November 2014

Winterbourne View & Social Investment

resonance

Contents

Resonance

Resonance is a social impact investment company with over a decade of experience helping social enterprises prepare for and raise capital from investors who value both their impact ambition and business model. The investment enables the enterprises to expand their social impact in a sustainable way. We have two teams that work together to achieve this:

Ventures – We support individual social enterprises to develop their business growth and financial strategies, to ensure they are in the best position to approach suitable investors who can really help their businesses grow. Resonance helps them approach investors and arrange finance from them.

Fund Management – We currently have over £40m under management through three impact investment funds. We developed the funds specifically from our work with social enterprises to address gaps in the social investment market. These funds provide investors with the opportunity to access good financial returns from projects generating significant social and community impact, and a way for social enterprises to tap into a pool of capital from investors that share their values.

Resonance has been commissioned to write this report by the Social Investment Business and Big Society Capital as part of Sir Stephen Bubb's committee established to develop a third sector solution to the "Winterbourne View" problem.

1. Executive Summary and Recommendations

1.1 What is the Problem?

The "Winterbourne View" problem has been defined by the c. 3,250 people with Learning Disabilities around the country who are residing in inpatient facilities where personal, health system and societal outcomes are very poor. Five hundred people have been in these institutions for over ten years, and 60% for over one year. It costs around £600m each year for people to remain in these institutions. Numbers are rising, and it appears that there are complex and entrenched barriers to individuals moving back into alternative housing and supported provision in community settings, which would be better for the individual and could also, over time, cost less.

1.2 How is the Third Sector Helping?

The third sector has a strong expertise in this area and a plurality of providers working hard to help individuals into better situations. It is developing person-centred solutions and offering a number of different models, allowing individuals and their families the choice to find the right solution for them. But there is an urgent need for more to be done in this area, and a sense that if concerted action was taken between Government and the third sector, then a step change could be made in addressing this problem.

1.3 Why this Report?

There is already much excellent work underway across the sector to address these issues. This report focuses on whether social investment may be able to play a significant role as part of a third sector solution; what exactly that role might be, and how to take it forward.

1.4 What Does the Third Sector Need in Order to do More?

Based on discussions with a significant number of leading third sector providers in this area, we believe that the main direct need is for capital in three areas. Firstly, and most importantly, working capital to scale up staffing and cover the costs of transitioning individuals and adapting property. Secondly, if there is a significant step change in provision, the availability of capital for property on a flexible basis. Thirdly, to underpin this, investment in wider sector infrastructure, particularly in the training of specialist staff and building up of in-area teams who can deal with emergency provision and prevent initial admissions.

1.5 What Are We Recommending as Action?

1.5.1 Key Recommendation

Government should commit at least £30m to a 'Life in the Community' Social Investment Fund. This should be composed of two linked social investment vehicles: £10m to seed a £30m 'Payment for Outcomes' Fund, financing the transition costs out of inpatient facilities; £10m to seed a linked Social Property Fund which could provide up to £200m of flexible leased property as numbers of people moving out of inpatient facilities accelerates; the final £10m should be used for strengthening sector infrastructure as outlined further below.

1.5.2 Core Rationale

This recommendation most directly meets the needs of third sector providers to significantly scale up their activities to these individuals. It encourages best practice commissioning and provides the capital needed to allow a plurality of providers to respond to individual need. Government seed investment / support is needed to kick-start this, providing leadership, confidence to investors and sector stakeholders and an acceleration of timelines. Ultimately this should unlock over £200m of additional capital for the sector, deliver savings of a significant proportion of the annual £600m spend in this area and, most importantly, lead to the numbers of people in inpatient facilities reducing by in excess of 2000 over a

3-4 year period. Better commissioning alone might in itself reduce net inflows to inpatient facilities but, without this investment impetus, constraints on providers will continue to imply thousands of individuals remaining in this situation for decades to come, and the likelihood of future "Winterbourne View" scenarios recurring.

1.6 'Payment for Outcomes' Fund

1.6.1 A 'Payment for Outcomes' Fund would simultaneously fund the transitional costs (including property adaptation) and build the capacity of the voluntary sector to ramp up the successful models of support for people who have exhibited challenging behaviour. Initial rough estimates suggest this should enable providers to double their annual capacity from 150 pa to 300 pa individuals moving out of inpatient facilities.

1.6.2 A 'Payment for Outcomes' Fund is a particularly good investment vehicle for tackling entrenched problems. Subject to further analysis of the cohort of individuals involved, it therefore seems likely that the focus should be, in the first instance, on the 2,000 people who have been an inpatient for more than 12 months; starting with the over 500 who have been an inpatient for more than 5 years.

1.6.3 NHS England as the largest of the commissioners of inpatient care in these facilities should immediately apply to the Commissioning Better Outcomes Fund to establish a 'Payment for Outcome' Fund that will raise circa £30m to finance the transitional costs (including property adaptation) of moving from an inpatient setting into supported living. NHS England and/or Department of Health should also allocate £10m of capital as seed investment for this fund and to attract an initial further £20m social investment.

1.6.4 Key Local Commissioners can then join in encouraged by both the 'carrot' of 20% of outcomes funding from the Lottery/Cabinet Office as well as the 'stick' of regulatory pressure. The top few Local Areas from where the largest percentage of inpatients are resident, would appear to be a sensible group with which to start.

1.6.5 NHS England needs to use all its available resources to demonstrate leadership to coalesce a critical mass of local commissioners to support such an intervention.

1.6.6 One potential idea to galvanise action would be for NHS England, Local Authorities and CCGs to agree to move people out of inpatient units into supported living without an initial change of commissioner or fee. The reason for this is that one of the biggest barriers to people moving out of inpatient facilities is the requirement to negotiate new fees or change commissioners. If this negotiation could be delayed for even 3 months post transfer, with the provider receiving the same fee for this period as would apply in an inpatient setting, then this would remove this barrier completely. At this point it would be clearer which commissioner(s) should now pay and what the true cost of the on-going support package would be.

1.7 Linked 'Social Property' Fund

1.7.1 Capital for housing is not currently perceived to be the most immediate bottle-neck, but if 2,000 people are to be moved within the next 3-4 years, we estimate a property fund of up to £200m (initially £50m) is needed to provide additional property that can be leased to specialist housing providers.

1.7.2 There are many different ways to introduce capital for property, but a specialist Social Property Fund that leases on standardized but flexible terms to existing providers is the only mechanism that is both accessible to all sizes and strengths of organization without requiring any subsidy.

1.7.3 NHS England and/or Department of Health should allocate £10m of capital as seed investment for the fund and to attract an initial further £10m social investment growing with demand to £200m.

1.8 Immediate Pilot Activities

1.8.1 These investment structures will take time to set up, but there are a few things that can happen immediately. A new Community Interest Company (or other appropriate vehicle) could be set up, as an asset locked vehicle to both ring-fence immediate Government funding for the proposed investment vehicle and also to serve as the legacy vehicle for receiving funds from the sale of the public sector inpatient units that are ultimately anticipated as a result of this work.

1.8.2 Additionally, either through this Community Interest Company, or directly we believe that a further £10m should be allocated to further strengthening of the wider sector infrastructure, including as priorities:

a) Pump priming a new Positive Behaviour Support Academy dedicated to training the anticipated 4,000 new support staff needed to support the 2,000 people moving out of inpatient facilities over the next 3-4 years.

b) Piloting customized adaptations for existing housing providers housing people moving out of inpatient facilities in the next 12 months, prior to a 'Payment for Outcomes' Fund being available for this element.

c) Funding some immediate advocacy and brokerage activity and to further train individuals, sharing best practice and begin to build capacity and acceptance of this essential function within existing and new organizations. These early activities will inform the pricing and running costs of a 'Payment for Outcomes' Fund, which is essential in building investor and commissioner confidence alike.

1.9 Wider Sector Commitments

1.9.1 Investment is not going to be enough on its own - the culture and practice of commissioning services for adults with learning disabilities will need to change. Mostly this is about the poorer performing commissioners learning from the better ones but, as a very basic starting point, all Local Authorities and CCGs should pool their Learning Disability budgets. This doesn't fix anything in itself but it provides the context for improvement. Where commissioners have done this, this has resulted in markedly lower numbers of people with Learning Disabilities living as inpatients.

1.9.2 If a supported living model is to be successful there are two key additional commitments needed from Government. These are:

a) A commitment to the sustainable funding of Local Infrastructure – particularly local assessment and treatment teams who can provide local support to individuals in the event of crisis events, with the aim of preventing the need for referral to out-of-area assessment and treatment units.

b) A commitment to prioritize early intervention for families with children with learning disabilities including better educational provision and in particular data available to providers that enables them to connect with young people and their families leaving school. We will never fix the "Winterbourne View" problem if we don't invest in children and young peoples services.

1.10 Additional Measures

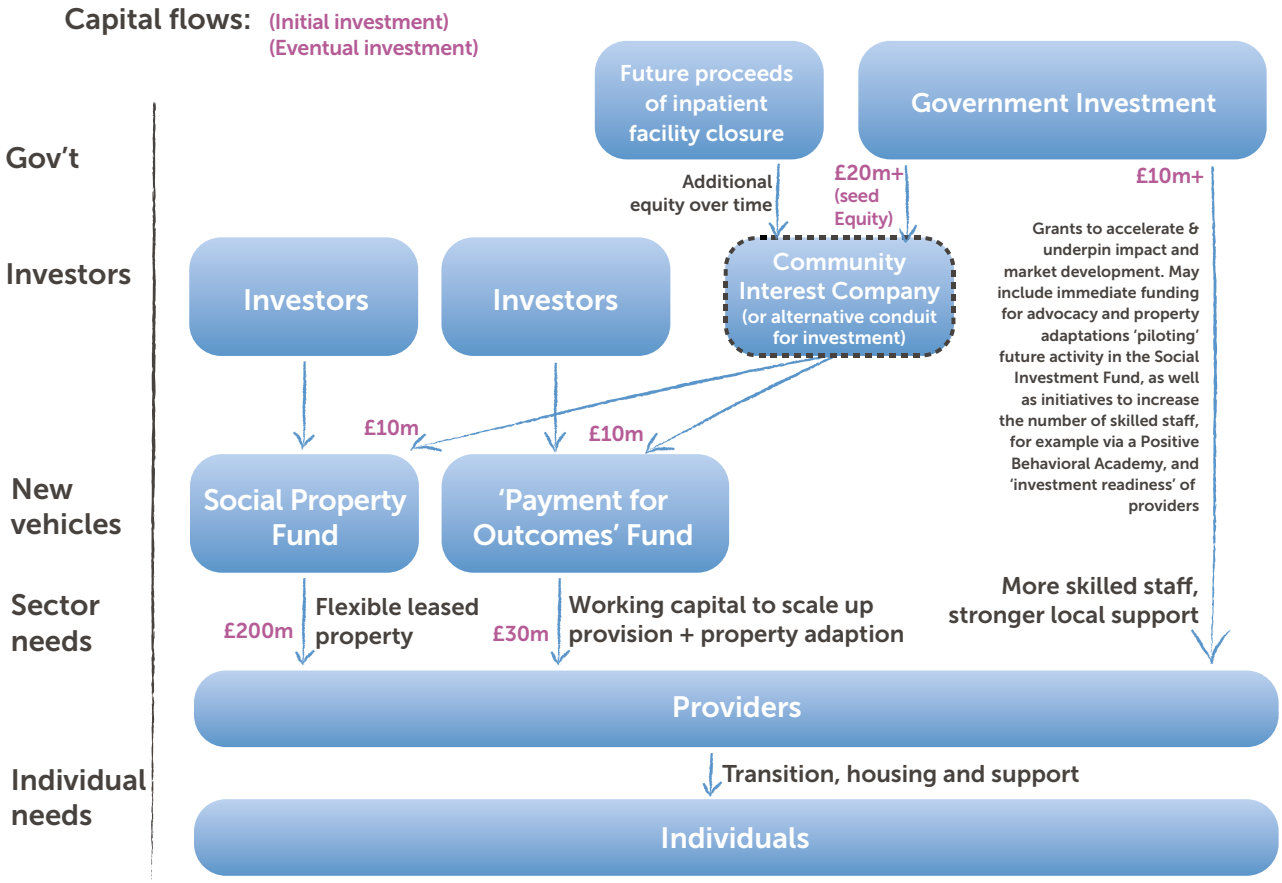
1.10.1 NHS England, Local Authorities and CCGs should cease making block purchases for bed spaces in inpatient units since block purchasing incentivizes a commissioner to fill their allocation as soon as possible, rather than to prioritise the right solution for the individual.

1.10.2 Local Authorities should agree to paying enhanced LHA rates to all charitable housing providers housing adults with Learning Disabilities - LHA rates have been consistently reduced and whilst some Housing Associations can access an enhanced LHA rate, and all providers can negotiate with Local Authorities for exempt or excluded housing benefit, this is an adversarial system that has encouraged both slow and poor decision making.

1.11 Putting It All Together

Our overall recommendations are shown below in summary, showing how initial investments would lead to much larger eventual capital flows into the main areas of sector need.

