Building the right support – Frequently Asked Questions (finance)

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Building the right support (BRS), is a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

Link to BRS here: https://www.england.nhs.uk/learningdisabilities/care/

Note: A finance task and finish group is being established to examine some of the financial arrangements described below in more detail. This is therefore a 'live' document and will be further updated.

1. **What are the financial underpinnings for the transforming care work?**

   BRS summarises the financial underpinnings as detailed below:

   > 4.41 A new financial framework will underpin and enable transformation.

   > 4.42 Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model of care will therefore be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. We estimate that the closure of inpatient services of the scale set out in chapter 3 will release hundreds of millions of pounds for investment in better support in the community.

   > 4.43 To enable that to happen, NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare. CCGs, NHS England specialised commissioning and local authorities will be supported to, where appropriate, put in place governance and financial mechanisms to align or pool resources and manage financial risk. The degree of change and financial risk will inevitably vary across localities, and we will support local commissioners to base decisions on transparent, open-book discussions, focussed on achieving the best outcomes for the people they serve.

   > 4.44 For people who have been an inpatient for five years or more (approximately one third of the total inpatient population) and who are ready for discharge, we expect the transformational change required to be one of 'resettlement' out of hospital and into a more suitable home, as opposed to redesigning services to reduce the 'revolving door' of admissions and discharges. For this group, money will 'follow the individual' through dowries.

   > 4.45 Dowries will be paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of

discharge. We expect that NHS England will pay for dowries when the inpatient is being discharged from NHS England-commissioned care, and that CCGs will pay for dowries when the individual is being discharged from CCG-commissioned care. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual. An annual confirmation of dowry-qualifying individuals should be undertaken by local authorities and CCGs. Dowries are to be prospective only, and so should not be applied to any patients that have already been discharged. They should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date). They should apply pro rata in the start and finish year. To ensure that the costs of the future model of care fit within the existing funding envelope, it is important that dowries are set at a level which is consistent with this principle. The absolute level of the dowry is not expected to be set nationally, but is to be left to local discussions which should be subject to the principles set out here. In addition to paying for these dowries, the NHS will continue to fund continuing healthcare (CHC) and relevant Section 117 aftercare.

> 4.46 In addition, from November 2015 Who Pays guidance - determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

> 4.47 Transformation of this scale will entail significant transition costs, including the temporary double running of services as inpatient facilities continue to be funded whilst new community services are established. The extent of the transition costs will depend on the efficiency of the bed closure programme, and the timing and extent of required new community investment. We will work with commissioners and providers to support the closure of inpatient capacity and development of new community services as efficiently as possible, but we recognise that non-recurrent investment will still be necessary. To support local areas with these transitional costs and building on the approach tested with fast track areas, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

> 4.48 In addition to this, £15 million capital funding over three years will be made available, and NHS England will explore making further capital funding available following the Spending Review.

> 4.49 As set out in the national service model, alongside these new financial underpinnings to enable transformation we expect to see a significant growth in personalised funding approaches (personal budgets, personal health budgets, and integrated personal budgets as well as education, health and care plans). Local transformation should, for instance, be aligned with existing requirements for CCGs to set out a 'local offer' on personal health budgets.

> 4.50 In some parts of the country, local transformation plans will also need to align with Integrated Personal Commissioning (IPC) pilots. IPC sites are currently testing approaches to enable people to purchase their care (including clinical services currently commissioned using NHS standard contracts) through personal budgets, combining resources from health, social care and other funding sources where applicable. The work these sites are undertaking includes linking cost and activity data across services and trialling new contracting and payment approaches that enable the money to be used differently. As IPC sites progress their work, we will support local transforming care partnerships to learn from them and apply the lessons to their own local areas.

2. **Can you clarify the match funding requirement to access further transformation funding?**

   As stated in paragraph 4.47 of BRS, transformation funding of up to £30 million over the next three years (starting 1st April 2016) will be made available by NHS England to the TCPs. The funding is conditional on match funding from local commissioners. The NHS planning guidance for 2016/17 describes nine 'must dos' for the NHS, of which transformation of learning disability services is one – CCGs are expected to give this work commensurate priority. Partners may want to consider the development of a memorandum of understanding where there are complex boundary arrangements and multiple CCGs, to establish arrangements for the management of match funding and risk sharing/expectations.

   NHS England will be setting out full details of the prioritisation criteria to access these funds separately.

