 1 |
| Stronger encouragement for pooled budgets (%) | 46% | 35% | 15% | 4% |
| Improved flexibility and reduced bureaucracy entailed with NHSEI funding and DHSC grants | 20 | 3 | 4 | 0 |
| Improved flexibility and reduced bureaucracy entailed with NHSEI funding and DHSC grants (%) | 74% | 11% | 15% | 0% |

### To what extent are you able to provide community packages of support for all patients that are capable of being discharged where they are required?

| Proportion of community packages able to provide | Number of councils | Percentage of councils |
|---|---|---|
| All or almost all (above 95%) | 3 | 12% |
| Large majority (81% to 95%) | 7 | 28% |
| Clear majority (67% to 80%) | 9 | 36% |
| Up to 2-thirds (0% to 66%) | 6 | 24% |
| Total responses | 25 | N/A |

### Perspectives on problems relating to funding flows for community packages of support

| Likely effect of … | Great concern | Moderate concern | Small concern | No concern | Total |
|---|---|---|---|---|---|
| High placement costs | 20 | 5 | No value | No value | 25 |
| High placement costs (%) | 80% | 20% | 0% | 0% | No value |
| Increased demand for support | 20 | 6 | No value | No value | 26 |
| Increased demand for support (%) | 77% | 23% | 0% | 0% | No value |
| Community providers are scarce | 18 | 7 | 2 | No value | 27 |
| Community providers are scarce (%) | 67% | 26% | 7% | 0% | No value |
| Scarce housing for patients | 20 | 5 | 2 | No value | 27 |
| Scarce housing for patients (%) | 74% | 19% | 7% | 0% | No value |
| No formal funding relationships with CCG | 8 | 5 | 7 | 7 | 27 |
| No formal funding relationships with CCG (%) | 30% | 19% | 26% | 26% | No value |
| Transitional funding being cut | 10 | 8 | 4 | 4 | 26 |
| Transitional funding being cut (%) | 38% | 31% | 15% | 15% | No value |

## Trends in spend on preventative and crisis work since 2016

| Change in spend in preventative work since 2016 in real terms (adjusting for inflation) | Number | Change in spend in crisis work since 2016 in real terms (adjusting for inflation) | Number |
|---|---|---|---|
| More than 25% decrease | 3 | More than 25% decrease | 0 |
| 11% to 25% decrease | 1 | 11% to 25% decrease | 0 |
| Up to 10% decrease | 1 | Up to 10% decrease | 1 |
| No change | 4 | No change | 4 |
| Up to 10% increase | 5 | Up to 10% increase | 3 |
| 11% to 25% increase | 3 | 11% to 25% increase | 2 |
| More than 25% increase | 2 | More than 25% increase | 9 |

## Change in spend in preventative work since 2016 in real terms (adjusting for inflation)

| Change in spend in preventative work | Number | % |
|---|---|---|
| More than 25% decrease | 3 | 16% |
| 11% to 25% decrease | 1 | 5% |
| Up to 10% decrease | 1 | 5% |
| No change | 4 | 21% |
| Up to 10% increase | 5 | 26% |
| 11% to 25% increase | 3 | 16% |
| More than 25% increase | 2 | 11% |

## Change in spend in crisis work since 2016 in real terms (adjusting for inflation)

| Change in spend in crisis work | Number | % |
|---|---|---|
| More than 25% decrease | 0 | 0% |
| 11% to 25% decrease | 0 | 0% |
| Up to 10% decrease | 1 | 5% |
| No change | 4 | 21% |
| Up to 10% increase | 3 | 16% |
| 11% to 25% increase | 2 | 11% |
| More than 25% increase | 9 | 47% |

**Average annual gross cost to council of a community package per patients discharged recently 2020 to present.**

| Number of responses | Cost | Maximum |
|---|---|---|
| 10 | Average £129,717 p.a. | £300,000 p.a. |
| 1 | Less than £100,000 p.a. | No value |
| 2 | Between £100,000 and £156,000 p.a. | No value |
| 3 | Between £156,001 and £470,000 | No value |
| 1 | Over £600,000 | No value |

**Average annual gross cost to council of community package per patients discharged earlier on in the BtRS process (2016 to 2019)**

| Number of responses | Cost | Maximum |
|---|---|---|
| 6 | Average £114,183 p.a. | £300,000 p.a. |
| 1 | Less than £100,000 p.a. | No value |
| 3 | Between £100,000 and £156,000 p.a. | No value |
| 2 | Between £156,001 and £320,000 | No value |