'Life in the Community' Social Investment Fund



1.12 Summary of Key Conclusions from Sections of this Report

Question	Key Conclusions
Why has this report been written?	The "Winterbourne View" problem has been defined by the c.3,250 people with Learning Disabilities around the country who are residing in inpatient facilities where personal, health system and societal outcomes are often very poor. This report focuses on whether social investment may be able to play a significant role as part of a third sector solution, what exactly that role might be, and how to take it forward.
What are the best and most viable outcomes for residents (both housing and support)?	There are 3250 people with learning disabilities living in inpatient facilities in the UK, 60% of whom have been doing so for more than one year. Through discussions with experienced sector practitioners, we have identified numerous barriers that prevent and delay the discharge of individuals from such facilities, a process which has proved to be fraught with inefficiencies, misperceptions and disincentives which work against the discharge process. In addition, there are numerous routes through which individuals have been (and continue to be) inappropriately admitted into inpatient facilities, often due to a lack of community provision or a lack of understanding of the individual's needs. Even if admitted for non-mental health reasons, individuals appear to become 'stuck'. Not only are they faced with multiple barriers to discharge but, for some, the negative effects of the inpatient environment begins a vicious cycle of increasingly challenging behaviour, and increasingly unlikely discharge. In order to deliver the best possible outcomes for individuals, interventions in this process should ensure 8 key principles: choice; strong, skilled advocacy; thorough assessment of needs; progression and development of positive behaviour; community integration; preference for Supported Living; consistency of provision; and resilience against future admissions into inpatient facilities.
What are the most effective business or operational third sector models, which can be scaled?	**Key Conclusions Relating to Property Provision** a) There needs to be variety, ideally based on the provision of a home with support (Supported Living) rather than a registered care facility. At the same time, there needs to be some tolerance of registered care where this is delivered as if it is the resident's home. b) Cost of housing ranges from £100k to £300k per unit depending primarily on land costs and how 'robust' the property needs to be. c) Having a number of units close to one another: benefits the individual being supported by having a likely provision of social interaction; generates the benefits of a flexible staffing model, especially if some more experienced staff are close at hand; and, of course, makes the property management function more efficient. d) Whilst there is a limited need for new housing provision at the current rates of transition out of inpatient facilities, capital and leadership on ramping up the property provision is going to be increasingly required with an initial fund of £50m required immediately. **Key Conclusions Relating to Managing the Transition** a) New capacity is required to provide advocacy and brokerage to individuals who have been independently identified as ready to move out of an inpatient facility. b) Mobilisation advances to Support Providers are required to prepare a service (including customising or otherwise commissioning a property), as commissioners do not generally have access to this 'double funding'. c) One idea to galvanise action would be if an individual moved back into the community before having the debate about pricing or who should be paying for the individual's care, allowing them to settle in their new home for 3-6 months and their needs to be appropriately assessed within the community.

Question	Key Conclusions
continued... **What are the most effective business or operational third sector models, which can be scaled?**	d) The medium term savings, even over a relatively short period of 12-18 months, should be more than enough to justify the transition costs associated with such an arrangement. e) Commissioners will have to move away from block purchasing beds in inpatient facilities if they are going to realize savings, otherwise they will continue to be incentivized to fill a bed space that has been vacated by an individual moving out of an inpatient facility. f) To accelerate the transition of individuals out of inpatient facilities, the supported housing sector will need approximately £30m of upfront investment.
What are the options for social investment or forms of capital to help finance the scale-up of third sector responses?	There are a very wide range of possible forms that social investment can take, and we have attempted to review the main possibilities under four groupings: 1) Pooled funding arrangements providing leased housing to providers, 2) Pooled funding arrangements providing flexible lending to providers, 3) Direct investment arrangements, 4) Revenue funding arrangements. These sit on a continuum between forms that are better suited for providing large scale property asset financing and forms which provide working capital to grow service provision. Our view is that a "hybrid" approach is likely to be necessary, which combines the best elements of more than one form whilst retaining sufficient focus to represent a deliverable solution around which action can be taken.
What criteria should be used in assessing these options?	Given the complexity of this issue and the number of stakeholders involved there are a very large number of views and interests that need to be taken into account. It is inevitable that not everyone will agree either on the subset of criteria focused on, or the priority and weighting given to them. We have tried to group the main criteria under four headings, which should hopefully all be recognized as important to delivering a preferred option, namely that it: 1) Meets the needs of the sector to help individuals, 2) Makes best use of Government support, 3) Fits with reasonable investor requirements, 4) Can be practically delivered.
Based on the criteria, what is the preferred option? **How might the preferred option change if current commissioning arrangements changed?**	Based on the criteria, we recommend a hybrid approach which uses investment structures in a complementary way: 1) A 'Payment for Outcomes' Fund to provide working capital funding to providers in order to scale up projects and staffing teams and fund property adaptations, ultimately funded by longer term savings to health budgets, and financed by social investment. 2) A linked Social Property Fund to help providers respond to increased property needs if provision was significantly scaled, providing a more standardized leased housing option across the sector, promoting plurality of providers and localized housing / support choices for individuals, and acting as a focus and catalyst for action. Whilst the two structures could, in principle, be developed independently, and one could exist without the other, in practice we believe there are strong reasons to develop the two in a coordinated and complementary way. Government seed investment / support is needed to kick-start this, providing leadership, confidence to investors and sector stakeholders and an acceleration of timelines. Better commissioning alone might in itself reduce net inflows to inpatient facilities but, without this investment impetus, constraints on providers will continue to imply thousands of individuals remaining in this situation for decades to come, and the likelihood of future "Winterbourne View" scenarios recurring.
What could the next steps be to implement the preferred option(s)?	There are some "quick wins" that can be achieved and, if possible, some resource should be released immediately to pilot parts of the strategy that will enable the fine tuning of operational relationships. We therefore propose that a new Community Interest Company (CIC) is set up with a £20m equity investment from NHS England and/or Department of Health. The purpose of this entity would be to channel existing capital funds available now and also in the future, when capital is released if some public sector run inpatient facilities are ultimately closed. These funds would be deployed by the CIC into a variety of capital projects that relate to increasing the capacity of supported living in the community, including the two funds recommended in this report as well as some of the capital elements of the wider sector infrastructure needed. A further £10m of Government funding should be used for strengthening sector infrastructure as outlined further in this report.

2. Background

Key Question:

Why has this report been written?

Key Conclusions:

The "Winterbourne View" problem has been defined by the c. 3,250 people with Learning Disabilities around the country who are residing in inpatient facilities, where personal, health system and societal outcomes are often very poor. This report focuses on whether social investment may be able to play a significant role as part of a third sector solution, what exactly that role might be, and how to take it forward.

2.1 Context to the Report

Resonance has been commissioned on a competitive basis to produce this research by the Social Investment Business and Big Society Capital.

This is not a new issue and there are a number of major initiatives already underway seeking to address the problem, as well as broader related questions in the provision of housing and support to individuals with Learning Disability.

The report is being provided initially to a committee established by the CEO of the NHS, Simon Stevens, and chaired by Sir Stephen Bubb, to develop a third sector solution to the "Winterbourne View" problem, with a focus on alternative housing and support provision in community settings.

The report has been produced according to a detailed brief for research, but on a very compressed timetable of 6 weeks. For this reason, it has sought to focus on potential solutions, through dialogue with experienced sector practitioners and provider organizations, rather than provide a comprehensive survey of all available data. Due to timing constraints it has not been possible to organize focus groups for this report involving families and individuals with Learning Disability, which is something we would have liked to do, and will be an essential part of the next steps. Resonance does however have direct experience of working with individuals with Learning Disability and their families. The organizations with whom we have interacted are listed in Appendix 4.

Resonance is a UK focused social investment company, with over a decade of experience working with social enterprises to raise investment. We create and deliver solutions, but also conduct research when we believe it can result in positive action. We take a "solution neutral" approach to assignments, being led by the capital needs of good social enterprise, which is, in turn, demonstrably meeting individuals' needs.

2.2 Structure of the Report

In order to reach recommendations, we have been asked to report on six key questions, which are dealt with in the sections which follow:

Section 3: What are the best and most viable outcomes for residents (both housing and support)?

Section 4: What are the most effective business or operational third sector models, which can be scaled?

Section 5: What are the options for social investment or forms of capital to help finance the scale up of third sector responses?

Section 6: What criteria should be used in assessing these options?

Section 7: Based on the criteria, what is the preferred option?
How might the preferred option change if current commissioning arrangements changed?

Section 8: What could the next steps be to implement the preferred option(s)?

3. Pathways for Individuals

3.1 Key Conclusions

There are c. 3250 people with learning disabilities living in inpatient facilities in the UK, 60% of whom have been doing so for more than one year. Through discussions with experienced sector practitioners, we have identified numerous barriers that prevent and delay the discharge of individuals from such facilities, a process that has proved to be fraught with inefficiencies, misperceptions and disincentives working against the discharge process.

In addition, there are numerous routes through which individuals have been (and continue to be) inappropriately admitted into inpatient facilities, often due to a lack of community provision or a lack of understanding of the individual's needs. Even if admitted for non-mental health reasons, individuals appear to become 'stuck'. Not only are they faced with multiple barriers to discharge, but for some, the negative effects of the inpatient environment begins a vicious cycle of increasingly challenging behaviour, and increasingly unlikely discharge.

In order to deliver the best possible outcomes for individuals, interventions in this process should ensure 8 key principles: choice; strong, skilled advocacy; thorough assessment of needs; progression and development of positive behaviour; community integration; preference for Supported Living; consistency of provision; and resilience against future admissions into inpatient facilities.

3.2 Introduction

This section focuses on the c. 3250 individuals with learning disabilities that are currently resident in inpatient facilities in the UK. Findings in this section draw on:

- Discussions with 25 housing and support providers and key stakeholders working in this sector;
- 30 responses to an online survey from housing and support providers;
- The Learning Disabilities Census of inpatient facilities;
- Data available on inpatient services commissioned by NHS England.

This has enabled us to consider the pathway of an individual as they transition from the community to an inpatient facility, and hopefully, back 'home' - something we essentially consider to be akin to a process of 'moving house' for an individual with learning disabilities. This section asks:

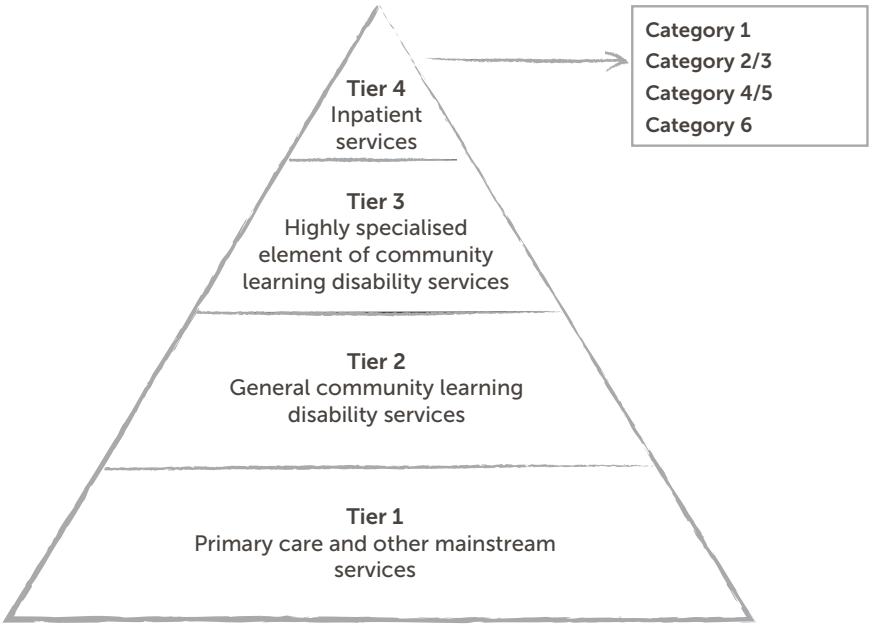
- What does 'home' now look like for individuals living in inpatient facilities?
- Why did people move there in the first place, and why are people still moving there? Is this always necessary?
- What barriers prevent people from moving back to the community?

3.3 Inpatient Facilities for People with Learning Disabilities

3.3.1 What is an ATU?

An Assessment and Treatment Unit (ATU) is a type of inpatient facility that provides specialist assessment and treatment for people with severe complex needs that cannot be managed within a community setting. ATUs are intended to support individuals for short periods of time if they have exhibited challenging behaviour that puts either themselves or others at major risk, or people who develop mental health problems that cannot be dealt with by community based psychiatric services.

The Royal College of Psychiatrists[1] present inpatient facilities as the 'top tier' of specialist learning disability service provision, within which there are six different types of inpatient beds:



These six categories of inpatient beds highlight the crucial point that the group of people currently resident in inpatient facilities are by no means homogenous – so using the term 'ATU' can often be unhelpful. This is why this report refers to 'inpatient facilities' instead. The 6 categories of inpatient beds are as follows:

Category 1: High, medium and low secure forensic beds. Both clinical decision making and the assessment of individuals within the Criminal Justice System will dictate whether a person is classified as a 'forensic patient'.

Category 2: Acute admission beds within specialized learning disability units. The intention is that these settings are adapted in a way that make them more suitable for people with learning disabilities, so that, in theory, such individuals can achieve the same outcomes as someone with the same mental disorder, but without a learning disability.

Category 3: Acute admission beds within generic mental health settings.

Category 4: Forensic rehabilitation beds where treatment is less restrictive than in Category 1. These beds are available for people that have transitioned from higher security forensic units, but are deemed to require on-going supervision due to a continued risk to themselves and others.

Category 5: Complex continuing care and rehabilitation beds. These types of beds are made available for people who are assessed as "not responding adequately to initial acute assessment and treatment". Thus, despite receiving the initial intended treatment, the individual is not deemed ready for discharge by clinicians, and cannot transition back into the community.

Category 6: Other beds including those for specialist neuropsychiatric conditions (such as epilepsy and movement disorders).

[1]People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services, Faculty Report, Royal College of Psychiatrists, July 2013.

3.3.2 What is the Size of the Issue?

The most recent Learning Disabilities Census suggests that there are currently c. 3250 people with learning disabilities, autistic spectrum disorder and/or behaviour that challenges[2] who are resident in an inpatient facility. This group of 3250 individuals are based in 104 different facilities: 58 of these were NHS providers and 46 of these were independent providers.

We thus know that there are over 100 inpatient facilities that currently house this cohort of people with some form of learning disability or who have exhibited challenging behaviour, but not all of these are classified as ATUs. Some inpatient facilities are classified as "Secure Units", but the boundaries between the two are often blurred with many residents in ATUs being detained under the Mental Health Act. Indeed in some ATUs, all residents are detained under the Mental Health Act[3]. This blurring of definitions within 'inpatient' facilities means there is a real lack of consistency in data provision on this topic.

3.3.3 What Kind of Needs are Being Addressed?

a) Types of Beds

76% of the people in this cohort are resident in wards that predominantly provide services for people with learning disability. 20% are inpatients in mental health wards. The remainder (4%) of this cohort are resident in wards that predominantly provide another type of service.

The cohort can by no means be classified as residing in a 'Category 2' type environment. Indeed the individuals within this 3250 person cohort were found to be based across the whole range of six categories, ranging from secure forensic wards to those for specialist neuropsychiatric conditions.

In terms of the security level of the relevant wards:

- 45% of people are classified as inpatients in general (i.e. non secure wards);
- 37% of people are resident in low security wards;
- 16% are resident in medium security wards;
- 2% are resident in high security wards.

b) Legal Status of Individuals

The majority of this group of individuals are subject to the Mental Health Act:

- 78%, (2536 people) are subject to the Mental Health Act, whilst 22% (714 people) are classed as 'informal patients';
- 45% (1445 people) are detained under Part II of the Act;
- 32% (1042 people) are detained under Part III of the Act (mostly where some kind of crime has occurred).

