Building the right support – Frequently Asked Questions (Finance)

Dated 21st September 2016

Publications Gateway Reference: 05698

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 has been 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 has set out full details of the prioritisation criteria to access these funds separately. However, the priority is based on the impact of bed closures in 2016/17 and using the value methodology in the individual TCP plans. Building on the process used with 6 fast track areas last year, it is proposed that investment will be focused on bids which show:

- Impact (what reduction in reliance on inpatient care will be achieved per pound spent in each year?).
- Credibility (are the proposals likely to lead to the impact envisaged?).
- Sustainability (are the proposals sustainable?) For example, from a return on investment perspective the proposal should “free up funds which can then be reinvested into community services, following upfront investment from the Transformation Fund and capital investment”.
- Buy-in (do the proposals have match-funding from local CCGs, either from 2016/17 or future years?)

TCPs have submitted bids for funding as part of the planning process. Regional teams have made recommendations for those bids that they consider:

- credible (i.e. where the investment proposed can credibly be seen as likely to lead to bed closures)
- Sustainable (i.e. where the reduced demand for inpatient services resulting from the investment is likely to be sustained, rather than re-emerging in future years).
- match-funded (i.e. where the proposals have match-funding from local CCGs, either from 2016/17 or future years)

NHS England have assessed those bids judged by regions to be credible and sustainable (i.e. with bids judged not credible/sustainable sifted out). The national team was seeking assurance that the proposed allocation achieves the desired total national bed closures; and that the resultant bed base maximises efficiency.

A first tranche of funding to TCPs (for 2016/17 only) was approved and notified in June 2016. However, TCPs will not be guaranteed to receive the total indicative budget. Following evaluation of proposals, NHS England may choose to award less funding than the total requested or phase the funding over the three years based on target delivery. It should also be noted that future year’s transformation funding is dependent on affordability by NHS England.

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, they may choose to include an element of children's services (social care or education) budgets and housing budgets. 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. **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.

Annex B provides data on specialised commissioning spend on people with a learning disability/autism in 2015/16, to support commissioners in cross-system discussions.

5. When will budgets be aligned?

The plan is to align budgets and undertake shadow reporting from July 2016, to enable delivery against TCP plans. NHS England will also work with a small number of TCPs to work through how these mechanisms will operate.

6. 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. Local commissioners will need to come to their own arrangements, depending on differing local circumstances. NHS England, the LGA and ADASS will support local areas to share learning.

7. 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 relevant TCP.

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

A Transforming Care dowry payment is defined differently from previous dowry payments.

The concept of a Transforming Care dowry is focussed on providing financial **support to the local authority for social care costs for eligible dowry patients**. Any agreed dowry amount will be passed to the local authority as a contribution to their costs. The local authority will use the dowry funds to pay for their element of a care package. It can be used to fund the local authority contribution to a S117 package.

Dowry eligibility and amount will be ascertained at the point of discharge from an inpatient bed and will be agreed locally. The dowry amount will be fixed at that point and will not increase during the course of the person's life. It may not be enough to cover the full costs of a person's social care package.

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.

A dowry is described as an annual amount, for the year starting 1st April and ending 31st March of the next year. Where a person moves out of hospital part way through the year, the dowry amount will be available for the person on a pro rata basis for the rest of that year. Similarly when a dowry is no longer required, for example, if a person passes away part way through a year, the dowry amount will be available for those months that it was required. It should be noted that hospital costs may not be releasable immediately at the time of discharge, so the implications of this need to be considered when agreeing the dowry.