3. **What funds should be included in describing the total budget?**

   The future model of care (in line with the service model) should be met from the total current envelope of spend by CCGs, specialised commissioning and local authorities on health and social care services for people with a learning disability and/or autism. Local areas will need to consider which budgets to include so that they achieve the transformation in care and support that is described in the new service model – for example, children's budgets and total housing contributions from across the system. Some TCPs may wish to include all of their services and spend for people with a learning disability and/or autism in order to prevent future use of inpatient services. This may include funds that have not historically been used for people with a learning disability and/or autism with behaviour described as challenging (but rather the wider learning disability population) in line with the service model focus on early intervention and prevention.

4. **If TCPs decide to reduce spend on NHS England commissioned beds and spend this budget on CCG commissioned community services how is the budget transferred?**

Alignment of specialised commissioning budgets is being worked through by NHS England. However, a fully agreed, co-ordinated approach needs to be undertaken to minimise the financial risk to both commissioners and providers. This should be modelled in the TCP financial plan.

It should, however, be noted that not all patients that are discharged will release a bed (or the funding attached to this service/activity). Thus, there should be an agreed level of bed capacity available over the transformation period

Based on the agreed plan of the TCP, funding should also be able to be 'transferred' from CCG to specialised commissioners if there is a requirement to admit or transfer an existing funded individual into specialised services above the agreed bed capacity levels in a TCP plan.

Conversely, it is also proposed that existing local authority funded individuals whose health needs highlight the need for in-patient hospital care then funding should also be released into a pooling type arrangement until discharge. Funding would then be reassessed with appropriate shares of funding from the CCG and LA to meet the individual care and support needs in the community.

5. What does alignment of specialised commissioning budgets mean and what governance arrangements are required?

From a financial perspective, alignment of specialised commissioning budgets will initially mean a closer identification and transparency of the funding that is required for the commissioning of specialised services for people with a learning disability and/or autism for each of the TCPs. We are working through the specific governing arrangements for how those budgets should then be managed in a way that enables the transformation of services we wish to see, and the shift of investment across the pathway that that will entail.

We are also exploring the combined reporting of the activity and finance position for TCPs. We expect to set out more details in the near future on the finance rules. However, TCPs should deliver much closer working to ensure that there are effective transformation plans at a local level. Specifically, we need to be clear about specialised commissioning activity if people are in 'mental health' beds (but have a learning disability/autism) and not in learning disability specific wards / hospitals / beds. Furthermore, we need to confirm that if the patient (and therefore bed) is recorded in Assuring Transformation data then it is part of this process.

6. When will budgets be aligned?

The plan is to align budgets after 1st April 2016 following the completion of plans.

7. What are the arrangements for pooling budgets?

As stated in paragraph 4.43 of BRS the arrangements for pooled budgets will need to be agreed and negotiated locally to ensure that no partner is disadvantaged by the

arrangements and that the risks are shared across the partnership. Partners may wish to involve legal and financial services to ensure that partnership agreements are sound.

8. How do emergent devolution arrangements fit into the budgets?

We will be shaped by the devolution agenda and reflect the local arrangements in learning disability policy. TCPs should factor in their local devolution proposals in their plans. Factors such as TCP footprints varying from devolution footprints need to be taken into account and worked on locally in each TCP.

9. How do dowries work and who will be eligible for a dowry?

The concept of a dowry payment is focussed on providing financial support for social care costs for eligible dowry patients (five years continuous in-patient). Dowry funding will be accessed only at the point of discharge and will be agreed locally.

As stated in BRS, dowries should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date). This means that, as at 1 April 2016, patients have to have been in hospital since 31 March 2011 or earlier to qualify for a dowry.

They should apply pro rata in the start and finish year. To ensure that the costs of the future model of care fit within the existing funding envelope, it is important that dowries are set at a level which is affordable locally. The absolute level of the dowry is not expected to be set nationally, but is to be left to local discussions which should be subject to the principles set out in BRS.

Integrated Personal Commissioning (IPC) in which individuals could control their combined health and social care support is encouraged for dowry individuals. The agreed value of the dowry should be based on the amount of NHS resource that is freed up following investment in the population based community service infrastructure. For example, a specialised or CCG commissioned in-patient who has been in hospital for the past six years would be eligible for a dowry. The amount of dowry that could be transferred to the local authority would be based on local affordability:

- Firstly, the recurrent costs released from decommissioning the hospital bed. These may be from NHS England or the CCG.
- Secondly, the level of investment required by the CCG in the community infrastructure to ensure good outcomes and effectively maintain services for people with a learning disability and/or autism.