It is not the case that individuals who are detained under the Mental Health Act are those currently resident in secure beds. Though this is the case for 49% of individuals, 51% reside in non-secure beds. Moreover, 15% of 'informal patients' are currently resident in secure beds. A summary of service users by legal status and ward setting is provided in Appendix 1A.

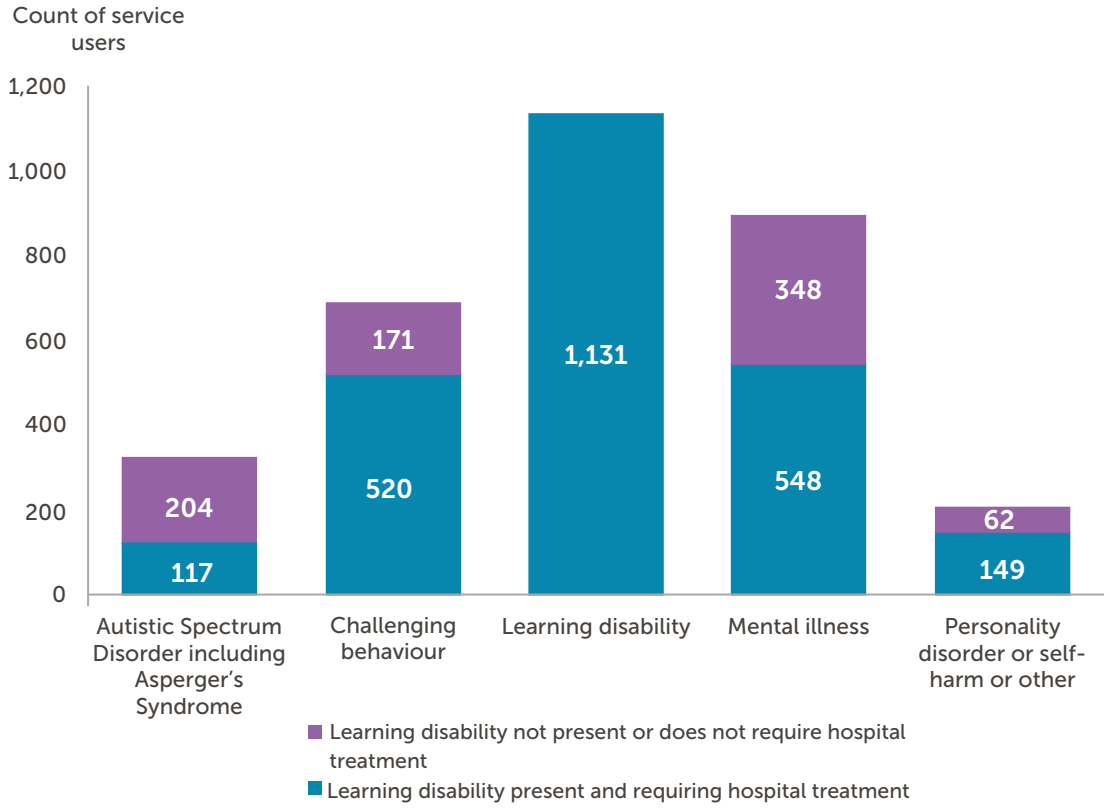
c) Reason for Admission

For 35% of people, 'Learning Disability' was highlighted as the main reason for admission to an inpatient facility. Two thirds of people were in hospital for either a 'Learning Disability', displaying 'Challenging Behaviour' or 'Autistic Spectrum Disorder'. A full overview of the main reason given for each of the 3250 individuals' admission to an inpatient facility, is presented in Figure 1 overleaf:

[2]Learning Disabilities Census Report, Health & Social Care Information Centre, Sep 2013.

[3]This was found in a review of 145 facilities for people with learning disabilities, 72 of which were ATUs. 86% of ATUs supported patients detained under the Mental Health Act, and in 24% of ATUs reviewed, all patients were detained under the Mental Health Act (A Review of the Results of the 2011/12 Focused CQC Inspection of Services for People with Learning Disabilities, Eric Emerson, Learning Disabilities Observatory, 2012).

Figure 1: Service Users by Main Reason for Hospital Admission



Base: All service users (3,250)
Data source: Table 5a of the reference data tables & Learning Disabilities Census, Learning Disabilities Census Report 2013 (further analysis)

3.3.4 Geographic Spread of Inpatient Facilities

Data suggests that the largest concentration of inpatient care is focused in Lancashire, followed by Northamptonshire and Nottinghamshire, Essex, Northumberland and Norfolk. The local authorities with over 50 inpatient beds are highlighted on the right (a summary of all ward stays can be found in Appendix 1C). It is worth remembering that these are not the commissioning authorities, but the recipients of inpatients from across the country.

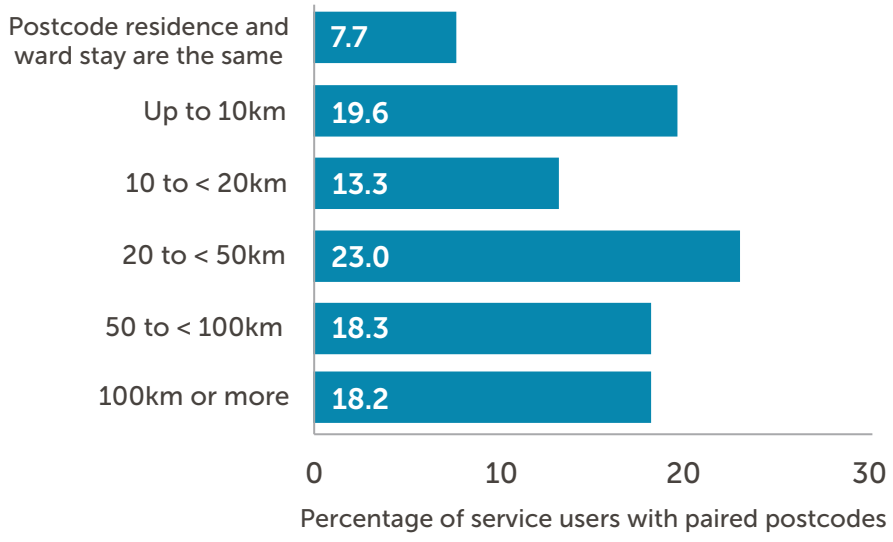
This data suggests that there is significant regional imbalance when considering the provision of inpatient facilities with learning disabilities. 34% of local authorities have no service users receiving inpatient care, whilst 49.5% of people are staying in inpatient facilities in only 12 local authorities.

The Department of Health's response to Winterbourne View[4] stated "sending people out of area into hospital or large residential settings can cause real harm to individuals by weakening relationships with family and friends and taking them away from familiar places and community. It can damage continuity of care. It can also mean putting people into settings, which they find stressful or frightening. This can damage mental health or increase the likelihood of challenging behaviour. There should always be clear and compelling reasons for sending any individual out of area." The 2013 Learning Disabilities Census found that only 7.7% of residents had the same postcode recorded for both their residence and ward stay, highlighting the extent to which individuals have to move out of area when transitioning into inpatient facilities. 19.6% of people were staying in facilities, which were within 10km of their home postcode. However, as summarized in Figure 2, nearly 60% of people were more than 20km away from their home postcode, with 18.2% of people being over 100km away.

[4]Department of Health, "Transforming care; a national response to Winterbourne View Hospital" (Department of Health, 2013).

Service Users by LA of Ward Stay			
	Local Authority	**Number of service users**	**% of total**
1	Lancashire	225	7%
2	Northamptonshire	188	6%
3	Nottinghamshire	182	6%
4	Essex	172	5%
5	Northumberland	168	5%
6	Norfolk	153	5%
7	Staffordshire	98	3%
8	Hertfordshire	89	3%
9	Solihull	87	3%
10	Middlesbrough	76	2%
11	Suffolk	73	2%
12	Kent	70	2%
13	Birmingham	69	2%
14	Hampshire	66	2%
15	Derbyshire	63	2%
16	Worcestershire	51	2%

Figure 2: Distance Between Residence and Ward Stay



Base: All service users with paired postcodes (3,129)
Data source: Table 9 of the Learning Disability Census reference data tables, 2013

A full summary of each individual's postcode of residence is presented in Appendix 1D.

3.3.5 Who is the Responsible Commissioner?

For the majority of people living in inpatient facilities, the lead commissioner responsible for them is a CCG. This is the case for 59% of people (1918 individuals). NHS England are the lead commissioner for 18% of people with learning disabilities in inpatient facilities, Local Authorities are the commissioner for 7%. The Responsible Commissioner is unknown for 16% of people (529 individuals).

3.3.6 Do Inpatient Facilities Provide Positive Outcomes for People?

The question as to whether inpatient facilities provide positive outcomes for individuals that have exhibited challenging behaviour is one that is widely debated. There are certainly examples of facilities that provide high quality care and treatment for individuals in time of crisis, effectively supporting individuals to recovery and back into their community.

Following the Winterbourne view scandal, however, which uncovered significant abuse of the highly vulnerable people it was established to serve, there has been a thorough review of this type of facility. Such reviews have revealed numerous examples where inpatient facilities do not seem to be serving the purpose for which they were created.

Aside from the admission and discharge process, which is explored in section 3.2, the quality and nature of treatment within inpatient facilities often comes into question. In a recent review of CQC inspections of services for people with learning disabilities[5], 145 services were inspected, included 72 ATUs, 39 Secure Units and 34 Residential Care Homes. Key findings of this report included:

- 89% of units were supporting someone who had been resident for more than one year;
- 75% of units were supporting someone who had been resident for more than two years;
- 64% of units were supporting someone who had been resident for more than three years;
- In one facility, 5 patients were highlighted as having been resident for over 7 years, with another 4 being there for 4 years;
- Only 1 in 7 of the current residents in this cohort were being supported in units that were compliant with Care & Welfare and Safeguarding requirements;
- Particular concerns were raised around deficiencies in care planning (including discharge planning), the range of activities and support available for residents, competencies of staff in terms of their understanding of safeguarding procedures, and the use of restrictive behaviour management practices such as physical restraint and seclusion;
- For every comparison made, units operated by NHS Trusts were more likely to be compliant than services operated by independent healthcare providers.

The 2013 Learning Disabilities Census revealed similarly concerning figures when analysing data from 104 inpatient facilities where 3250 people with learning disabilities were resident:

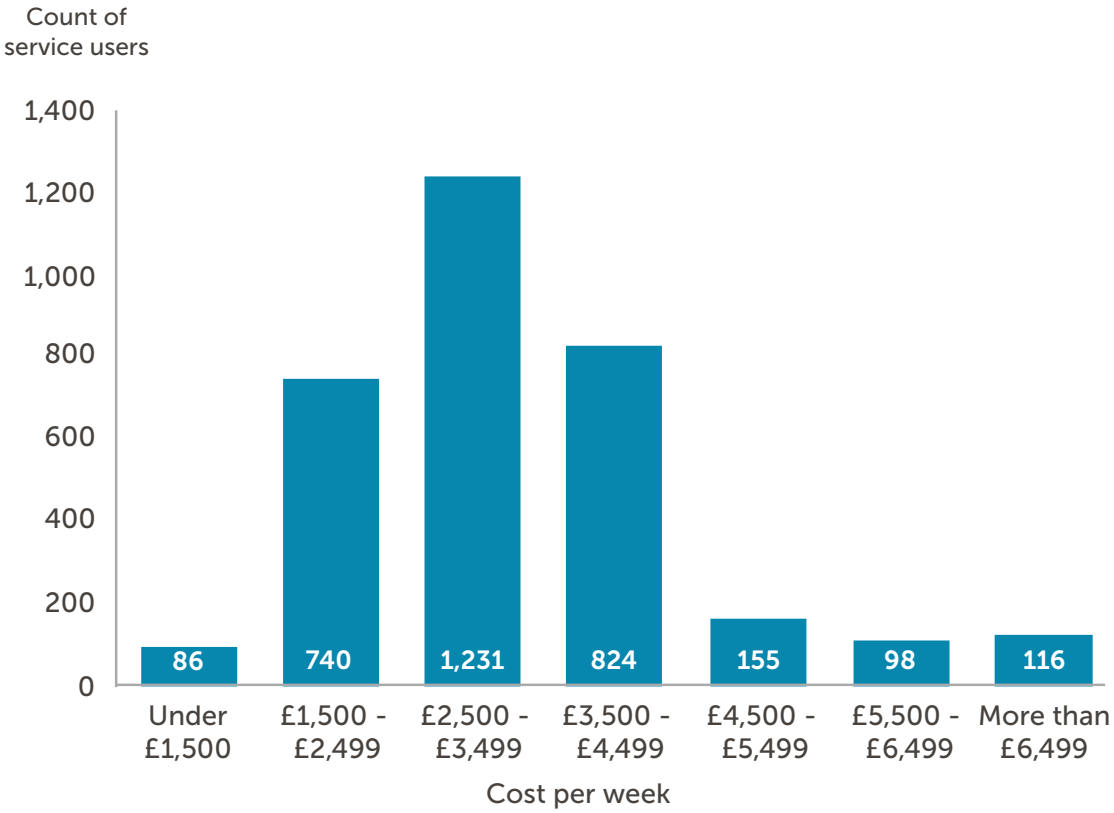
- 68% of people (2220) had been given anti-psychotic medication leading up to the day of the Census;
- 57% of people (1841) had experienced at least one incident of self-harm, accident, physical assault, hands on restraint or seclusion during the 3 months before the Census was conducted;
- 60% of people had been in the current inpatient facility for over 12months;
- 572 people had been in the inpatient facility for more than 5 years (nearly 200 of these had been there for 10 years or more).

[5]A Review of the Results of the 2011/12 Focused CQC Inspection of Services for People with Learning Disabilities, Eric Emerson, Learning Disabilities Observatory, 2012.

3.3.7 How Much Do These Services Cost?

The most commonly reported weekly cost of inpatient service provision reported in the 2013 Learning Disabilities Census was £2,000-£3,499 per week (up to £182,000 per annum). 37% of the beds were costing more than this, costing between £3,500-£6,499 per week (£182,000-£338,000 per annum per person). The full spectrum of service provision costs are presented in Figure 3 below:

Figure 3: Cost of Service Provision Per Week



Base: 3,250

Data source: Table 6a/6b of the reference data tables from the Learning Disabilities Census Report Sept. 2013.