**What, approximately, would you forecast the average annual amount of gross cost to your council of a community package per patient discharged to be, for 2023 to 2024, as action is to be taken to meet the NHS long term plan targets**

| Number of responses | Cost | Maximum |
|---|---|---|
| 5 | Average £127,039 p.a. | £300,000 p.a. |
| 1 | Less than £100,000 p.a. | No value |
| 2 | Between £100,000 and £190,000 p.a. | No value |
| 1 | Between £260,000 and£360,000 p.a. | No value |
| 1 | £500,000 p.a. | No value |

## Appendix E: NHSEI linear regression model for adult inpatient length of stay

### Linear regression model for adult inpatient length of stay

**Background**

This analysis has been done at the request of RedQuadrant, which is undertaking a funding flow project on behalf of the Building the Right Support Delivery Board. Data are from Assuring Transformation (published by NHS Digital) as at September 2021.

**Methodology**

Linear regression models were built to try and predict length of stay for patients with a learning disability and autistic patients admitted to mental health hospital. Length of stay was based on patients' total length of stay in hospital (for example, if a patient was admitted to one hospital and then transferred to another, their length of stay included the time spent in both hospitals). The modelling was based on adults with a learning disability and autistic people who were in a mental health hospital on or after March 2015 and subsequently reported as discharged from hospital (to the community). Adults were between 18 and 70 years on admission.

Hospital spells for adults over the age of 70 were excluded as were hospital spells with a total length of less than 14 days, or longer than 30 years. These cases were excluded from the data set as they are outliers that decreased the model performance.

Linear regression models were found to perform poorly in predicting Assuring Transformation (AT) inpatient length of stay. This was largely due to the limitations of the data available and the small sample size.

The sample size (around 7000 hospital inpatient spells) is very small and is an issue which negatively impacts the ability to create a good model that is able to predict length of stay.

The risk of omitted variable bias in the model is high. There are important factors that are likely to significantly impact length of stay that are not captured in the current data set. These include reason for admission, clinical diagnoses, complexity of patient need and or clinical diagnosis, availability of health and social care community services, knowledge and or skills and or expertise of commissioners, availability of housing at point of discharge, agreement on responsibility for funding community support.

The data set is incomplete in so far as it does not have a complete record of hospital stays if the patient was admitted to hospital prior to 2015 and the hospital they were admitted to originally was different to that first recorded on AT.

**Main findings**

Despite the limitations of the model there were a number of key findings:

1. The model suggests that patient spells for those in NHS hospitals are likely to be shorter than for those in independent sector hospitals.

Additional analysis of admissions in the 2 year period between April 2019 and March 2021 confirms this with significantly higher proportions of those admitted to NHS hospitals having lower lengths of stay of up to a year.

Table 1 below shows adult admissions over the 2 year period and the percentage discharged within 3 months, 6 months and 12 months. 56% of patients admitted to NHS hospitals were discharged within 3 months of admission, compared to 34% of patients admitted to independent sector hospitals. The percentage of patients discharged within 6 months rose to 76% for those admitted to NHS hospitals and compares to 49% amongst those admitted to independent sector hospitals

Table 1: Adult admissions between April 2019 and March 2021

| Length of Stay to Discharge | NHS Hospital Admissions | Independent Hospital Admissions |
|---|---|---|
| 0-3 months | 56% | 34% |
| 0-6 months | 76% | 49% |
| 0-12 months | 93% | 74% |

**Source**: Assuring Transformation dataset (published by NHS Digital), November 2021. Admissions from the community discharged up to November 2021. Analysis by NHSEI

Some caution should be exercised when interpreting this finding as there may be factors that it was not possible to control for in the data set that have impacted the findings. We have heard anecdotally that there may be a disproportionate number of patients with more complex needs in independent sector hospitals. For example, the Norfolk Safeguarding Adult Review into the deaths of 3 young adults at Cawston Park found that the commissioner had contacted 39 hospitals before placing one of the adults at Cawston Park. This issue is something that NHSEI plan to explore further. A key ambition for provider collaboratives is to ensure good practice across all providers in the collaborative. This would include an expectation that people with similar needs would have similar lengths of stay.