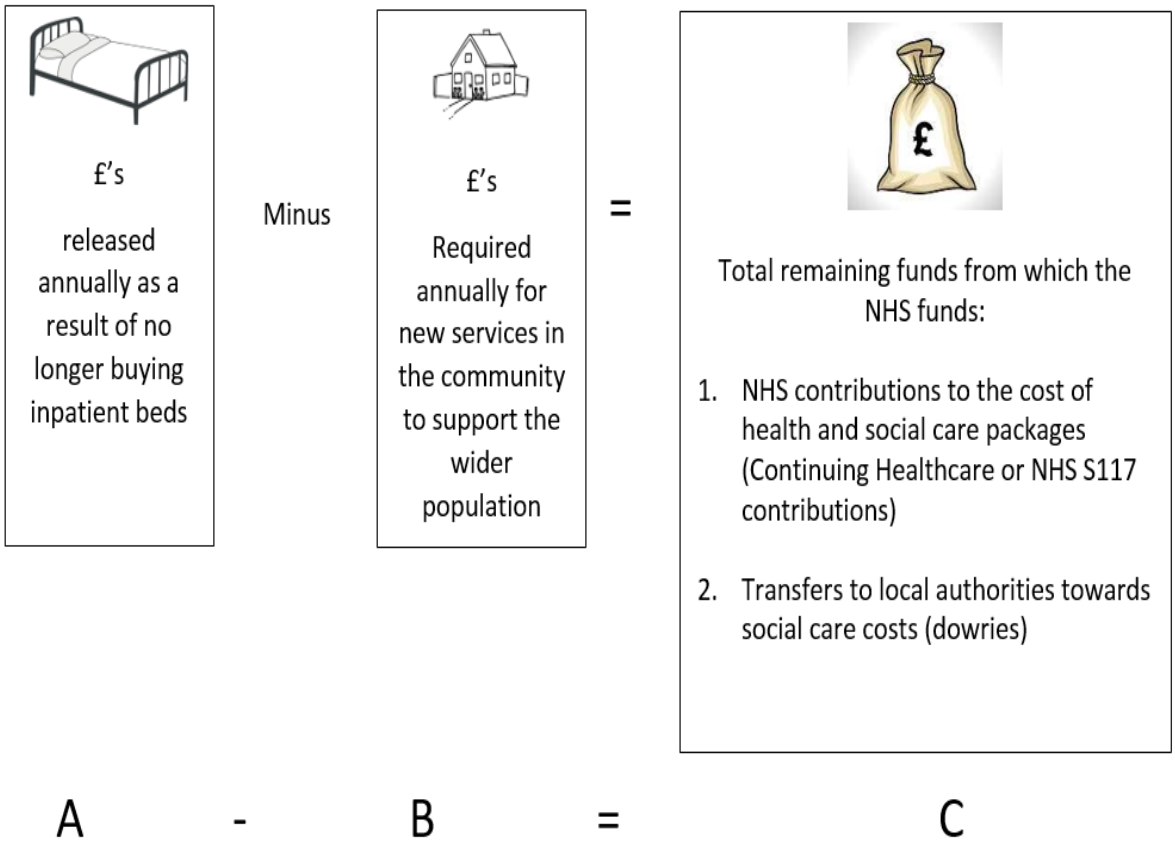
To ensure that the costs of the future model of care fit within the existing funding envelope, it is important that dowries are set at a level which is affordable locally. The absolute level of the dowry will not be set nationally. TCPs will need to establish what level of dowry is affordable locally.

Integrated Personal Commissioning (IPC) in which individuals can control their combined health and social care support is encouraged for dowry eligible individuals.

TCPs should maintain an up-to-date list of dowry-qualifying individuals. This should include and identify both individuals who have had their inpatient services commissioned by a CCG and those who have had their inpatient services commissioned by NHS England. The Finance and Activity spreadsheet template, submitted as an annex with the TCP plan included boxes to record the numbers for these cohorts as at 1/4/16.

Principles for calculating dowry amounts

BRS is clear that dowries must be affordable within local resources. The following diagram provides a visual representation of how the amounts available can be calculated:



Information on the Finance and Activity spreadsheet template, submitted as an annex with the TCP plan, identifies the total annual expenditure of the CCG partners, NHS England and local authority partners in 2015/16. This is categorised as follows:

- Section 1: Inpatient Provision and Utilisation: This section identifies the total amounts involved; this figure will need to be considered in the identification of how much it will be possible to release as patient's moves out of hospital.
- Section 2: Community Provision: This is split into costs relating to individual packages of support, and costs of services that cater for many individuals (that is, for the relevant learning disability and autism community)

Costs released from decommissioning hospital beds.