3.4 Inpatient Admission and Discharge: Pathway & Barriers

3.4.1 Inflows & Outflows Data

One of the key problems that we have sought to understand is around the discharge of individuals from inpatient settings back into the community. Despite the intention for the majority of inpatient facilities to provide a setting for short-term, acute assessment and treatment as part of a defined pathway of care, for many of the individuals, their stay has often, in practice, continued for years.

The number of people leaving inpatient facilities has been between 120-250 people per quarter, but considering the larger numbers that are being admitted, the total number of people living in inpatient facilities has been increasing. The table below summarizes figures available on admission and discharges of individuals where inpatient beds have been commissioned by NHS Commissioners[6]. The aggregate numbers are thus lower than the 3250 total discussed in Section 3.1, which also includes Local Authority Commissioning.

Figure 4: Inpatient Admissions and Discharges Source: NHS Commissioners Quarterly Returns

Source

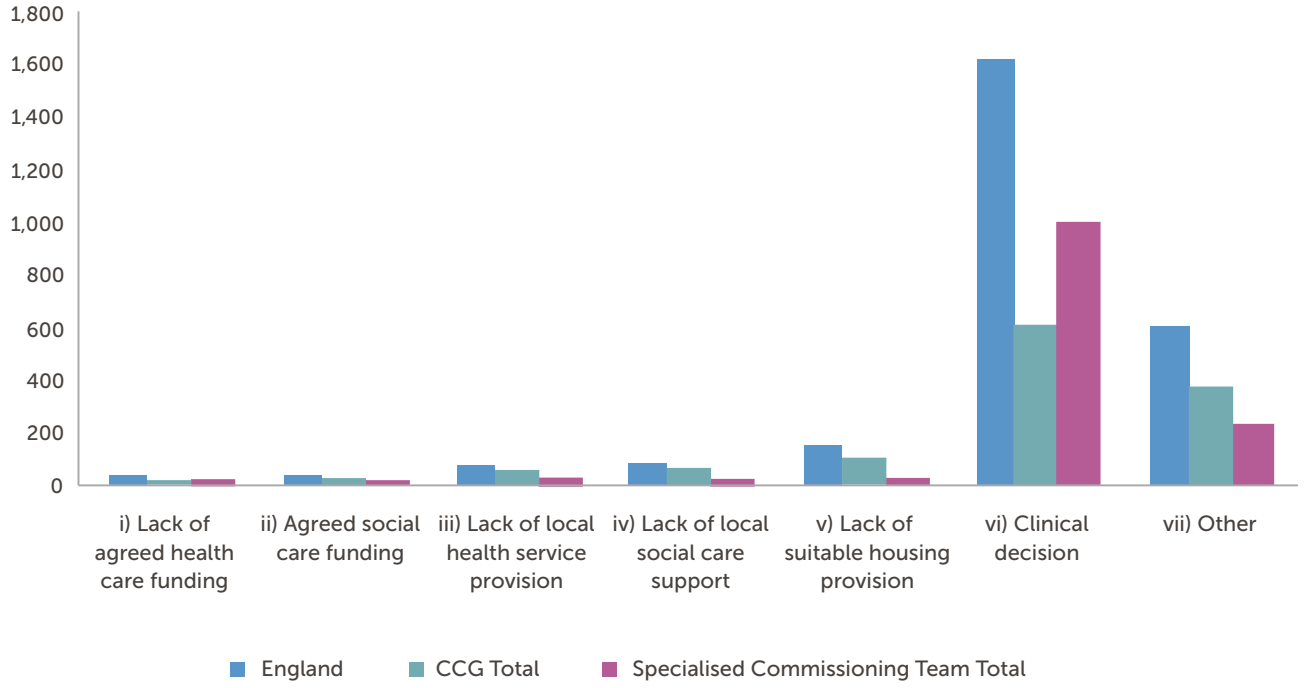
End Date of Quarterly Review	Dec-13	Mar-14	Jun-14
Total number of patients where inpatient services commissioned by NHS Commissioners	2577	2615	2601
Number of patients admitted to inpatient care in period	247	297	358
Number of patients transferred out of inpatient care in period	124	215	261

The 2013 Learning Disabilities Census found that of the 3250 residing in inpatient facilities with a learning disability, 46.4% (1508) people have active care plans, without any discharge plan in place. The vast majority of people (78% of the 2600 inpatients where services are commissioned by NHS England) continue to have no agreed transfer date (Appendix 1B) .

For 325 of the people that NHS England has highlighted as having no agreed discharge date, their lack of an agreed transfer is not for clinical reasons. As Figure 5 below highlights, this is instead because of a lack of suitable housing or care in the community, or because a funding agreement has not been reached. In other words, we know that over 300 of the people currently in inpatient facilities remain there because of a failure of alternative provision.

[6]This includes 211 CCGs and 10 NHS England Specialised Commissioning Teams.

Figure 5: Reason Given by Commissioner for Lack of Transfer Date[7]



On the surface however, this data suggests that the main reason people do not have a discharge date is down to a clinical decision. One may thus assume that this group of people need to remain in an inpatient facility because of their current mental state, and have no other care option. However, we believe the barriers preventing discharge of individuals out of inpatient facilities are much more nuanced than this data may suggest. These findings are presented in Section 3.4.4.

3.4.2 Inpatient Admission: Additional Process Breakdown

Data also suggests (as supported by Figure 4 above) that the number of people being admitted into inpatient facilities is also not decreasing – it actually appears to be increasing.

It is crucial to consider why such large numbers of people with learning disabilities are being admitted into inpatient facilities, as well as the barriers to discharge, if a preventative solution is to be developed. This is particularly crucial when considering the projected growth in the number of people with learning disabilities requiring community-based support over the next 10 years. Through analysing the number of children in England with Special Education Needs and the likelihood they will become eligible for adult social care services, Professor Emerson concluded that there could be a need to provide support for up to an additional 52,000 adults with learning disabilities by 2030[8] .

3.4.3 The Pathway for An Individual: What It Really Looks Like

Our discussions with a wide range of individuals working within this area has highlighted two fundamental aspects of breakdown in the current pathway for an individual with learning disabilities being admitted into an inpatient facility:

There are a number of routes through which large groups of people are admitted into inpatient facilities for inappropriate reasons. In another examples that have been shared with us, this has often proved to be related to a lack of local area care provision – the fundamental

[7]Assuring Transformation: Meeting the Winterbourne View Concordat Commitments, NHS England, June 2014.

[8] The Future Need for Social Care Services for Adults with Disabilities in England 2012-2030, NIHR School for Social Care Research, Emerson, 2013.

problem proved to be "there was nowhere else" for the individual to go.

There are a number of barriers that must be worked through in a consecutive manner before an individual can be discharged from an inpatient facility, which are fraught with inefficiencies, lack of resource and significant incentives to prevent discharge. This results in people remaining in inpatient facilities much longer than is necessary, often with detrimental effects on their quality of life.

This process from admission to discharge is presented in Figure 6, with key aspects of process breakdown highlighted. Broken lines demonstrate the intended path of an individual with learning disabilities, if they experience a breakdown in their community based housing and/or support, or if they have a legitimate need to be admitted into an inpatient facility. The solid lines demonstrate the actual path that people tend to follow, resulting in more admissions than necessary, and fewer discharges than should be possible.

a) Community Living

An individual begins at point 1 in the diagram – the individual may or may not be receiving care and support in the community for longer term mental health issues, may have a learning disability, or may have more specialist needs after exhibiting challenging behaviour, for which they require specialist support. The individual could be living in a Registered Care Home, Supported Living, in a residential school for young people with learning disabilities, or even living independently or with family.

b) Transition Into An Inpatient Facility

This diagram considers a scenario where this individual makes the transition into an inpatient facility, because it is deemed they cannot currently live in the community without putting either themselves or others at risk. This may be an appropriate course of action if the individual has suffered from an acute mental health episode, which requires specialist, dedicated, short-term treatment (Route A). An individual may also be admitted into an inpatient facility after committing a criminal offence – this may be before a serious offence is committed as a preventative measure, or after a court disposal whereby the Ministry of Justice deem prison to be unsuitable because of an individual's learning disability (Route B).

Route C: A considerable group of individuals transitioning into inpatient facilities have been previously based within residential schools, which they need to move on from at the age of 25. When cohorts of people leave these schools at the end of the school year, the Local Authority is faced with a group of individuals for whom adequate preparation for support may not have been made. We have seen several examples where, because of this lack of forward planning and lack of local provision, these individuals are admitted into inpatient facilities – despite not having an acute mental health episode.

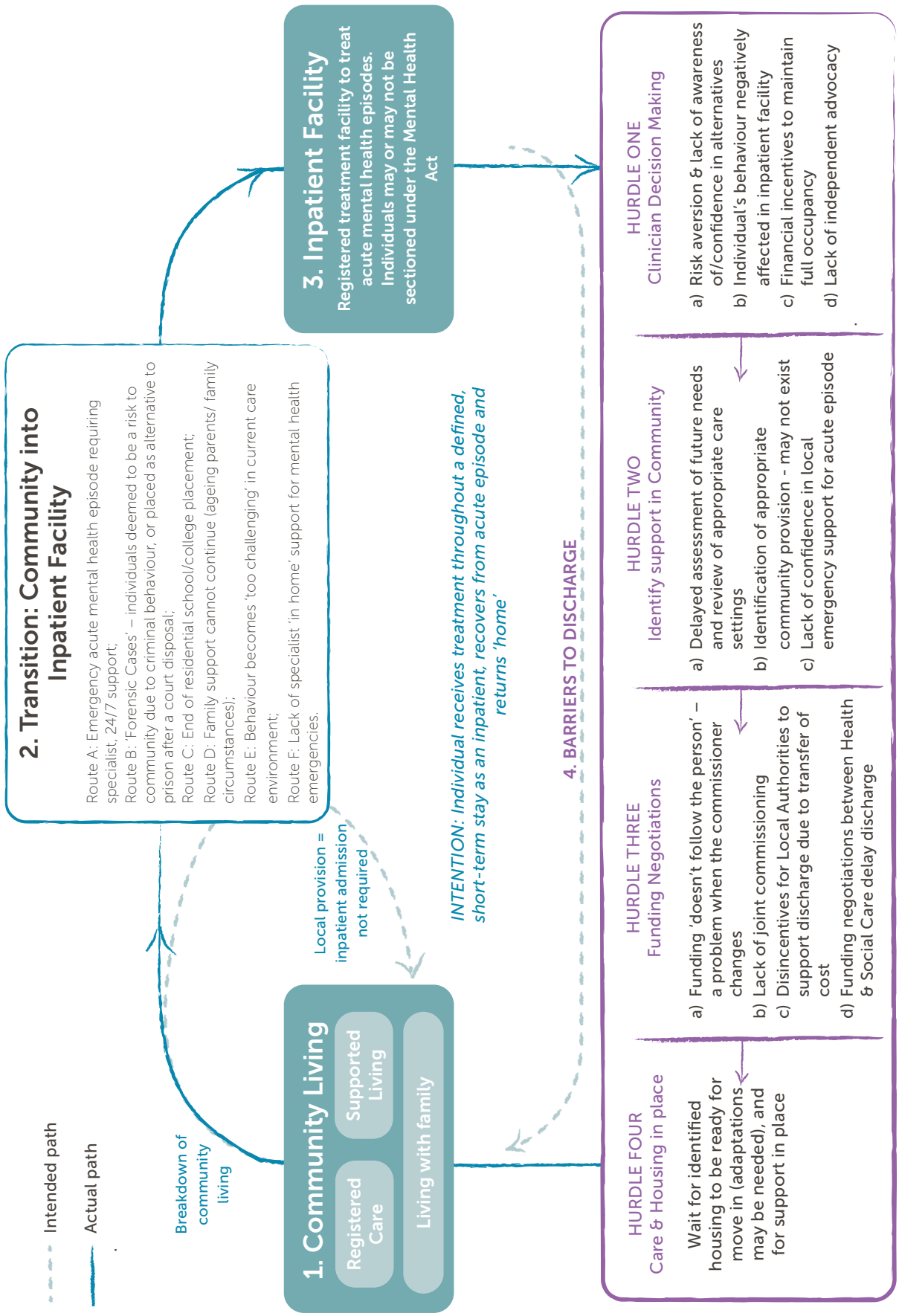
Route D: Other examples have included where individuals cannot continue to live with family because family circumstances change, parents become too elderly, or perhaps certain behaviour that an individual displays becomes inappropriate due to younger family members. Again, because of a lack of care in the community, this individual has been forwarded to an inpatient facility, because the local authority did not have commissioned services that could provide sufficient support for them.

Route E: In some cases, individuals have been admitted because their behaviour has been deemed 'too challenging' to manage within their existing care and support environment. However, this has often been because the individual was placed in inappropriate accommodation initially, or was receiving inappropriate support, rather than because they require medical treatment. For example, an individual who should be living alone may have been placed in shared accommodation with others, whose behaviour triggers challenging behaviour for the individual in question. Some respondents suggested that this often happens because providers and/or commissioners place an individual in accommodation just to fill a void (because places have been 'block purchased', so an empty space results in a loss), even though the placement does not really support the individual's requirements. Their behaviour suffers as a result of not being supported well enough, the placement breaks down, and the individual is forwarded to an inpatient facility because 'there is nowhere else for them to move to'.

Route F: It may be that the individual suddenly requires a short-term increase in specialist support because of an acute episode or an abrupt change in circumstances. We have had examples of situations where even though the current support provider could provide this support, the commissioner was unwilling to pay for additional hours of support (perhaps, for example, support hours need to be doubled for a month or so). There are also very few areas in the UK that have any kind of local specialist support teams that can provide emergency support within an individuals' home. So without this locally based team, and with commissioners unwilling to increase care hours, the individual is instead sent to an inpatient facility (which will be funded from an alterative budget). This is explored further in 'Hurdle 3' below .