2. The model also suggests that ward security is an important factor, with those in non-secure hospital settings more likely to have a lower length of stay than those in secure settings.
3. Mental Health Act status was also identified as a factor impacting length of stay. Inpatient spells relating to patients not subject to the Mental Health Act are likely to be shorter. Inpatient spells for those on Mental Health Act sections with Ministry of Justice restrictions (Part III restricted) are likely to be longer.

**Limitations, fit of the model and strength of relationships**

Although R2 was 0.49 this is likely due to the high coefficient values for the NHS and or independent sector and ward security variables. The sample size is very small and there is a high risk of omitted variable bias in the model. The model is not considered suitable for predicting length of stay for inpatients.

The relationships for NHS and or independent sector hospital and ward security are strong in the model but our concern is with omitted variable bias. This is where there is an important variable(s) in the model that is missing and that is correlated to another variable in the model.

Important variables that were not in the model due to lack of data include reason for admission, clinical diagnoses, complexity of patient need and or clinical diagnosis, availability of health and social care community services, knowledge and or skills and or expertise of commissioners, availability of housing at point of discharge, agreement on responsibility for funding community support. Omitted variable bias can lead to variables in the model appearing important when they may not be.

## Appendix F: Contributions and thanks

We are sincerely grateful to all who have engaged with this important project. The success of BtRS relies on many people and systems working together. In the same way, we have needed to engage widely in order to fully understand and review the funding flows relating to BtRS. Our particular thanks go to the 12 TCP areas which engaged with us so productively in a period of particularly high pressures.

We are grateful to representatives from all of the below, for your time and effort that was generously given which enabled us to gain a fuller picture of funding flows in relation to BtRS:

- the Department for Health and Social Care
- NHS England and NHS Improvement, especially regional representatives, strategic finance and data analysts
- BtRS Delivery Board members
- BtRS Advisory Group members
- LGA
- ADASS
- 12 TCP areas
- Golden Lane Housing
- Associate Director, Housing, NHS trust
- the Avenues Trust
- Sense
- Association for Change
- Bild
- Care England
- Elysium Healthcare
- Learning Disability England
- Norfolk SAB Chair
- Cawston Park SAR Author
- Office of the Children's Commissioner
- OFSTED
- Priory Group
- Skills for Care

## Appendix G: Co-authors

Terry Rich BSc, MSc, is a qualified social worker and has several vocational qualifications, including Certificate in Qualification in Social Work, Foundations of Programme Management, and Civil Service College Senior Management Training Programme. Terry has a deep understanding of the policy area and experience as a senior public sector leader. He served as Director of Social Services and Director of Adult Social Care in 3 authorities. He has worked as an LGA Care and Health Improvement Advisor providing advice and support to local authorities across the country.

Terry's experience of this policy area is extensive, including as DASS, LGA advisor and as Chair of a learning disability and autism provider organisation. He has represented ADASS on a previous Transforming Care delivery group, supported the ADASS learning disability and autism policy network and was member of the stakeholder reference group on CQC's thematic review of restraint which included inspections of most ATUs. Terry is also non-executive chair of the Avenues Group, a charity providing care and support to people with a learning disability and or autism.

He has worked on reviewing service models including financial flows in Northamptonshire, Sefton, and Dudley councils and Ealing CCG. He was mental health programme Director in Norfolk. He was advisor to NHS London on the transfer of public health from the NHS to local government, and to the Institute of Health Visitors before and during the transfer of health visiting to local government in 2015.

Chris O'Gorman MA(Oxon), MA, has a WPF diploma in individual and organisational dynamics. Chris has wide experience at senior levels in the NHS. He has held senior management positions in both commissioning and provider organisations and is now an independent chair and consultant. He will contribute his expert knowledge of healthcare commissioning and provision, and he will be the main link with NHS stakeholders during the project lifetime. He has previously worked on financial flow analysis and programmes of financial re-alignment to secure policy objectives, for example, in establishing integrated commissioning arrangements between local authorities and NHS commissioning bodies. Chris O'Gorman will bring to the team skills for analysis in complex situations and realistic problem-solving in the health and social care sector. He also has specialist knowledge of NHS continuing healthcare which will be of importance to key client cohorts within this research study.

Lesley Moore is an AAT qualified accountant with 39 years of experience in public sector finance, including as Head of Finance for Adults and Children's Social Care, Deputy Director of Finance and Director of Commissioning and Procurement. She has led on the delivery of major programmes, including those linked to learning disabilities and mental health such as the pooled budgets with Bromley Primary Care Trust for Service Users with mental health and learning disabilities and the learning disabilities campus reprovision programme. She has a comprehensive knowledge of financial flows and data, examining how these can be maximised for greater efficiencies, to drive achievement, challenge under performance, and deliver better outcomes for service users. Lesley will bring to the team her financial skills, detailed knowledge.