- TCP partners will need to consider strategically the total amount that can be released from decommissioning hospital beds.
- It will also be important to consider both the contractual basis of each commissioned bed, and when amounts will be releasable (that is, the schedule of planned discharge dates for each person).
- The profiling of the planned and actual cash flow will be important in understanding affordability at a given time.
- It is recognised that in some cases, costs will only be released once a number of patients have been discharged, for example, when a whole ward closes. This is why transformational funds (or existing resources where transformation funding is not available) are required to cover double-running costs.
- The actual amount released at the time of discharge of each patient will therefore vary. Partners should work together to ensure an agreed approach is developed for handling this situation, so that risk is shared and no organisation is unfairly disadvantaged. Whilst this is not only relevant to dowries, it is worth noting here, so that TCPs can understand the whole system risk.

Community Provision

- As described in the Finance and Activity spreadsheet template, Community Provision includes both the total amount spent on care packages for individuals and also the amount spent on services provided for the benefit of the whole learning disability and autism population.
- There may be some recurrent and non-recurrent development costs of new community services. This may include both revenue and capital. Non-recurrent revenue expenditure and capital expenditure should be kept **totally** separate from, and outside, the calculation of dowry amounts, which are recurrent costs.

Principles for managing the funding flows to cover the cost of care packages

- All people being discharged from an inpatient bed, regardless of whether they are eligible for a dowry or not, will require a package of care and support to enable them to live in the community. They will also need access to mainstream services and those provided to the whole learning disability and autism population.
- TCPs need to develop a clear understanding of the range of, and average, cost of care packages in their area for this group of people.
- TCPs should then apply the following principles:

a. Dowries are payable for the lifetime of the individual; on the death of an individual the local authority should inform health partners.
b. TCPs should agree what should happen with any dowry funds that are no longer required for that purpose. It may be agreed to add such funds into a pooled budget where one is in place.
c. It is expected that local authorities will commission the services to be funded by the dowry funding.

- Dowries will be paid to the local authority by the CCG of the dowry eligible individual. It may be held in a pooled/aligned budget dependent on local arrangements.

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

Interface between dowries and Continuing Healthcare/S117 funding

- Health funding may involve S117 or Continuing Healthcare funding.
- For an individual who is eligible for a dowry, if the person is discharged with the right to Mental Health Act S117 aftercare, it will be essential to ensure this right is honoured. The person must not be charged for social care aftercare services provided under S117. The Care Act is clear about the purpose of S117 aftercare services. A dowry would apply to any social care services which are provided as S117 aftercare services as well as non S117 social care services.
- The locally agreed policy on apportioning S117 costs should be applied. The local authority would be able to use the dowry funding to contribute to the social care element of a S117 package.
- If an adult is discharged from hospital with 100% continuing health care needs, they will not need to access dowry at that point. If they would otherwise have been eligible for a dowry, this should be noted.
- It is essential to work through the CHC/S117 and dowry interface on a case by case basis, in terms of the amount of dowry that should be allocated for each person. An adult will be subject to the local adult social care charging policy for any relevant elements of their care and support package.

Further questions on dowries

Question	Answer
Principle of dowries for life – what about those who have a period of crisis?	Emphasis should be on community capacity to deal with crisis (i.e. not a readmission). However, in a small number of cases a period of readmission may be necessary. They should not lose their dowry during the period of crisis. Where readmission to an in-patient service is necessary then a dowry should facilitate the funding of the in-patient package (depending on length of stay and the nature of the social care package). Local agreement should be put in place to ensure that funds flow around the system. Pooling of budgets may assist in this process.
What should happen if the health needs of a person who is funded through a dowry increase so that they have to be readmitted to an inpatient setting?	The time spent in an inpatient setting should be kept to a minimum. Whilst the person is in hospital, the dowry remains a local NHS resource to be used for the health and social care system. The person would retain the eligibility for the dowry but the resource could be utilised by the local system to fund all/element of the in-patient stay. If at some later point, the person's health improves so that they no longer need to be in an inpatient setting, their dowry will remain available to fund their social care.
What should happen if the health needs of a person who is funded through a dowry increase so that they become eligible for 100% Continuing Healthcare (CHC) funding?	If at any time the individual no longer requires dowry funding (in the short or long term) then the dowry remains a local NHS resource to be used for the health and social care system. If at some later point, the person's health improves so that they no longer need 100% CHC funding, their dowry will remain available to fund their social care.
What should happen for those people with a dowry who go into the prison system?	It should be assumed that funding would be utilised by the TCP (CCG/LA) to commission other LD services/packages as the dowry is no longer required for the period of the sentence. Dowry would be reinstated on release.