In the majority of these cases, if appropriate community based provision were in place, admission into an inpatient facility could be avoided. Even in cases A and B, for many people admission into an inpatient facility is not the only option – and indeed is rarely the one that delivers the best outcomes for individuals. Our research has highlighted examples of acute mental health episodes and periods of challenging behaviour being treated within

Figure 6: Inpatient Admission and Discharge:
The Journey of an Individual



the community through specialist 'crisis teams', or even existing providers. Several successful examples have also been shared where people with 'forensic background' have been supported to live in the community in a risk managed, safe environment. One of these is highlighted in Case Study 3.1.

c) Assessment and Treatment

With a lack of community based provision, many individuals in cases A-F will transition into an inpatient facility. In the ideal scenario, once an individual has been admitted, they should receive treatment through a defined care plan, perhaps even as part of a time scheduled discharge pathway. Once recovering from an acute mental health episode, the individual should return 'home', wherever that may be for them in the community. This is particularly the case for ATUs, which were developed specifically to deliver short-term assessment and treatment. ATUs were never developed to provide a long-term home for individuals.

d) Barriers to Discharge

However, we have found from discussions with practitioners that there are numerous barriers preventing this discharge process from happening. These barriers are often addressed consecutively, leading to a cumulative effect when it comes to the problems opposing discharge.

CASE STUDY 3.1

Transition from Secure Hospital to the Community: For individuals with offending backgrounds. Provider: X Unnamed due to Sensitive Nature of this Work.

Kevin is a man with mild learning disabilities living in the South West of England. Kevin had been accused of sexual offences towards children but, due to his learning disability, the Criminal Justice Service had not been able to proceed to prosecution and it was agreed that Criminal Justice Services would not be an effective resolution or meet his needs. He was initially sent to a secure hospital.

With the support of Provider X, Kevin was later discharged into his own home in the community. The property was sourced through a private landlord with the support of a specialist clinician to choose a suitable location.

Provider X initially supported Kevin on a one-to-one basis for 24 hours a day (168 hours a week). A Specialist team of Clinical Consultants worked regularly with Kevin to build his social skills and confidence and to challenge offence related thinking patterns. After six months, support was reduced to 112 hours a week.

To support Kevin to develop further, the provider formed a partnership with the local police station where Kevin could be involved in selling unclaimed bicycles. Kevin was supported to develop this into a local social enterprise, which he now manages with support from the provider. He has now employed a friend and another colleague to help him run the business. Kevin and his colleagues are now giving something back to the community and making a positive contribution.

Kevin has developed good social skills, he is managing his offending behaviour, and he asks for help to do this when he needs it. Today, Kevin is supported for only 16 hours per week and this is likely to reduce further in the coming months. In the first six months after support commenced Kevin's support costs reduced by £47,000. After a year they had reduced by £126,000.

Hurdle 1: Clinical Decision Making

As highlighted in Figure 6 on page 25, the most commonly cited reason why discharge has not occurred is a clinical decision. However, in many cases it appears that this decision may not necessarily be based on the ability of the individual to live successfully in a community setting. It has been suggested by practitioners that this may arise from a complex mix of factors, including:

i) Risk aversion of clinicians and lack of awareness of, or confidence in, alternatives

Firstly, several respondents felt that clinicians/ psychiatrists within inpatient facilities are very risk averse. Respondents have suggested that because clinicians have only ever dealt with people as 'patients' within a health (rather than social care/non-medical) setting, they find it difficult to consider how this individual could be supported outside of this setting, within the community. It seems that some clinicians lack confidence in community provision of support for individuals with complex needs or who have exhibited challenging behaviour, because they are not well informed of the types of support and expertise that is available, or have not been provided with compelling evidence that it can work. This either leads clinicians to continue to decide that the individual is not fit for discharge, or means they put such onerous requirements on what type of treatment and restraint must be provided within an alternative setting that a community solution becomes unfeasible.

Some respondents also stressed that some clinicians significantly underestimate the risk management ability of the community – community providers are both able and willing to manage much higher levels of risk than clinicians continue to think is the case. These issues are highlighted in Case Study 3.2.

ii) An individual's behaviour is negatively affected in an inpatient facility

Many individuals may be caught in a 'catch 22' situation. They may have been admitted for a relatively minor mental health issue, or perhaps just due to a lack of provision in their local community, but the inpatient setting affects them so negatively that the behaviour they begin to display leads a clinician to decide they need to stay. The longer the individual stays, the more challenging behaviour they display. This results in their stay in an inpatient facility becoming extended, with an increasingly lower probability of being assessed as suitable for discharge. This was the case in a number of examples that were shared with us as part of this research, particularly where individuals had been abused within inpatient facilities, regularly physically restrained, and where individuals were sharing space with other inpatients who behave in a threatening way. The clinician is assessing whether an individual could live successfully in an alternative environment whilst they are still in an inpatient environment, which may itself be a significant cause of the behaviour they are displaying.

iii) Financial incentives to prevent discharge

Whilst we have not found concrete evidence to support this notion, a significant number of respondents we spoke to felt that some clinicians may be incentivized to recommend against discharge because of the significant financial factors involved. These include the extremely high prices that are being paid for each inpatient, the fact that financial viability of the service often relies on keeping the units full (particularly if private finance is involved) and because the clinician who is making the decision is unlikely to be independent. The clinician is, in the majority of cases, a direct employee of that facility, and in some cases even a Board member. Ultimately, discharging one individual could cost a significant amount of income – up to £600,000 per annum. See the example in Case Study 3.3.

CASE STUDY 3.2

Transition from an Inpatient Facility: Clinician's over-prescription of support and restraint
Provider: Dimensions

John came to Dimensions in August 2011, after living in an inpatient facility for 6 years. A behaviour support programme was developed, which focused on reducing challenging behaviour while at the same time increasing John's quality of life. As a condition of discharge, the clinician and funding Local Authority placed certain requirements on the provider that was to support John in the community – particularly around the use of physical restraint. Dimensions policy does not support the use of physical restraint, but in order to ensure John could finally move out of the inpatient facility, they agreed to train their staff as required.

At his previous placement, John was physically restrained daily and received 3:1 support for the majority of the time. After the first three months of being supported by Dimensions, support in the community was reduced to 2:1, and in-house support was reduced to 1:1. Despite the requirement on Dimensions to be trained in physical restraint as a condition of John's discharge, restraint was never required and permission to use such techniques was soon removed.

John's support has eventually reduced to 1:1 during the daytime, with no support overnight. Dimensions have used Positive Behaviour Support, ensuring that John had a Behaviour Support programme supported by Functional Behaviour Assessment, as well as a robust communication programme. John also chooses his own staff and chooses what he wants to do with his day.

John is now leading a life where he feels more included in his community and is far less likely to display challenging behaviour. He has a much better quality of life and is safe and happy. The saving is more than £130,000 per year, compared with the previous support package where John was receiving 3:1 support within an inpatient facility.

iv) A lack of highly trained, specialist, independent advocacy and brokerage

In order to challenge clinicians' decisions, present alternative community based solutions, and highlight the root causes of certain behaviours being displayed, an individual requires a highly skilled, independent advocate. This advocate not only needs to raise cases where a discharge should be considered, but they need to be able to: challenge clinician decisions; be aware of what alternative housing options are directly available for the individual at that time; be fully aware what kind of support the individual requires; appreciate what key stakeholders need to be contacted to ensure there is a strong case for discharge; be able to present a clear example of alternative community provision and specialist support within the community. Unfortunately, we have found this is lacking in the majority of cases, despite individuals having some form of advocate.

CASE STUDY 3.3

The Barriers to Discharge: Chris P's story

After suffering from abuse in a previous care facility, at the age of 17 Chris was moved to a secure unit, with the plan being for him to return to the community within 18 months. The placement cost nearly £1million to set up and now costs £520,000 per annum to maintain. Chris is now 22, and is currently still living in the secure unit. The last 5 years have been an on-going battle for his family, who have been through numerous legal processes and petitions in the hope of seeing Chris move back to his community. It has only been in the last month or so that these efforts have begun to have effect.

18 months ago, it was discovered that Chris had been subject to further abuse in the secure unit where he currently lives. He had been physically hit on multiple occasions and had even had cleaning fluids sprayed in his face. His advocate had also made complaints due to the lack of education and stimulation that Chris receives. After a failed investigation, Chris remained in the secure unit, and his family were unable to do anything about it.

The current clinician decision-making process has presented a real barrier for Chris. Chris' advocate stresses how inappropriate it has been to assess him within an environment where he has been abused, where he has very little outside time, and one that he finds very stressful. Chris has been assessed as to how he might cope outside of this environment whilst he is still living in it – something that his family and advocate feel is the reason why he has been unable to return home for so long.

Chris' advocate and family have remained confident that alternative care and support within a community setting, closer to home and his family, would enable him to live a much higher quality of life - at a fraction of the cost. Currently Chris' support costs nearly £12,000 per week. His advocate stresses that if an initial investment were made to develop appropriate housing, Chris' support costs could drop by at least 50% in the community, even if he had his own dedicated staff team. So, despite 5 years of set backs, Chris' family and advocate have continued the fight.

With the help of the Joint Improvement Programme, support of the Challenging Behaviour Foundation, and various petitions and campaigns (including a channel 4 documentary which gathered significant support), there has finally been a full report of Chris' case undertaken by professionals. It has been agreed that, with the right housing and support, Chris could be supported back into the community.

Chris' story really highlights the importance of highly skilled, dedicated and well-informed advocacy, as well as the incredible amount of effort that is sometimes required to challenge an individual's placement in an inpatient facility. Unfortunately, many people currently living in inpatient facilities do not have such support. Chris' advocate has over 20 years experience in this sector, particularly in brokering housing solutions for people with complex needs and those who have exhibited challenging behaviour. Even in this case, a resolution required still further resource and support to ensure that Chris' voice, as well as that of his family, is finally being heard.

Hurdle 2: Identifying Support in the Community (Delayed Discharge)

The next hurdle is related to Delayed Discharge – i.e. "a situation where a patient is deemed medically fit for discharge, but is unable to leave hospital because arrangements for continuing care have not been finalised"[9]. In 2003, the Department of Health published guidance around the discharge pathway and Delayed Discharge[10] and this was brought into law as part of the Community Care Act of 2003. This Act introduced Delayed Discharge Payments (penalties) if a patient's discharge was delayed for reasons relating to provision of community care services. This legislation, however, did not extend to mental health or learning disability services, which is why Delayed Discharge within inpatient facilities are not monitored or sanctioned in the same way.

There would therefore appear to be no financial incentive to avoid Delayed Discharge – especially considering the high levels of income that are received for each week the discharge is delayed. Regardless of the incentive, discharge is delayed for several reasons (as well as those related to financial decisions, explored under Hurdle 3):

i) Delayed assessment of future needs and review of appropriate care settings

Ideally, as soon as the individual moves into an inpatient facility, a care pathway would be developed which prepares all necessary stakeholders for a future discharge. The individual's needs are not only assessed in the present, but a 'forward thinking' assessment should also take place. What are the root causes of the challenging behaviour that this individual has displayed? Which elements of this can eventually be supported within the community? Who provides that service? Is it already available? Who can develop it if not? This process should begin as soon as a person is admitted. Instead, in many cases when a person is deemed fit for discharge, no alternative provision has been previously considered, and the whole process needs to begin from scratch.

This again relates back to the need for an independent advocacy and brokerage role – to identify the individual, the local commissioners who are responsible for their community care, the alternative options available to them, and to project manage the whole process as soon as the individual is admitted.

ii) Delayed identification of appropriate community provision - or may not even exist

A key problem is there still may not be anywhere for the person to move to in the community, even if their mental state no longer requires them to remain in an inpatient facility. Indeed, this may have been the very reason the individual was admitted in the first place. This would often appear to be linked to a lack of forward planning at a local level.

Many local authorities do not even appear to be aware of the people that are in inpatient facilities who would fall under their responsibility to care for in the future, let alone those who are approaching being ready for discharge. NHS data suggests that in nearly 1300 cases, the relevant Local Authority was found to be unaware of a proposed transfer[11]. The individuals seem to 'drop off the radar' when arriving at an inpatient facility, so forward planning at the local level does not happen either. This is highlighted in the 2013 Learning Disabilities Census [12], which found that 28% of the 3250 cohort had no known original postcode of residence – this was either because the postcodes provided were ones that no longer existed, or because their postcode was simply unknown.

Many providers have also expressed frustration at the way in which commissioners approach them when someone is highlighted as ready for discharge - they often only get a few weeks notice. They then cannot support the individual or offer an appropriate housing solution, because they have not been given enough lead in time. It can take up to 6-12 months for a provider to adequately prepare for the effective discharge of an individual, put a support package in place, build up staff teams and source and adapt a suitable property – but this is time that they may not be given in many cases due to commissioning occurring too near to the time of need.

The person may thus end up staying in an inpatient facility for several years after they were deemed fit for discharge, just because no-one has been able to develop an appropriate support and housing solution for them in their community.

iii) Lack of confidence in local emergency support for acute episodes

Even if a housing and support solution is identified in the community, there may not be any local support if the individual suffers from another acute mental health episode. In this case, it may be decided that even though the individual is currently fit for discharge and has a housing solution that suits currents needs, the lack of local infrastructure means the move might be too risky.

[9]Bryan K, Gage H, Gilbert K. Delayed transfers of older people from hospital: causes and policy implications. Health Policy 2006; 76: 194-201.
[10]Department of Health. Discharge from Hospital: Pathway, Process and Practice. Department of Health, 2003.
[11]Data presented in Appendix 1E.
[12]Learning Disabilities Census Report, Health & Social Care Information Centre, Sep 2013.

Hurdle 3: Funding Negotiations

One of the most crucial barriers is the change of funding responsibility as an individual moves from an inpatient facility back into the community.

Crudely speaking, when in an inpatient facility, an individual's care is funded by the central Government's Health budget. If living in the community, the Local Authority must fund the individual's Social Care. The Local Authority is able to access a Continuing Health Care (CHC) budget to cover the individual's support costs that are still considered to be Health, rather than Social Care related.

The current division of Health and Social Care budgets in this manner adds further stages of lengthy negotiation to the discharge process:

- Individual is deemed fit for discharge and case submitted to CHC panel;
- CHC panel make decision as to what proportion of care can be funded from CHC budget;
- Health and Local Authority Panels must come to agreement and authorize deployment of funding. Disputes and challenges of decisions can continue for some time.

The problem is more than just an inefficient delay, however. We have been informed of a number of cases where there have been intentional delays and push backs from Local Authorities who suggest they cannot afford to take individuals 'back onto their budget'. Even though inpatient beds are significantly more expensive than community based care, Local Authorities stand to save nothing in monetary terms if they support the discharge of an individual back into the community. Instead, their cost liability in relation to that individual immediately increases from zero, to a substantial weekly support bill. It is not surprising, considering these perverse incentives that persist in Health and Social Care funding structures, and the ever increasing pressures on Local Authorities to cut budgets, that we have heard anecdotal evidence that some Local Authorities resist the discharge of individuals from inpatient facilities back into the community. This is also, of course, an incentive to admit individuals into inpatient facilities, if the cost liability shifts in such a way.