Neil Reeder BSc (Econ), MSc (Econ) has a master's degrees in economics and in applied mathematics from the London School of Economics. He carried out the financial analysis and modelling. He has expertise in the economic analysis of outcomes, efficiency, and innovation in public services. His experience spans more than 20 years in consulting, civil service policy-making, business planning, and academia. Highlights to his career include leading the analysis team to the Gershon Review of efficiency in public services at HM Treasury; co-authorship of one of the path-breaking reports on social impact bonds at the Young Foundation; and leading his policy team on local government efficiency to an Excellence in Delivery award at the Office of the Deputy Prime Minister. His work has included economic modelling for various health-related projects, including deriving costings to stakeholders of changes to pharmacy training by HEE and assessing the business case for a social prescribing pilot for a southern England CCG.

Gerald Midgley, BA, MPhil, PhD, and Professor at the University of Hull oversaw the design and implementation of our systems methodology. He has extensive experience in systems thinking, both as an academic researcher and in government practice. Gerald is Professor of Systems Thinking in the Centre for Systems Studies, Faculty of Business, Law and Politics, University of Hull, UK. He also holds Adjunct Professorships at Linnaeus University, Sweden; the University of Queensland, Australia; the University of Canterbury, New Zealand; Mälardalen University, Sweden; and Victoria University of Wellington, New Zealand. He has held research leadership roles in both academia and government, having spent 11 years as Director of the Centre for Systems Studies at Hull, and 7 years as a Senior Science Leader in the Institute for Environmental Science and Research (ESR), New Zealand. Gerald has written over 300 papers for academics and practitioners on systems thinking and community operational research, and has been involved in a wide variety of public sector, community development, health service, technology foresight and resource management projects. He was the 2013 to 2014 President of the International Society for the Systems Sciences, and has written or edited 12 books. These include: Systemic Intervention: Philosophy, Methodology, and Practice (Kluwer, 2000); Systems Thinking, Volumes I-IV (Sage, 2003); Community Operational Research: OR and Systems Thinking for Community Development (Kluwer, 2004); Forensic DNA Evidence on Trial: Science and Uncertainty in the Courtroom (Emergent, 2011); and the Routledge Handbook of Systems Thinking (Routledge, 2021).

Frank Curran MA MCIH has a deep understanding of the policy area and his experience of managing complex consultancy and or research projects. A consultant since 2000, he has worked with 120+ local authorities and CCGs on adult social care transformation and integration. He has also led complex projects for central government, including a portfolio of projects for EU Exit preparation and Test and Trace and has advised national charities working in this space, including Mencap and MacIntyre.

Janice Prentice MA is a consultant project manager and has worked to support public sector organisations to change and improve since 2011. She has managed a range of consultancy (both major and targeted) projects, including those with political and cultural importance for government departments and councils, amongst others. She has a particular focus on building equality, diversity and inclusion.

## Appendix H: References


Building the right support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour than challenges, including those with a mental health condition, (NHSEI, ADASS, LGA, 2015) https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

*Building the Right Support, National Service Model* (NHSEI, ADASS LGA) - https://www.england.nhs.uk/wp-content/uploads/2015/10/servicemodel-291015.pdf

NHSEI, 'Learning disability and autism programme: data and information', *England.NHS.uk* https://www.england.nhs.uk/learning-disabilities/learning-disability-and-autism-programme-data-and-information/ (Accessed 02-09-2021).

NHSEI, 'Learning disability and autism projects', *England.NHS.uk*, https://www.england.nhs.uk/learning-disabilities/projects/ (Accessed 02-09-2021).

NHSEI, 'Homes not hospitals', *England.NHS.uk*, https://www.england.nhs.uk/learning-disabilities/care/ (Accessed 02-09-2021).

NHSEI, 'Transforming Care: service model specification (January 2017)', *England.NHS.uk*, https://www.england.nhs.uk/publication/transforming-care-service-model-specification-january-2017/ (Originally January 2017, updated December 2017, Accessed 02-09-2021).