Dowries will be managed by the CCG as local community services commissioner and passed to their local authorities and held in a pooled/aligned budget dependent on local preferred arrangements adopted and the conditions stated in BRS apply. If at

any time the individual no longer requires dowry funding (short or long term) as no longer social care funded (for example, 100% CHC, becomes an in-patient again or dies), then the dowry remains a local NHS resource to be used for the health and social care system.

In the CHC example, it is proposed that if a person is discharged into social care with a dowry but then their condition deteriorates and is assessed as requiring continuing healthcare then the person would become 100% health funded so they have no need for a dowry.

In the readmission example, it is assumed that the person would retain the eligibility for the dowry but the resource would be utilised by the local system to fund all/element of the in-patient stay.

Finally, if an individual moves to another local authority then the funding will also transfer if commissioning responsibility changes. This is to ensure that the dowry moves with the individual if commissioning responsibility changes in the future due to legislative changes.

10. How do we stop dowries being a perverse incentive for commissioners?

In keeping with the aims and principles of the Transforming Care programme, there needs to be effective case management and discharge planning at a local level to ensure patients are prioritised so that they do not remain in an in-patient setting for longer than their discharge plan highlights.

The focus must be on the rights and wellbeing of the individual with the person and their family at the centre and we would expect the needs of patients to be met above other considerations so that commissioners will work effectively to discharge patients into appropriate community settings.

11. Can you clarify the reasons for the proposed amendment to 'Who Pays' guidance?

As stated in paragraph 4.46 of BRS, we are proposing to revise NHS England's 'Who Pays' guidance in relation to the commissioning responsibility for section 117 aftercare services. The rationale for an amendment to the guidance focusses on the need:

- To facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area as specialist provision is not available locally. It should also increase commissioner motivation to maintain local services and help individuals stay in their local areas post discharge.
- To make it clearer around responsibilities and enable better service planning.
- To ensure continuity of care from the person's locality community team. Furthermore, the knowledge of and responsibility for the persons needs will remain with the responsible commissioner/CCG rather than be passed from commissioner to commissioner.

It is proposed that there will be no retrospective impact on existing s117 individuals.

12. How do we access the £15m capital funding and what is the prioritisation process?

The process will be through the existing capital business case and Project Initiation Document (PID) process via the four NHS England Regions. Bids should come through the host CCG commissioner of the TCP or individual CCG organisations and any funding agreed would be used to give grants to support the transforming care agenda. There will also be revised national principles/guidance, potentially including support for home ownership. Funding will be made available from 1st April 2016.

13. How are capital receipts considered in the capital arrangements?

Capital receipts will be managed at Region level. To enable the recycling of these funds, commissioners would use the existing capital business case and PID process (via Regions) which will contain some revised national principles/guidance for learning disability capital schemes.

14. What happens if there is a dispute amongst TCP partners on activity and financial plans?

As part of the assurance process, regional (and national) involvement can take place to understand the issue and propose next steps. We intend setting out national guidance on how this will be managed. TCP partners should be mindful of the principles and aims of the Transforming Care programme, which is focused around the development of person-centred services and whole system solutions, with the person and their family at the centre, rather than individual agencies, accountability and funding.

15. **Can you clarify the information governance (IG) issues that need to be considered in the transforming care work?**

There may be IG issues or complexity that TCPs may need help or guidance such as:

- The proposed sharing of funding with local authorities
- The linking of data sets for cost and activity analysis

It is likely that the transactions, budgeting and pooling required will prompt finance teams to seek personal data (who was treated, what were they treated for, what was the cost) to validate invoices, approve spend and manage budgets. This is a secondary use of healthcare data, complex (outside of the HSCIC) and will require local organisations to undertake significant work to discharge (fair processing, patient objection management, data analysis). Where organisations use non-identifiable data this will not be an issue but experience suggests that this requires work. This is particularly complex across health and local authorities due to different legal framework).

Please note: linking data across services to examine cost and activity requires considerable planning, work and governance. Organisations should seek the support of their local information governance resource, the input of their informatics teams and the latest guidance published by the Information Governance Alliance in order to enable appropriate information sharing. Details about the IGA Can be found at: http://systems.hscic.gov.uk/infogov/iga

16. Who can we contact for help with any further financial queries?

Financial queries should be emailed to: Tim.heneghan@nhs.net