Unless changes are made to ensure that 'funding follows the person', the 'discharge disincentive' will persist. For example, if the funding available for one individual's care was to come out of one pot, and follow that person regardless of the setting in which their care was required, there would always be an incentive for discharge, considering the high price charged for inpatient beds. Some Local Authorities have overcome this issue by developing a Joint Commissioning arrangement, where Health and Social Care come together to commission the care of individuals with a learning disability. This pooling of budgets enables them to collectively develop the best option for the individual, share any savings as well as cost implications, and avoid funding disputes and delays.

Hurdle 4: Getting Support and Housing in Place

Finally, once all decisions and agreements have been made, the individual must wait for their new home to be ready. For example, there may have been property adaptations required, or staff may need to have been trained.

3.5 What Might "Good" Outcomes Look Like for This Group of People?

Overall then, there are clearly numerous aspects of both the admission and discharge process that need to be addressed. Interventions are required not only to support the discharge of individuals who remain in ATUs and other inpatient facilities, but also to prevent so many individuals moving into such settings through numerous inappropriate channels.

As well as enabling us to highlight the key areas of required intervention, our discussions with providers and other key stakeholders in this area have also highlighted a number of key considerations that will be essential in ensuring any solutions develop the best possible outcomes for these individuals.

These include:

a) Choice
Individuals and their families should have the power to choose both housing and support provision. This implies a plurality of providers, able to bring forward different solutions to meet different needs. Ideally, the best outcome for an individual would ensure that their housing provision is separated from their support provision, so that if the individual or their family choose to change service provider, the individual's home is not jeopardised. Support provision should ensure that frameworks are put in place to encourage individuals to make positive choices, rather than support providers implementing restrictive practices.

b) Strong Advocacy for the Individual
The best outcomes for individuals must enable their voices to be heard, both directly and through strong advocates. Individuals should have access to advocates that are well trained and have a wide knowledge base in terms of what kind of support and housing options would enable the individual to be cared for most effectively. Advocacy should ensure that the individual receives person-centred support and decision making throughout their life.

c) Thorough Assessment of Both Housing & Support Need
The best outcomes for individuals must involve a thorough assessment of their specific need, both in terms of housing (housing type, if they should live in shared accommodation or on their own, where the property should be located etc.), as well as specific support requirements.

d) Progression & Development of Positive Behaviour
The support that an individual receives, and the house in which they live, should create an environment that is focused on the individual progressing to less support over time, even if this is what seems to be a small reduction in support (this is, of course, notwithstanding fluctuations when an individual's circumstances change). Support and housing provision should be developed so as to encourage behaviour to become less challenging over time through positive behavioural techniques, rather than physical restraint or seclusion.

e) Community Integration
Individuals should be able to live in their local community, close to family and friends, where possible. Support should encourage individuals to integrate with their community, where this is possible, both those with and without learning disabilities.

f) A Focus on Independent Supported Living (where possible)
Solutions should strive to support individuals to transition into Supported Living where they can maintain their own independent tenancy, where possible. This may not be possible for all people transitioning out of inpatient facilities, but even where this is the case, there should be a focus on supporting the individual into a Supported Living environment in the longer term.

g) Consistency of Provision (with flexibility if needed)
The best outcomes for individuals are also likely to be those which ensure consistency. The best solutions should not require individuals to move between homes numerous times, or require them to change their support more than they wish to. Moving home causes unnecessary stress and disruption, which can have significantly damaging consequences for people who have exhibited challenging behaviour or have complex needs. A consistent, positive living environment is a crucial outcome to strive for, whilst also retaining the individual's right to choice (should they wish to move home).

h) Resilience Against Future Admission
The best outcomes for individuals will be those that ensure that unnecessary re-admission into an inpatient facility is avoided. This will involve developing local provision of specialist services, and ensuring that an individual's housing and care package has been fully reviewed and developed specifically for their needs.

4. Provider Models

Key Question:

What are the most effective business or operational third sector models, which can be scaled?

Key Conclusions: Relating to Property Provision

- There needs to be variety, ideally based on the provision of a home with support (Supported Living) rather than a registered care facility. At the same time, there needs to be some tolerance of registered care where this is delivered as if it is the resident's home;
- Cost of housing ranges from £100k to £300k per unit depending primarily on land costs and how 'robust' the property needs to be;
- Having a number of units close to one another: benefits the individual being supported by having a likely provision of social interaction; generates the benefits of a flexible staffing model, especially if some more experienced staff are close at hand; and, of course, makes the property management function more efficient;
- Whilst there is a limited need for new housing provision at the current rates of transition out of inpatient facilities, capital and leadership on ramping up the property provision is going to be increasingly required with an initial fund of £50m required immediately.

Key Conclusions: Relating to Managing the Transition

- New capacity is required to provide advocacy and brokerage to individuals who have been independently identified as ready to move out of an inpatient facility.
- Mobilisation advances to Support Providers are required to prepare a service (including customising or otherwise commissioning a property), as commissioners do not generally have access to this 'double funding';
- One idea to galvanise action would be if an individual moved back into the community before having the debate about pricing or who should be paying for the individual's care, allowing them to settle in their new home for 3-6 months and their needs to be appropriately assessed within the community;
- The medium term savings, even over a relatively short period of 12-18 months, should be more than enough to justify the transition costs associated with such an arrangement;
- Commissioners will have to move away from block purchasing beds in inpatient facilities if they are going to realise savings, otherwise they will continue to be incentivized to fill a bed space that has been vacated by an individual moving out of an inpatient facility;
- To accelerate the transition of individuals out of inpatient facilities, the supported housing sector will need approximately £30m of upfront investment.

4.1 Introduction

There are an encouraging number of sizeable voluntary sector organizations with specific and extensive expertise in supporting adults with learning disabilities and who exhibit challenging behaviours.

These can be categorized into a number of groupings described below, although these are of course not exclusive definitions and many organizations overlap a number of these groupings.

4.1.1 Support Providers

Most organizations operate primarily as care and support providers, some have housing stock that they own, many operate a housing arm that manages their own stock and that of other housing providers[13]. Some are Registered Providers (housing associations registered with the Homes and Communities Agency, "HCA"), specialising in this field. There are many organizations operating and our research did not allow us to speak to as many as we would have liked. Our thanks to those that did spare the time to talk to us and fill in our questionnaire. A list of organizations consulted can be found in Appendix 4.

4.1.2 Housing Providers

There are a few housing providers that do not provide support but are specialists in creating spaces for adults who have exhibited very challenging behaviours, often building bespoke high specification premises. For example, Best (Bespoke Supported Tenancies Ltd) build and lease to care providers; Ashley House plc build and sell to housing providers and Golden Lane Housing buy existing stock, adapt where necessary and lease direct to tenants with support. Some housing is made available to the specialist providers by mainstream Housing Associations, but this is often an uncomfortable relationship as this client group do have a different need from the majority of mainstream housing association tenants. As a result, mainstream housing providers and other private sector landlords are often not attracted to this sector.

4.1.3 Other Organizations

The wider eco-system is made up of strategic support organizations. Such organizations include the Housing and Support Alliance (HSA), The Challenging Behaviour Foundation, the Royal College of Psychiatrists, the Care Quality Commission, the Local Government Association (LGA)[14] and of course Department of Health and NHS England. There is an intense commitment from all these organizations to see change to the status quo.

4.1.4 The System

Whilst there are exceptions, the system appears to often assume that commissioners and providers should trade without specific people in mind. This results in the purchase of blocks of bed spaces with a person being fitted into an available space, rather than the right solution being specified for the individual and the provision fitting around them. Despite this rather detached system, there is some good practice where quality provision and joined up commissioning is taking place. It is not difficult to see, however, why constraints on budgets, time pressure and a desire for simplicity and certainty would result in a tendency to fall in to poor practice with individuals being moved into the only available space.

[13]Of the 40 providers that we engaged with as part of this research, 20 were Support Providers (with 2 specialising in Advocacy), 16 provided both Support and Housing and 4 provided housing only.

[14]Where dedicated support is being delivered through the Joint Improvement Programme (JIP).

4.2 Some Good Practice

There are, encouragingly, many examples of vulnerable individuals being supported to move out of an inpatient facility into their own home, with positive results time and again for both the individual and the public purse. One such example is outlined in Case Study 4.1.

The case is compelling from all angles and yet the scale of the practice is underwhelming when compared with the increasing demand. Indeed, anecdotal research completed by The Housing & Support Alliance (HSA) indicates there is current capacity in the sector to support up to 200 people out of inpatient facilities in the next year.[15]

There are many diverse models of support that appear to work. Many providers have strong opinions about the benefits of their specific model, and it was not unusual to hear perceived concerns of the shortcomings of others.

In our discussions with providers, there was a clear tendency towards a single solution where an individual would be supported to live in their own home. This is where the individual has a tenancy of their own, but additional support (often necessarily very extensive) to help them to live as independently as possible. The tenant receives housing benefit to pay the rent, and the support is paid for separately. Multiple respondents gave examples of individuals who had displayed considerably challenging behaviour, some sectioned under part 3 of the Mental Health Act (known as 'forensic' cases), still being supported to live in this way. Such examples are presented in Case Studies 3.1 (page 26) and 4.2 (page 38).

Supported Living is not the only model. Increasingly less common, but popular amongst a few providers and commissioners, is the Registered Care model. Here an individual could still potentially be living in a single unit dwelling (though it tends to be based around a shared living environment), but the house, flat or bedroom is occupied under licence, as opposed to the individual having an independent tenancy agreement. With Registered Care, a health/social care commissioner pays for the whole service, including the housing costs.

In reality, a good provider will operate both regimes with equal quality and commitment to the best needs of the individual being supported and there are many cases of homes being registered and (more commonly) de-registered without the quality of the service changing at all.

[15]This figure was arrived at after asking HSA members how many people they felt they would be able to support out of inpatient facilities in the next 12 months, with their current level of capacity.

CASE STUDY 4.1

Transition from ATU to Independent Living: Improved outcomes, and the need for project management

Provider: United Response

Trudy had been living in an ATU for 18 months when United Response first met her. She has a mild learning disability, hydrocephalus, spina bifida and mental health support needs. In the ATU, Trudy was on regular psychotropic medication to treat episodes of challenging behaviour, and was deemed to require 2:1 support.

United Response spent 6-8 weeks with Trudy whilst she was in the ATU. The team took various activities to Trudy in the ATU, so that she began to trust and interact with them. They identified what kind of support Trudy liked and didn't like, how she wanted her life to be, and how she communicated with others. Trudy didn't like that she was never involved in preparing her own food, didn't get to go outside as much as she wanted to, and she got frustrated having to wait for authorisation to do things – she felt that nobody trusted her and constantly thought she was 'going to be in trouble'. She also didn't see her family very often, as they had become concerned about taking children into the ATU environment, which she didn't like. The United Response team began to take a lead in providing Trudy's support, and the unit staff took a step back. This enabled United Response to increase Trudy's opportunities to access community based support. Trudy began to trust the team and even on days they didn't visit, she asked if the team could phone her, which they always did.

United Response has now supported Trudy into her own bungalow, which required no adaptations. Having her own home was crucial, as she finds it difficult to share space and support with others. Trudy viewed the house herself and decided she would like to move in, interviewed and selected her own support staff, and even selected her own colour schemes.

United Response used the insights they gained from the time spent with Trudy in the ATU to develop a tailored support plan – this was only possible because of the relationship and trust the team had built with Trudy over time. Despite the initial

assessment of the ATU, Trudy requires only 1:1 (rather than 2:1) support and United Response have never needed to use psychotropic medication. Trudy has recently even been on a holiday to Spain with one of her members of staff!

Since moving from the ATU, Trudy's housing and support costs have dropped from £160,000 per year to £90,000 per year.

CASE STUDY 4.2

Community Based Support Living for People with Forensic Issues
Provider: Golden Lane Housing

In early 2013 GLH was approached by the council to relocate an existing four person supported living forensic service. The current service was being closed, and the four individuals were at risk of being moved back to an inpatient facility.

The Council, Health Authority, Mencap and GLH worked closely together to agree on a suitable neighbourhood and search for the right home. They purchased a large semi-detached house for £385,000 using capital GLH had raised through their 2013 bond issue.

The house was extensively modernised with additional fire safety and security enhancements. It also includes a self-contained flat for one resident, a ground floor bedroom with wet room, and a large workshop in the rear garden, which is ideal for the residents, as they enjoy making things.

Outcomes for Individuals

After 12 months of careful planning the tenants moved in during April 2014. This move has provided the much-needed housing for six individuals with a learning disability with offending backgrounds, two of whom had moved from inpatient facilities, including one from out of area. Care providers suggest the residents have become notably more confident and their emotional wellbeing has shown sign of improvement. Each resident is also making progress towards targets they set themselves before they moved.

Cost Savings

GLH estimate that this provision has enabled cost savings of circa £85,000 per annum per tenant – a total of over £500,000 per annum.

Looking to the Future

Based on the success of this scheme GLH are in early discussions to help more people with offending backgrounds to move into supported living in the North East of England.

The 'pro and cons' of Supported Living and Registered Care models that have been highlighted through our provider discussions are summarized in the table below:

Supported Living	
Pros	**Cons**
More money to the individual.	Two revenue streams to manage.
'Feels' like their home – staff often behave differently.	Irregular housing benefit practice by providers and local authorities, open to abuse[16].
Choice and freedoms are the norm.	Lightly regulated, relative to Registered Care - poor support is often not picked up quickly or easily.
Local and Health commissioners do not have to pay the housing costs – Housing Benefit is paid by central government.	Support often subject to Local Authority hourly rate maximums with complex needs not taken into account.
Ability to choose care and support providers independently of the housing provider.	Tenancy can come under threat if resident goes into hospital for any period of time.

Registered Care	
Pros	**Cons**
Simple and speedy to commission.	Individuals often allocated available bed spaces, rather than a housing option that works specifically for them.
Generally more carefully regulated.	Can feel institutional, even when small.
Except in single unit, there is more staff accountability / support.	Inability for individuals to choose providers separately from their home.
Less easy for commissioners to undermine costs through budgetary constraints.	