Guidance on the implementation and operation of the Learning Disability and Autism Pathway Fund, NHS England and NHS improvement

Winterbourne View: Time for Change – the challenge ahead https://www.acevo.org.uk/sites/default/files/ACEVO_report_TCA_final_web.pdf

NHSEI website - https://www.england.nhs.uk/learningdisabilities/care/

NHSEI, 'Transforming Care Partnerships', *England.NHS.uk* https://www.england.nhs.uk/learning-disabilities/tcp/

NHSEI, 'Learning disability and autism: our work', *England.NHS.uk* https://www.england.nhs.uk/learning-disabilities/about/

Pathways Associates and NHSEI, 'Beyond the high fence' https://www.england.nhs.uk/publication/beyond-the-high-fence/

'Evaluation of Building the Right Support: findings to date, (January 2019)', *The Strategy Unit* https://www.strategyunitwm.nhs.uk/publications/building-right-support

Public Health England, 'People with learning disabilities in England', *Gov.uk* https://www.gov.uk/government/publications/people-with-learning-disabilities-in-england (published 5 August 2019, updated 27 January 2020).

The Learning Disabilities Mortality Review (LeDeR) programme at the University of Bristol 2015-2021

http://www.bristol.ac.uk/sps/leder/uob-2015-21/#d.en.544358

NHSE and NHSI transforming care for people with learning disabilities – next steps

https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf

Local Government Association, 'Change from funding transfer agreements to the pathway fund', *Local.gov.uk* https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/building-right-support-and/pathway-fund (February 2020)

Transforming Care Cross-System Finance group, 'Learning disability and autism finance briefing', *Local.gov.uk* https://www.local.gov.uk/learning-disability-and-autism-finance-briefing (March 2021).

NHS Benchmarking Network: NHS England and NHS Improvement Year 2 Improvement Standards report (2018/19):

https://www.nhsbenchmarking.nhs.uk/s/NHSE-NHSI-Learning-Disabilities-Improvement-Standards-Year-2.pdf

The NHS Benchmarking Network NHS England and NHS Improvement Year 1 Improvement Standards report (2017/18):

https://www.nhsbenchmarking.nhs.uk/s/Learning_disabilities_standards_benchmarking_report_FINAL.pdf

Helping People Thrive is the first of 2 planned practical guides looking at how to transform the lives of people with a learning disability and or autism who have been detained in hospital or in Long Term Segregation for too long.

https://www.bild.org.uk/helpingpeoplethrive/

Pathways to unlocking secure mental health care, Centre for Mental Health

https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Pathways_to_unlocking_secure_mental_health_care.pdf

Home For Good: Successful community support for people with a learning disability, a mental health need and autistic people

https://www.cqc.org.uk/publications/themed-work/home-good-successful-community-support-people-learning-disability-mental

ADASS/Home Group Report 'Transforming care: How can progress be improved?' https://www.adass.org.uk/adasshome-group-report-transforming-care-how-can-progress-be-improved

Services for people with learning disabilities and challenging behaviour or mental health needs (The Mansell Report), Her Majesty's Stationery Office/Department of Health, 1993, revised 2007

SCIE Knowledge review 20: Commissioning person-centred, cost-effective, local support for people with learning disabilities by Eric Emerson and Janet Robertson. Social Care Institute For Excellence (SCIE) July 2008

There is an alternative Association For Supported Living 2012

Another way: transforming peoples' lives through good practice in adult social care Voluntary Organisations Disability Group 2011

Transforming Care Programme. NHSEI 2015 onwards

National service model. NHSEI, the Local Government Association and the Association of Directors of Adult Social Services 2015

Transforming care – the challenges and solutions. Voluntary Organisations Disability Group 2018

CQC inspections and regulation of Whorlton Hall 2015-2019: an independent review and CQC inspections and regulation of Whorlton Hall: second independent report by Prof Glynis Murphy

The costs and the benefits of Small Support organisations in England by Victoria Mason-Angelow, August 2020, Updated August 2021 https://www.ndti.org.uk/assets/files/Small-Supports-Cost-Benefit-FINAL-2021.pdf

The Autism Act: 10 Years On, All Parliamentary Group on Autism and National Autistic Society, (undated – appears to be approximately July 2019).

Building the Right Support, Local Government Associations, Association of Directors of Adult Social Services, NHSEI, (October 2015).

Evaluation of Building the Right Support: stakeholder feedback report, ICF, the Strategy Unit, University of Birmingham, Bild, (July 2018).