Question	Answer
Are there any issues attached to MOJ conditions where there may need to be a contingency element identified as part of conditional discharge arrangements?	Additional non-recurrent costs would need to be identified and considered in any final dowry sum agreed for an individual.
If needs increase, does dowry increase?	Dowry is a once only negotiated amount and would not go up or go down once set.
How will dowries work where there is no cost saving – i.e. where individual packages of care are very high?	Dowries are not specifically about a case by case approach but are part of the overall transformation process. Dowries are not about cost savings but about contributing to new spend on LD/autism community services catering for everyone and individual packages of support. It is assumed that the bed capacity for the 5 year plus cohort should be decommissioned. Where the new package is higher than what is releasable then there would be an additional contribution from the responsible commissioner/s.
What will happen to dowries on death of an individual?	On the death of the individual then the funding is no longer required for the original purpose. Therefore, dowry funding would cease and the funding would then be retained by the NHS commissioner to invest in other LD/autism services.

An example of how to calculate a dowry

Principles	Worked example
TCP partners will need to strategically calculate costs released from decommissioning of hospital beds by identifying the total number of people to be discharged over the next three years; this will establish indicative cost savings from discharges **To consider:** • *It will be important to consider when amounts will be releasable* • *Identify cohort eligible* • *Understand the split between those individuals commissioned by the CCG & those by Specialised Commissioned* • *Identify planned discharge dates* • *Understand the current in-patient costs for each individual (standard bed rate & any enhanced services provided).* • *Understand the contractual basis of the bed and the timing for the release of those funds.* • *Identify the total number of in-patients to discharge over the next three years to get to the national plan trajectories and establish indicative cost savings from discharge.*	10 beds in total being decommissioned. All patients are from the same TCP. Cost per bed is £180,000 per annum, so **£1.8 million releasable.**
TCPs will then need to factor in the provision of recurrent community infrastructure investment; this amount will need to be subtracted from the total sum of money as identified above. **To consider:** • *Consider and understand the overall investment in community services catering to many individuals by the CCG/Specialised Commissioners over the next three years.*	Community infrastructure investment £300,000 by CCG. **£1.5 million left from the releasable funds.** This is the amount available to fund CHC, NHS S117 contributions and dowries.
Of those people to be discharged, the TCP will need to identify those who are dowry eligible (ie over 5 years at 1/4/16) and those who are not (under 5 years at 1/4/16)	3 patients in a TCP are eligible for a dowry. 7 patients are not dowry eligible.
For those **non-dowry** eligible people, the TCP calculates what more it needs to spend on CHC and S117 contributions for those being	Of the 7 who are not eligible for a dowry:

Principles	Worked example
discharged based on the cost of the individual's package in the community (and on an understanding of local funding rules between LA and CCG.) Subtracting this amount provides an amount available to support dowry payments. **<u>To consider</u>**: • *Assess whether the individuals are to be discharged under S117/CHC/other basis.* • *Understand the local funding rules between LA/CCG (including the locally agreed S117 apportionment policy)*	• 4 patients are entitled to S117 services • 3 patients have been assessed as being eligible for CHC. Each person's package costs £150,000. For the 3 CHC non-dowry funded people the cost of the individual support packages are £450,000 (i.e,£150k x 3 people), which is payable by the CCG. The local policy is to split all S117 packages 50/50 between NHS and Local Authority. For the 4 non-dowry funded S117 people, the cost of the individual support packages are £600,000 (£150k x 4 people); this is £300,000 cost for the CCG and £300,000 cost for the local authority. TOTAL costs for the 7 non-dowry eligible people are therefore: • £750,000 for the CCG • £300,000 for the LA
Of the **dowry** eligible patients; the TCP again calculates spend on CHC and S117 contributions for those being discharged based on the cost of the individual's package in the community (and on an understanding local funding rules between LA and CCG.) **To consider:** • Dowry should be no more than the actual cost of the individual support package cost (incurred by the LA) at the	3 patients dowry eligible; 1 is discharged under CHC; 2 under S117. Each person's package costs £150,000. For the 1 CHC person the cost of the support package is £150,000, which is payable by the CCG.