A criticism often levelled at Supported Living providers happened when they were both the provider of housing and the provider of support. Sometimes the regulator would challenge whether what actually was being provided was Registered Care, if the support was in someway attached to the tenancy agreement. Best and common practice however is that the housing provision is structured as an entirely separate product, with no reference to the support provider in the tenancy agreement (other than to require them to make use of their support) and vice versa. In essence, an individual could choose to move house and keep their support package, or they could choose to stay in their home and change support provider. This appears to satisfy the Care Quality Commission (CQC) as regulator and follow common sense. The regulator has forced some supported living schemes to register as care homes where the tenancy is somehow linked to the support provision, but this practice is now rare.

Overall, there is a clear and mostly welcome shift towards the Supported Living structures. This comes with a strong caveat that if this is seen as a way of driving down cost, ultimately quality will drop and scandals will no doubt appear in this scenario as well.

We have also come across a number of instances where voluntary sector providers have bailed out poorly performing hospitals that were inappropriately and expensively 'home' to adults with learning disabilities. A few years later, despite the high degree of skill needed by experienced and dedicated support workers in handling complex cases, the rates now being paid are sometimes subject to caps of as little as £12.50 an hour.

[16]There are some instances where rents of 2-3 times the Local Housing Allowance is being charged using the exempt rent rules. In most cases unreasonable levels are contested by Local Authorities.

4.3 Property Models

Mostly organizations operate with enormous commitment to a person centred approach. There was a strong resistance to any one 'right solution' for everyone. This is as true for the property specification as it is for the care or support package. The property models that were shared as working well included:

- Individual single person dwellings;
- Shared houses typically for 2-3 residents; and
- Blocks of 5-12 self contained units with some communal space for some/all of the flats.

It is not clear from a property specification point where some of these larger blocks verge into 'apart hotels', increasing the risk of the 'feel' tending towards an institutional setting.

4.3.1 Design

There was also a clear call for a range of customisation options. Some people moving out of inpatient facilities can indeed be supported in very ordinary homes with little or no adaptations (as highlighted in case study 4.1). Often the specification is more about access to open space, bus routes, specific amenities or having no overlooking neighbours.

More common is a need for relatively normal housing but with a significant need for adaptations. This can involve considerable costs and can often include things like high quality fittings, unbreakable windows, all room air conditioning, wet rooms or assistive technology which do not add to the intrinsic market value of the property. There are some clients who require accommodation that really can only efficiently be delivered on a new build basis. Some units will need to be built to be "bomb proof" to protect individuals from themselves, for staff safety, and if there is a level of security required. There are specialist housing providers who, through careful design of relatively small units, are able to achieve this quality and robustness without creating a "prison-like" setting.

It is often observed that the occurrence and severity of challenging behaviour increases in inpatient facilities. There are many reasons why this could be true, but one of them is undoubtedly the increased level of restrictions that exist in a secure hospital environment. By the same rationale, where supported housing can be constructed such that there are as many freedoms as possible built in, there are naturally fewer triggers for episodes of challenging behaviour. This is a significant driver for the location and the design of suitable homes. One common problem, for example is the creation of communal living space. For some individuals, communal space is a crucial element of a housing solution, if they enjoy spending time interacting with others. However for some people who have periods of challenging behaviour, communal areas can often exacerbate challenging behaviour. Because some types of behaviour are unacceptable in a shared space, this can often lead to individuals being physically restrained, which typically exacerbates challenging behaviour still further.

An example of an award winning development which has been designed specifically for people who have exhibited challenging behaviour is detailed in Case Study 4.3 below. A list of organizations consulted can be found in Appendix 4.

4.3.2 Core and Cluster

One model that was often described as an ideal was a concept known as 'Core and Cluster'. This is where a number of independent units and / or shared houses are peppered around a neighbourhood, but with a central facility or block of flats where more specialist staff are based. These members of staff are able to be on call to the satellite homes if needed. This is a powerful integrated model of property strategy re-enforcing strong social care support.

4.3.3 Financial Strength

Housing providers had significantly differing financial strengths, but despite large balance sheets and sizeable revenues, there was a general lack of appetite to consider taking on debt without also very significant grant subsidy. Grants have historically come from the Local Authority, NHS grant programmes and, where a provider was registered with them, the Homes and Communities Agency. Indeed, the example highlighted in Case Study 4.3 relied heavily on grant funding, as highlighted in the summary box on page 42.

CASE STUDY 4.3 (a)

From an Inpatient Facility to Supported Living for an Individual who has Exhibited Complex, Challenging Behaviour

Provider: mcch & Avenues

Robert is 38 years old. He has a severe learning disability, has Autistic Spectrum Disorder and Epilepsy, and also displays challenging behaviour. He has limited cognitive ability but has a great sense of humour and loves physical activities. After 4 placements had broken down over 5 years, Robert was detained under the Mental Health Act in 2003 and was moved to an inpatient facility.

Because of Robert's episodes of challenging behaviour, a whole 6 bed ward was cleared to accommodate him. Robert quickly caused damage of £25,000 in addition to the cost of 6 inpatient bed spaces, because this environment was completely unsuited to his needs. Thankfully though, the high cost of this placement meant there was pressure to move Robert to an alternative place to live within 6 months.

Holly Lodge

- mcch has now supported Robert into Holly Lodge – a unique service designed for people with behaviours that challenge.
- The scheme consists of 5 self-contained Supported Living properties and staff accommodation.

- Holly Lodge gives people their own space, without having to share with staff.
- Technology has been used to facilitate as much independence as possible and to create an environment that positively influences behaviour.

- The properties have mood lighting, water shut off valves, and movement sensors to track and learn how people use their environment, and to establish patterns.
- Windows have been designed to be narrow to avoid breakages and have integral blinds with magnetic controls. Kitchen doors have magnetic release without handles, internal walls are curved and non load-bearing allowing them to be moved or removed to meet individual needs and there are no internal doors.

The environment of Holly Lodge allows Robert to have more independence and support interventions have decreased. He is able to spend more time on his own, which he prefers, and whilst he continues to display behaviour that challenges, his behaviour has improved. Despite the high costs associated with this accommodation, savings of £30,000 per annum have already been made, and the costs are set to continue to reduce over time.

CASE STUDY 4.3(b)

Holly Lodge: The Costs

- £1.6 million upfront costs for building and land (£320,000 per unit)
- Development only possible because of up-front grants accessed by mcch. The grant was from the Primary Care Trust (PCT) – the PCT transferred a number of properties to mcch that were sold, and the capital receipts were used to seed fund the new service at Holly Lodge. The additional finance came from mcch's own funds.
- As a result of this arrangement, mcch have committed to cap rents at Holly Lodge at LHA level.
- But Holly Lodge has supported individuals out of inpatient facilities where beds were costing £7000-£8000 per week.

Some organizations were already approaching a maximum level of gearing, and others were clear that their trustees had a very clear aversion to any form of debt.

Instead of debt financing, most care and support providers told a story of collaboration with their peers: when they needed a property that they didn't have themselves, they would lease one from a willing peer. This disaggregated model shows genuine collaboration, however there was often dissatisfaction with the constant need to arrange bespoke property packages with deals ranging widely from leases based on LHA through to very high exempt rents. Sometimes this reflected build and/or adaptation costs, as well as the local market, and sometimes a deal was struck simply because the Local Authority would sign up to it. Some of the more organized and better-capitalised housing providers, especially the ones that primarily or only provided housing, were either less interested in developing this market or were perceived by their support providing peers to be very expensive.

There was a clear lack of consistency in the area of housing provision. What is sorely missing is a common framework against which housing is provided that takes account of geography, type of housing, cost of adaptations / removal, costs of a property being damaged by the tenant, and Local Housing Allowance. Without this, the volume of stock available to support providers is highly unlikely to ramp up to meet the demand that is needed in scenarios where greater numbers of individuals transition out of inpatient facilities. There is a shortage of housing generally in the UK and relying on housing benefit to 'take the strain' is less and less viable. Without having a common framework that both housing providers and local authorities sign up to, ensuring that the most vulnerable in society have access to appropriate accommodation will always be a bottleneck. At present the supply of property is not the most significant bottleneck, but if circa 2,000 new homes are needed in the short term (to facilitate individuals moving out of inpatient facilities), and the general demand for supported housing continues to rise, there is a need to have access to more capital for property at affordable rates.

4.3.4 Funding Required

If nothing more than the current inpatient discharge rate is maintained, then there is probably limited need for any additional capital to make more properties available. However, the ambition behind the commissioning of this report is that this rate is considerably accelerated.

Some housing providers do not need any capital, but others are starved of it. There is a greater need for some consistently priced provision such that the new properties can be accessed quickly. Assuming there is capacity to deliver 200 units a year with existing capacity, it follows that an additional real estate resource of 300 units pa over 4 years is needed to move 2,000 people out of inpatient facilities. Taking an average unit cost of £180,000 this equates to real estate resources of £216m and an immediate need of £54m.

4.4 Commissioning Support Provision

Providers have rightly highlighted that, every day, good provision is preventing the unnecessary admission of individuals with learning disabilities into inpatient facilities. However, as was highlighted in Section 3, thousands of individuals remain at risk of admission, due to a lack of community based provision and perverse incentives influencing the pathway to admission.

4.4.1 Joined up Commissioning

It is worth noting that in some areas, particularly where the Learning Disability Budgets of the Local Authority and CCGs have been pooled, there is strong practice around both prevention from individuals entering inpatient facilities and also bringing individuals into community based supported housing from out-of-area inpatient facilities. Four key things were repeatedly apparent where this pooling of budgets had happened:

- The number of individuals in out of area inpatient facilities were in low single figures if any at all;
- The commissioner had an inclusive framework of providers with whom there was a strong relationship, enabling the pooling of training and crisis avoidance;
- The commissioner had good visibility of the demand for services and shared this data with its providers so there was rarely a situation where emergency provision was needed;
- There was local leadership at all levels with clear commitment to taking responsibility for its citizens and a refusal to participate in the widespread 'gaming' that some authorities have felt forced into.

More common however was the opposite of these situations. Some providers shared examples of regularly having to turn away clients, one quoting as many as 4 a week, simply because they were given just a few days notice. As highlighted in Section 3, visibility of potential discharges is often non-existent at the local level. This lack of forward planning and visibility has also proved to be the case for people at risk of being admitted into inpatient facilities. In particular, considering that a significant proportion of the inpatient population are within the younger age range, there is a commonly held view that solutions for individuals leaving residential educational institutions are not identified early enough. This begs the question of how hard it would be to require the Local Education Authorities and the Adult Social Care team to work together more effectively in the transition of an individual from school to adulthood. If the data was visible, providers would probably be able to do the "joining up" naturally, as the majority have a small number of geographies they operate in and could even visit the schools themselves to make their services known to the schools, the families and the individual students.

4.4.2 Managing the Transition

Ever since the 1970s when a deliberate policy began to close what would then have been referred to as 'mental asylums', there have been various projects to move vulnerable adults out of a hospital setting and into some form of supported living. But this is now a significant generational moment where there is the political will and the momentum to close a number of hospitals that still exist as permanent places of residence for some very vulnerable adults.

The volume of people being actively managed out of ATUs and other inpatient facilities is currently very small. Despite most providers housing or supporting hundreds of individuals, the majority have only been able to actively manage 5 - 10 individuals out of inpatient facilities in the last 12 months. Indeed, across all of the 31 providers who submitted responses to a survey we conducted as part of this research, only 58 individuals had been supported out of inpatient facilities over the last 12 months – an average of only 2 people per organization. One organization had supported 15 individuals, but the majority had supported none at all over the last 12 months.

This is, we feel, mostly due to the lack of urgency, transparency and planning on behalf of some commissioners, but there is also a capacity issue amongst many good service providers. For every one person leaving an inpatient facility, at least two staff need to be recruited, and sometimes as many as six[17]. Recruiting, training and mobilising the staff takes 2-4 months. The property itself needs to be found, built, adapted and commissioned, which often means there is at least a couple of months of salaries to pay, in addition to the recruitment and training costs. Typically a month of rent also needs to be covered before an individual can move in.

[17] 24/7 2:1 support effectively needs 3 pairs of support workers working 8 hour shifts throughout the week.

The appetite from providers to ramp this up is there, but more than doubling this would require these mobilisation costs to be advanced to providers upfront, even with certainty of the contract to support an individual. As highlighted by findings from the Housing & Support Alliance survey of members, there is currently capacity to take between 100 and 200 people per annum, but at this rate there is no net reduction in patient admission[18]. This notion of limited current capacity is supported by our survey findings, where in aggregate, 31 respondents felt they would be able to support a total of circa 60 individuals out of inpatient facilities in the next 12 months – an average 2.3 individuals per organization.

There needs to be a change of gear, to more than double the transitions out of, and preventing further admissions into, inpatient facilities. Such acceleration will require a shift away from the immediate priority to save money for the public purse and instead focus on building the capacity in organizations providing supported living for people who have exhibited challenging behaviour. The savings will undoubtedly follow; there is no circumstance that we have come across in our research where someone supported in their own home was not at least £1,000 per week cheaper to support in the medium term, compared with the cost of their support in an inpatient facility.

	Low	High
Staff Recruitment / Training	£7,000	£20,000
Rent / Adaptations	£3,000	£20,000

4.4.3 Advocacy and Brokerage

Managing the transition, after an individual is identified as ready to transition out of an inpatient facility, is non trivial and too often is simply a commissioner deciding what is best (or cheapest) for the individual concerned. Best practice would incorporate the individual's and family's views, but too often an individual is just told what the decision is, and is moved. Even if the provider is able to manage the transition well, there is a missing piece in the process.

Advocacy and Brokerage is an essential piece of the jigsaw, which is currently overlooked. The data indicates that most inpatients do have access to an advocate, but the reality is that this tends to be toothless and somewhat tokenistic. Effective advocates need to be highly skilled and experienced, be aware of a range of community based, alternative solutions, be able to challenge the current process, and broker the solution. Together Advocacy and Brokerage needs to take responsibility for preparing the support plan, identifying a provider and project managing the discharge process throughout.

As an independent service, this function does not exist at any meaningful scale and the demand is too great to build something from scratch that can handle all the demand. It may be that this service cannot be fully independent from providers as the most likely recruits for an independent service would be some of the most skilled staff that providers currently employ, thereby diminishing their capacity on other ways. This should not stop the commissioning of the service, which is an essential step in the chain, but means simply that it would be impossible to meet the need without compromising on 'total independence' to some level. In practice, these conflicts of interest should not be difficult to manage.