Evaluation of Building the Right Support: summary of findings to date and recommendations arising, ICF, The Strategy Unity, The University of Birmingham, Bild, (October 2018)

Supporting people with a learning disability and or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services, Local Government Association, Association of Directors of Adult Social Services, NHSEI, (October 2015).

Supporting people with a learning disability and or autism who display behaviour that challenges, including those with a mental health condition: Supplementary information for commissioners, Local Government Association, Association of Directors of Adult Social Services, NHSEI, (October 2015).

Steven Kennedy, Rob Long, Elizabeth Parking, Andrew Powell, Support for people with a Learning Disability, House of Commons Library, (8th June 2021)

The Treatment of Autistic People and People with Learning Disabilities: Fifth Report of Session 2021-22, House of Commons Health and Social Care Committee, (13th July 2021).

G. Midgley, I. Munlo and M. Brown, 'The Theory and practice of boundary critique: developing housing services for older people', Journal of the Operational Research Society, 49:5, (May 1998), pp. 467-478Ronald K. Mitchell, Bradly R. Agle and Donna J. Wood, 'Toward a theory of stakeholder identification and salience: defining the principle of who and what really counts', The Academy of Management Review, 22:4, (October 1997), pp. 853-886.

Peter May, Richard Lombard Vance, Esther Murphy, Mary-Ann O'Donovan, Naoise Webb, Greg Sheaf, Philip McCallion, Roger Stancliffe, Charles Normand, Valerie Smith, Mary McCarron, Effect of deinstitutionalisation for adults with intellectual disabilities on costs: a systematic review, BMJ Open, 10.1136/bmjopen-2018-025736, **9**, 9, (e025736), (2019). https://bmjopen.bmj.com/content/9/9/e025736

Caraíosa Kelly, Roy McConkey, Sarah Craig, A case-study of policy change in residential service provision for adult persons with intellectual disability in Ireland, Health and Social Care in the Community, 10.1111/hsc.12803, **27**, 5, (e760-e768), (2019). https://onlinelibrary.wiley.com/doi/10.1111/hsc.12803

Denise Razzouk, Accommodation and Health Costs of Deinstitutionalized People with Mental Illness Living in Residential Services in Brazil, PharmacoEconomics - Open, 10.1007/s41669-018-0078-z, (2018). Crossref

Max Read, Transforming Care: supporting people with learning disabilities, autism and mental health issues to move out of long-stay hospitals, Learning Disability Practice, 10.7748/ldp.2020.e2064, (2020).

https://journals.rcni.com/learning-disability-practice/evidence-and-practice/transforming-care-supporting-people-with-learning-disabilities-autism-and-mental-health-issues-to-move-out-of-longstay-hospitals-ldp.2020.e2064/abs

Anna Leonie Wark, 'Contributing factors to providing an effective community-based forensic service for people with a learning disability: a literature Review', Journal of Intellectual disabilities and Offending Behaviour, October 2019, https://www.emerald.com/insight/content/doi/10.1108/JIDOB-03-2019-0005/full/html

Annabel Head, Helen Ellis-Caird, Louisa Rhodes, Kathie Parkinson, Transforming identities through Transforming Care: How people with learning disabilities experience moving out of hospital, British Journal of Learning Disabilities, 10.1111/bld.12213, 46, 1, (64-70), (2018). https://onlinelibrary.wiley.com/doi/abs/10.1111/bld.12213

Brian Leaning, Hope Adderley, From long-stay hospitals to community care: reconstructing the narratives of people with learning disabilities, British Journal of Learning Disabilities, 10.1111/bld.12139, 44, 2, (167-171), (2015). https://onlinelibrary.wiley.com/doi/10.1111/bld.12139

Sabyasachi Bhaumik, Freya Tyrer, Satheesh Ganghadaran, Assessing Quality of Life and Mortality in Adults With Intellectual Disability and Complex Health Problems Following Move From a Long-Stay Hospital, Journal of Policy and Practice in Intellectual Disabilities, 10.1111/j.1741-1130.2011.00308.x, 8, 3, (183-190), (2011).

https://onlinelibrary.wiley.com/doi/10.1111/j.1741-1130.2011.00308.x

Regi Alexander, John Devapriam, Dasari Michael, Jane McCarthy, Verity Chester, Rahul Rai, Aezad Naseem, Ashok Roy, 'Why can't they be in the community? 'A policy and practice analysis of transforming care for offenders with intellectual disability, Advances in Mental Health and Intellectual Disabilities, 10.1108/AMHID-02-2015-0011, 9, 3, (139-148), (2015). https://www.emerald.com/insight/content/doi/10.1108/AMHID-02-2015-0011/full/html