Principles	Worked example
point of discharge. However, the actual value will be based on what can be released by the system and the level of investment that the TCP is committed to in terms of services catering to many individuals. This infrastructure investment is required to ensure that we manage admissions more appropriately and develop a preventative approach to services.	For the 2 patients discharged under s117 (split is 50/50), the cost of the individual support packages are £300,000 (£150k x 2 people); this is £150,000 cost for the CCG (£75k x 2 people) and £150,000 cost for the local authority (£75k x 2 people). TOTAL costs before the dowry calculation are therefore: • £300,000 CCG • £150,000 LA
The dowry amount for each individual which is transferable to the local authority each year (pro rata) can then be worked out based on affordability to the NHS as agreed in the TCP plan. .	£150,000 (£75k x 2 people) The local authority receives this in a transfer of dowry funding from the CCG and can use it to pay for the social care element of the S117 packages. In this example, of the total funds available from decommissioning beds (minus the amount available to fund CHC, NHS S117 and community infrastructure costs) there is enough to cover the full social-care costs of those dowry eligible individuals
Total re-investment by TCP remains at £1,800,000.	The whole system invests the total funds available from decommissioning the bed, but of the £1.8 million released, the CCG funds £1,200,000, as follows: • £750,000 on non-dowry eligible people

Principles	Worked example
	• £300,000 on dowry eligible people • £150,000 on dowry transfer to the local authority A further £300,000 is used to support development of community services. In total, this is £1.5 million. The CCG therefore has £300,000 remaining from its £1.8m, and is in a position to discuss with TCP partners how best to use these funds for the benefit of people with learning disabilities and/or autism. The LA invests £300,000 on the people who are not eligible for a dowry. In this example, the local authority does not need to spend any of its funds on those who are eligible for a dowry, as the dowry funding available is sufficient to cover the social care costs.

Further clarification questions on dowries (July 2016)

Qi: We want to set the amount of dowry that everyone will receive, so that we can plan ahead. How can we do this?

TCP partners will find it useful to estimate the dowry amounts that will be available in 17/18 and 18/19, to enable the setting of budgets required to fund services for individuals due to be discharged in future years. It will, however, only be possible to calculate the **actual** dowry amount available at the time of discharge.

Estimates of the dowry amounts available in future years will be based on assumptions about the amounts that will be releasable, the costs of services to be developed and the amounts that the NHS will be required to contribute to packages, before passing funds to the local authorities under dowry

arrangements. NHS financial obligations under Continuing Healthcare requirements or for Mental Health Act S117 aftercare services will need to be funded prior to the calculation of the actual dowry amount available, and these amounts are unlikely to be available until close to the time of discharge.

Qii: I don't understand how a dowry is combined with other types of funding. What combination of funding is possible?

Health funding for community packages will usually include continuing healthcare or S117 funding or both. Continuing Healthcare is often assumed to mean 100% NHS funded, but in some cases Continuing Healthcare funds are used to fund part of a jointly funded package, which may also involve funding from the local authority.

Broadly, the funding arrangements available for each individual being discharged from hospital will be as follows:

Type of Funding Arrangement:
a) Fully funded by a dowry
b) Dowry funded plus additional local authority funding
c) Dowry funded plus additional health funding
d) Dowry funded plus a combination of health and local authority funding
e) 100% Local authority funded (no dowry)
f) 100% Health funded
g) Jointly funded by health and local authority (no dowry).

Each TCP will need to discuss and agree how to handle situations where the needs of a person who is eligible for a dowry require a package that will cost more than the amount of dowry available. This discussion is likely to involve agreeing a mechanism for apportioning any costs that are not covered by the dowry. It is anticipated that the approach will be the same as that used for apportioning costs of a package for a person who is not eligible for a dowry. Once calculated, the actual dowry amount will not change in future years. For any additional costs that arise in the future, for example due to a change of needs or inflation, the TCP partners will need to agree how the costs will be apportioned.

Qiii: What happens to the available dowry funds if they are not required?

TCP partners may wish to agree what will happen to available funds when a dowry eligible patient requires less than the available dowry funding. If the

care package cost is less than the available dowry funding, the lesser value becomes the dowry amount for that individual and passed to the local authority. There is no obligation for the CCG to transfer the full dowry amount to the local authority. If there are available funds that are not required for dowry payments, the CCG may choose to contribute these to a pooled budget, if one exists, or may invest them in other services that benefit the wider learning disability and autism population.

Qiv: Can funds released from decommissioning hospital beds be used to fund non-recurrent costs of developing new services?

TCPs will need to consider the contribution of local funds from both health and the local authority towards both non-recurrent revenue costs of development as well as recurrent costs of any new community services. This contribution will:

- include any match-funding required to draw down the national transformation funding
- be over and above any transformation funding available from the national programme

Qv: Can the local authority charging policy be applied to services funded by a dowry?

The relevant local authority charging policy will need to be applied on a case by case basis. As dowries are transferred to the local authority, and used to fund the local authority (social care) element of the care package, it is anticipated that the local authority can apply their charging policy to care packages funded using dowries. TCPs may wish to discuss the local charging policies to ensure that partners understand the policies that apply.

9. 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.

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

As stated in paragraph 4.46 of BRS, we have revised 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 confirmed that there will be no retrospective impact on existing s117 individuals.

Revised NHS England guidance on section 117 can be found in Annex A. The regulations underpinning this guidance have also been revised to the same end.

11. 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.

In 2016/17, funding of £20 million has been made available at an NHS England Region level to the programme.

12. 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.

13. 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.

14. **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 frameworks).

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

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

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

Annex A

‘Who Pays’ amendment to the section on ‘persons detained under the Mental Health Act 1983’

1. Paragraphs 33 and 34 of the August 2013 ‘Who Pays’ document have been replaced by the following sections *(in italics below)* effective from 1st April 2016.

> ‘’*If a person is detained for treatment under the Mental Health Act 1983, the responsible commissioner will be as set out in paragraph 1 of the ‘who pays’ guidance. Every effort should be made to determine GP practice registration or establish an address where they are usually resident, but if this fails and the patient refuses to assist, then as a last resort the responsible commissioner should be determined by the location of the unit providing treatment.*
>
> *It is the duty of both the CCG and the appropriate local authority to commission after-care services for those persons discharged from hospital following detention under one of the relevant sections of the Mental Health Act. The responsible CCG should be established by the usual means (see paragraph 1) for their typical secondary healthcare. However, if a patient who is resident in one area (CCG A) is discharged to another area (CCG B), it is then the responsibility of the CCG in the area where the patient moves (CCG B) to jointly work with CCG A, who will retain the responsibility to pay for their aftercare under section 117 of the Act as agreed with the appropriate local authority. The purpose of this is to ensure that the person has access to local clinical support and advice in the area they will be moving to (CCG B), whilst remaining the commissioning responsibility of the original CCG (CCG A).*
>
> *If a detained person who has been discharged, and is in receipt of services provided under section 117 of the Mental Health Act, is subsequently readmitted or recalled to hospital for assessment or treatment of their mental disorder, the responsible CCG will continue to be the CCG that is currently responsible for funding the aftercare under section 117 (except where the admission is into specialised commissioned services).*
>
> *If a detained person who was registered with a GP in one area (CCG A) is discharged to another area (CCG B) and is in receipt of services provided under section 117 of the Mental Health Act) is subsequently readmitted or recalled to hospital for assessment or treatment of their mental disorder, it is the responsibility of CCG A to arrange and fund the admission to hospital (except where the admission is into specialised commissioned services). Furthermore, the originating CCG (CCG A) would remain responsible for the NHS contribution to their subsequent aftercare under S117 MHA, even where the person changes their GP practice (and associated CCG).*
>
> *The table below should provide a useful distinction of the changing commissioner responsibilities for patients discharged under section 117.*

• *Patients discharged pre 1 April 2013 come under the pre August 2013 PCT Who Pays Guidance and the legacy/originating CCG continues to be responsible for subsequent compulsory admissions under the MHA, and current and subsequent S117 services until such time as they are assessed to no longer need these services.*
• *Patients discharged between 1 April 2013 and 31 March 2016 fall under August 2013 Who Pays Guidance –CCG B would be responsible if a patient is discharged into a location in CCG B and registers with a GP in CCG B.*
• *New revised guidance from 1 April 2016 will revert back to the pre 1 April 2013 position where the legacy/originating CCG continues to be responsible in most cases."*

Annex B

Alignment of NHS England specialised commissioning budgets for people with a learning disability and/or autism with Transforming Care Partnerships (TCPs)

Methodology:

All patients who appeared in the Secure Mental Health (SMH) dataset (the dataset used by NHS England to monitor activity and spend in the secure mental health services it commissions) in 2015/16, who also appear in Assuring Transformation in 2015/16, have been 'flagged' as patients in scope.