Michael Brown, Anna Higgins, Juliet MacArthur, Transition from child to adult health services: A qualitative study of the views and experiences of families of young adults with intellectual disabilities, Journal of Clinical Nursing, 10.1111/jocn.15077, 29, 1-2, (195-207), (2019). https://onlinelibrary.wiley.com/doi/10.1111/j.1741-1130.2011.00286.x

Michael Brown, Juliet Macarthur, Anna Higgins, Zoë Chouliara, Transitions from child to adult health care for young people with intellectual disabilities: A systematic review, Journal of Advanced Nursing, 10.1111/jan.13985, 75, 11, (2418-2434), (2019). https://onlinelibrary.wiley.com/doi/10.1111/jan.13985

Roger Ellis, Elaine Hogard, David Sines, Resettlement of individuals with learning disabilities into community care, Journal of Intellectual Disabilities, 10.1177/1744629513497630, 17, 3, (252-264), (2013). https://journals.sagepub.com/doi/10.1177/1744629513497630

R. Romeo, M. Knapp, J. Morrison, C. Melville, L. Allan, J. Finlayson, S.-A. Cooper, Cost estimation of a health-check intervention for adults with intellectual disabilities in the UK, Journal of Intellectual Disability Research, 10.1111/j.1365-2788.2009.01159.x, 53, 5, (426-439), (2009). https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2788.2009.01159.x

Antonio Rojas-Garcia, Charlotte Woodhead, Elsie Imwensi, Angela Hassiotis, Fiona Aspinal, Managing demand for social care among adults with intellectual disabilities: A systematic scoping review, Journal of Applied Research in Intellectual Disabilities, 10.1111/jar.12652, 33, 2, (111-125), (2019). https://onlinelibrary.wiley.com/doi/10.1111/jar.12652

Annette Bauer, Laurence Taggart, Jill Rasmussen, Chris Hatton, Lesley Owen, Martin Knapp, Access to health care for older people with intellectual disability: a modelling study to explore the cost-effectiveness of health checks, BMC Public Health, 10.1186/s12889-019-6912-0, 19, 1, (2019). https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6912-0

Iain M Carey, Fay J Hosking, Tess Harris, Stephen DeWilde, Carole Beighton, Sunil M Shah, Derek G Cook, Do health checks for adults with intellectual disability reduce emergency hospital admissions? Evaluation of a natural experiment, Journal of Epidemiology and Community Health, 10.1136/jech-2016-207557, 71, 1, (52-58), (2016). https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2788.2009.01159.x

David Felce, Community Living for Adults with Intellectual Disabilities: Unravelling the Cost Effectiveness Discourse, Journal of Policy and Practice in Intellectual Disabilities, 10.1111/jppi.12180, 14, 3, (187-197), (2016). https://onlinelibrary.wiley.com/doi/10.1111/jppi.12180

Sabyasachi Bhaumik, Joanna Watson, Mary Barrett, Bala Raju, Tracey Burton, Jane Forte, Transition for Teenagers With Intellectual Disability: Carers' Perspectives, Journal of Policy and Practice in Intellectual Disabilities, 10.1111/j.1741-1130.2011.00286.x, 8, 1, (53-61), (2011).

https://onlinelibrary.wiley.com/doi/10.1111/j.1741-1130.2011.00286.x

Devescovi,Raffaella; Monasta,Lorenzo; Mancini,Alice; Bin,Maura; Vellante,Valerio; Carrozzi,Marco; Colombi,Costanza, Early diagnosis and Early Start Denver Model intervention in autism spectrum disorders delivered in an Italian Public Health System service, (Dove press, 2016)

A. Bignotto, D. Celona, E. Pascolo Fabrici and D. Garino, 'Child and adolescent service and community mental health center: HoNOS findings in a joint take in charge model in Trieste', European Psychiatry, March 2020. https://www.cambridge.org/core/journals/european-psychiatry/article/child-and-adolescent-service-and-community-mental-health-center-honos-findings-in-a-joint-take-in-charge-model-in-trieste/674097C66323DF2B12157AF01FB3BB57

Rosemary Tozer, 'Continuity Commitment and context: Adult siblings of people with autism plus learning disability', Health and Social Care in the Community, 31:5 https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12034