For each of these patients, date of admission, date of discharge, patient type, provider, commissioner and patient origin (from which TCP can be determined) are recorded in the SMH. As hub and TCP of origin can be determined for each patient, it is possible to re-align OBDs and related costs from a provider perspective to a patient population (origin) perspective for each patient.

The rate used to calculate costs for each patient is based on the baseline contract OBD rate in £ (2015/16) for the relevant provider (proxy rates have been used for certain types of contract, such as block contracts).

Secure Inpatient Services by Origin – 2015/16

Note: Adults Only, patient numbers as at 31st March 2016, cost based upon occupied bed days (OBD) during 2015/16

Hub & TCP of Origin 2015/16	OBD	Cost £000	Cost £ per OBD
Bedford, Luton & Milton Keynes	2,058	1,052	511
Derbyshire	10,658	5,373	504
Leicestershire	7,284	3,874	532
Lincolnshire	6,345	3,390	534
Northamptonshire	5,854	3,037	519
Nottinghamshire	18,099	8,800	486
East Midlands	**50,298**	**25,526**	**507**
Bedford, Luton & Milton Keynes	2,729	1,482	543
Cambridge & Peterborough	4,499	2,682	596
Essex	10,967	5,800	529
Hertfordshire	9,310	4,506	484
Norfolk	7,364	3,864	525
Suffolk	5,321	3,139	590
East of England	**40,190**	**21,473**	**534**
Inner North East London	7,213	3,624	502
London North West	12,078	6,162	510
London South East	11,812	6,112	517
London South West	10,618	5,408	509
North Central London	16,012	7,640	477
Outer North East London	3,697	1,873	507
London	**61,430**	**30,819**	**502**
Cumbria & North East	48,745	23,214	476
North East	**48,745**	**23,214**	**476**
Cheshire & Merseyside	21,662	10,750	496
Greater Manchester	28,068	12,647	451
Lancashire	24,251	11,399	470
North West	**73,981**	**34,796**	**470**
Berkshire	4,900	2,605	532
Buckinghamshire	1,830	908	496
Dorset	2,142	1,047	489
Hampshire & Isle of Wight	15,422	8,293	538
Oxfordshire	4,993	2,516	504
South Central	**29,287**	**15,369**	**525**
Kent & Medway	20,209	11,466	567
Surrey	3,407	2,221	652
Sussex	13,011	7,448	572
South East Coast	**36,627**	**21,135**	**577**

Bristol, Bane, South Gloucester	9,300	4,884	525
Cornwall	2,577	1,367	530
Devon	6,358	3,320	522
Gloucester	5,136	2,646	515
Somerset	2,106	1,060	503
Wiltshire & Swindon	2,249	1,164	518
South West	**27,726**	**14,441**	**521**
Birmingham	14,893	7,786	523
Black Country	21,347	11,840	555
Coventry, Rugby, Warwick	12,802	6,848	535
Hereford	991	524	529
Shropshire	8,214	4,671	569
South Worcester, Redditch, Bromsgrove & Wyre Forest	5,650	3,034	537
Staffordshire	12,538	6,550	522
West Midlands	**76,435**	**41,253**	**540**
Calderdale, Kirklees, Wakefield & Barnsley	10,188	5,054	496
Bradford	5,143	2,439	474
East Riding & Hull	10,130	4,611	455
Leeds	10,685	5,157	483
North Yorkshire	6,780	3,253	480
Nottinghamshire	1,177	613	521
Sheffield, Doncaster, Rotherham & North Lincolnshire	14,181	6,750	476
Yorkshire & Humber	**58,284**	**27,877**	**478**
Non English patients	872	494	567
Non English	**872**	**494**	**567**
TOTAL	**503,875**	**256,397**	**509**