4.4.4 Funding Required

Again we begin with the assumption that there is current capacity in the system to support 200 people out of inpatient facilities per annum, but we have an ambition to see at least 2,000 people discharged over the next four years. In this case, there is a need to inject some additional funding into providers. Assuming an average mobilization cost per resident of £20,000, plus £5,000 for advocacy and brokerage, providers will need a resource of approximately £30m to facilitate the move of this number of people.

[18]As highlighted by inpatient admission figures in Figure 4, Section 3.

4.5 Additional Strategic Needs

Creating new housing and investing in support providers, however, will never be enough. There are three additional elements that need to be resourced and championed if we are to see the eventual closure of the majority of ATUs and other inpatient facilities. Some of these may not be "investable" elements of the solution but appear from our discussions to be necessary to ensure that focused investment into the two areas above will have a long term impact:

a) A Positive Behaviour Training Academy to Train the New Generation of Support Workers

There are at least 2,000 individuals needing to move into supported living immediately, plus a continuing stream of people emerging from special needs schooling. There is therefore an immediate need to train over 4,000 individuals as professional support workers skilled in the understanding and practice of Positive Behavioural Support. Leaders in the sector have already sketched out a business case for an academy to achieve this, to be part paid for by the sector itself through membership fees, and part paid for through standard qualification models. This however needs pump priming with circa £2.5m of working capital, plus a further £3m for a physical location. This could be wrapped into a real estate investment fund, but the start up working capital would need to be provided as a grant.

b) Local Infrastructure – Assessment & Treatment Teams, Not Assessment & Treatment Units

Whilst there are clearly some assessment and treatment centres delivering positive outcomes for individuals, best practice indicates that, if a residential stay is necessary at all, it needn't be for more than a few days or weeks. Stays measured in multiple months are entirely inappropriate for the individual. There is some persuasive anecdotal evidence that assessment and treatment of acute episodes of challenging behaviour is best delivered in the home of the individual in order to minimise the disruption to the individual - with moving between locations itself often being a trigger for challenging behaviour. This may be true even for the most acute or forensic cases. There will undoubtedly be exceptions, and some providers have worked with commissioners to develop a small number of emergency bed spaces locally to be able to respond to such a demand.

If there is to be widespread closing of inpatient facilities and a significant number of individuals who have exhibited more challenging behaviour moving into supported living, commissioners must invest in local, specialist infrastructure. This should be based around a staff team of experienced community psychiatrists, psychologists, and other therapists capable of supporting, training and auditing provision within the community. Some of the larger providers have teams that do this internally, however, this type of service should be separately resourced and probably be both independent of provider as well as being locally distributed.

Commissioners will need to make a long-term commitment to fund this work.

c) Early Intervention for Families with Children with Learning Disabilities Including Better Educational Provision

Ultimately unless we stem the flow of people with learning disabilities into inpatient facilities, we will never achieve a sustainable solution. Whilst this is an obvious statement, achieving this is non trivial. It is essential to invest in widely improving practice in relation to children and young people with learning disability. Early intervention is regularly cited as the most significant action in the positive development of those with learning disabilities. There is some outstanding practice from organizations such as 'BeyondAutism' and 'Ambitious about Autism' that operate primary and secondary educational non-residential provision for children with severe autism, and those who have had episodes of challenging behaviour. Both are parent-led ABA (Applied Behavioural Analysis) schools who unswervingly stay focused on building functional living skills with their students to prepare them to be able to live as independently as possible. Both schools and their growing number of peers not only educate their students, they also work with families, employers and the wider community to prepare them for a society where people with autism are a visible and functioning part of our community. Replicating the success of these organizations in other parts of the country could be one part of a solution.

It may be that there are some poor residential schools feeding young people into poorly commissioned inpatient facilities, but there is undoubtedly a systematic failure in the transition from Educational funded services to Adult Social Care. Considering the visibility commissioners have of young people approaching adulthood this lack of joined up thinking at transition is indefensible.

4.6 Final Thoughts

Whilst it has proven very difficult to anticipate existing capacity in the sector, we do not believe that the sector can do much more than keep up with the rate of inpatient admission and support circa 100 discharges, above the natural flows, per annum.

With access to investment capital our estimates are that the rate of transitions out could easily double. This obviously requires some commissioners to continue to focus on this as a priority and others to adopt the good practice of their peers, such as pooling the CCG and LA Learning Disability budgets. However, to achieve a transformational effect and achieve circa 500 inpatient discharges per annum, whilst simultaneously preventing individuals from ending up there in the first place, there will need to be sustained funding and commitment to the three strategic priorities highlighted above, in addition to the social investment.

There may also need to be some strong commissioning changes explored to eliminate the perverse incentives that currently encourage poor practice. For example:

- Make the use of personal budgets for this client group mandatory or at least enable a right to request it by the individual. Whilst a non-trivial exercise, where the immediate effect might be less action and more restructuring, this kind of shift would undoubtedly kick start a change in culture for the long term;
- Support individuals to more easily exercise a right to challenge the service they are receiving;
- Allow providers to have the right to challenge as they do with local authority services. If a provider can put a case to a commissioner that they are able to support an individual better and more cheaply than via their inpatient status, then this should trigger a change/intervention. This obviously needs to take into account the individual's and their family's views to prevent a race to the bottom in terms of price and quality;
- Develop NHS England's specialist commissioning budget to Local Areas, as a way to force the pooling of all Learning Disability budgets across CCG and Local Authority spending.

4.6.1 Capacity Scenarios

We currently envisage three potential scenarios in terms of how the number of people resident in inpatient facilities could reduce over time:

a) Business as Usual' - No Change in Commissioning Environment or Capacity of Community Based Providers

The December 2013 census indicates an inpatient population of 3250 and data indicates an average net increase per quarter of 100 is commonplace in recent years.

b) Improved Commissioning with the Supported Living Sector Working at Full Capacity

Commissioning arrangements change (for example, enforcing joint commissioning may overcome the financial barrier to discharge, and ensuring independent clinician decision making may help reduce an element of the Clinician Decision barrier to discharge) so that providers are able to utilise their full capacity to support people to move out of inpatient facilities. Current research suggests providers have capacity to support an additional 200 people per annum. If the commissioning environment were made more favourable, we also envisage this could reduce the number of people being admitted into inpatient facilities.

c) Accelerated Case – Improved Commissioning and Investment in the Supported Living Sector

The SIB model incentivises commissioners and providers to encourage the discharge of individuals out of inpatient facilities, and funds additional resource to advocate on behalf of individuals, broker alternative community provision and project manage the whole process. Availability of investment also ensures the capacity of the sector grows, facilitating this higher number of discharges. Local infrastructure developments, "joined up" commissioning, and incentives attached to individuals remaining in community-based placements also stand to further reduce admissions.

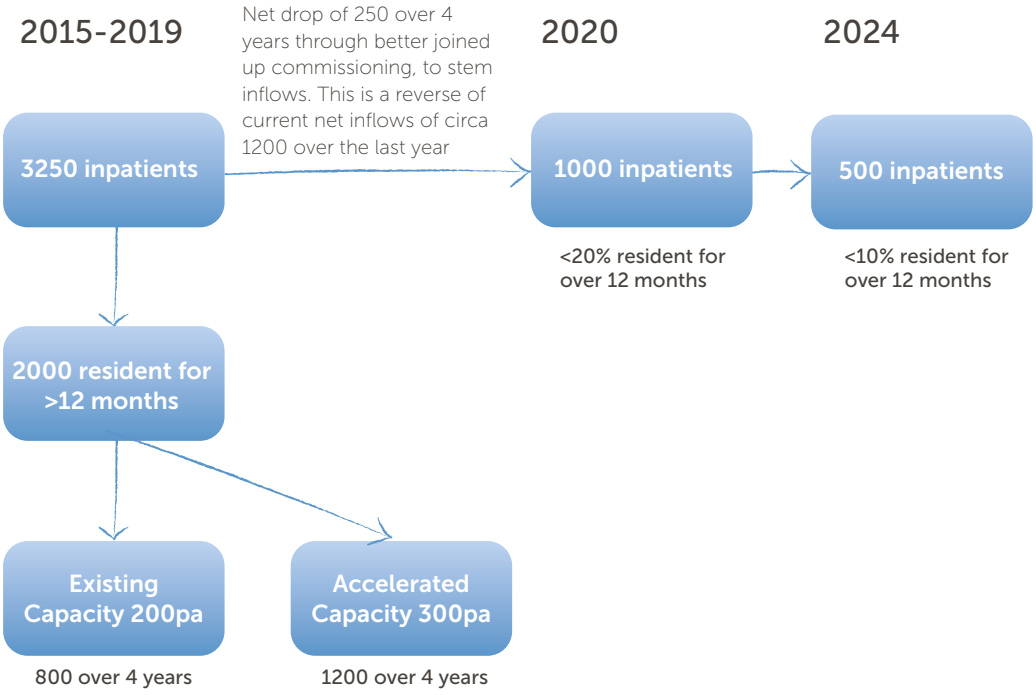
As summarised in the table on page 47, under the 'Business as Usual' scenario, there is currently a net inflow of approximately 100 people into inpatient facilities each year. In 4 years time then, the total inpatient cohort could reach at least 3650 people, should no intervention take place.

Scenario 2 assumes that providers become able to work at full capacity because of enforced changes to commissioning and policy. This sees a maximum of an additional 200 people being discharged per year, and an estimated maximum of 100 prevented admissions per year (because of local area incentives to prevent admissions into higher cost inpatient facilities). Even then, a net outflow of only 100 people per annum would result, taking the cohort to 2850 people by 2019.

	Business as Usual	Improved Commissioning, No Investment	Accelerated - Improved Commissioning AND Investment
Admissions Per Year	Circa 300	Circa 200 (reduction of 100)	Circa 100
Discharges Per Year	Circa 200	Circa 400 (additional 200)	Additional 300 (700 in total)
Net Inflows/ Outflows Per Year	Circa 100 **inflows** pa	Circa 100 **outflows** pa	600 **outflows** pa
Inpatient Cohort 2019 (4 years' time)	3650	2850	850
Reduction in Current Inpatient Population Over 4 Years	400 increase	400 reduction	2400 reduction

Under the accelerated scenario, we estimate that an additional 300 people per year could be supported out of inpatient facilities – a total of 700 people per annum (200 under 'business as usual'; 400 at 'full capacity'; 700 at accelerated capacity). We also assume admission levels fall by an additional 100 pa due to improvements in commissioning and local infrastructure. This would see a net reduction of the inpatient population by 600 people, with the total cohort standing at circa 850 by 2019. Overall, this would represent a reduction of the current inpatient population by 2400 people.

We propose that this reduction in the number of people currently resident in inpatient facilities could be achieved by focusing on the c. 2000 people who have been resident for over 12 months. In scenario 3, we assume that 500 people are discharged each year, in addition to the 200 people already expected to be discharged, amounting to 2000 additional discharges over 4 years. A direct focus on this 12 month+ cohort people could ensure these objectives are met in a targeted way.



5. Social Investment Options

The image of Holly Lodge courtesy of mcch: Artist drawing of individual's bungalows in supported living.

Key Question:

What are the options for social investment or forms of capital to help finance the scale-up of third sector responses?

Key Conclusions:

There are a very wide range of possible forms that social investment can take, and we have attempted to review the main possibilities under four groupings: a) Pooled funding arrangements providing leased housing to providers, b) Pooled funding arrangements providing flexible lending to providers, c) Direct investment arrangements, d) Revenue funding arrangements. These sit on a continuum between forms that are better suited for providing large-scale property asset financing and forms that provide working capital to grow service provision. Our view is that a "hybrid" approach is likely to be necessary, which combines the best elements of more than one form whilst retaining sufficient focus to represent a deliverable solution around which action can be taken.

5.1 Introduction

This report focuses on the options for "social investment or forms of capital" to help finance the scale-up of third sector response to the issue defined. By "social investment" we mean real financial investment (which has a realistic expectation of return of capital, and return on capital) but which is also intentionally seeking to have a measurable impact of a defined social issue. Social investment can therefore come in a very wide range of forms, and involve varying degrees of trade-off between pure financial returns and social impact (including no trade-off).

We believe that good social investment is "demand led" – in other words, the investment structures created fit the needs of social enterprises that have the demand for capital. They of course also need to be robust and attractive for investors who are seeking investment returns alongside social impact.

This section sets out a number of potential approaches to social investment in this area. The objective is to give a relatively wide survey of the broad possibilities before narrowing the focus in the following sections by using some specific criteria for need in this case. It does not attempt to be a comprehensive survey of investment approaches – for example, we have not considered crowd-funding approaches simply due to the scale of the issue at hand.

Some of the approaches summarized have been put forward in previous discussions around this issue. Others are new options. All have a number of advantages and disadvantages, and applications to different aspects of the problem. Our view is that a "hybrid" approach is likely to be necessary, which combines the best elements of more than one form whilst retaining sufficient focus to represent a deliverable solution around which action can be taken. Our approach is also to recognize that it may be necessary to start with something feasible, even if an ideal would take some time to grow from that. The important thing in this case is to make initial steps compatible with a bigger eventual solution for what is almost certain to be a growing problem.

5.2 Summary of Options

The brief for this research made reference to at least five approaches that have been previously mooted to support the provision of more appropriate housing and support to this client group. We have expanded this to eight approaches, but recognized that some of these are close variations on each other so can be thought of under four groupings, with two possible structures exemplifying each:

a) Pooled funding arrangements providing leased housing to providers;
b) Pooled funding arrangements provide flexible lending to providers;
c) Direct investment arrangements;
d) Revenue funding arrangements.

Appendix 3 gives a brief overview of each for those who are not familiar with the structures.

Each of these is explained in outline below. The first three focus primarily on capital for housing provision (with some elements of support) whereas the fourth focuses mostly on working capital for the support element (with potential to overlap with some housing related elements, particularly adaptations). However, in reality there is a continuum between structures, which are better placed to deliver each, as shown below, with the first three solutions more to the right of this diagram and the fourth more to the left.

We have set out below a brief description and analysis of each approach.

a) Pooled Funding Arrangements Providing Leased Housing to Providers

The common factor in these arrangements is the formation of a pooled funding vehicle of some form, which raises investment, acquires suitable properties and makes them available to providers under some form of long-term lease arrangement.

The form of the funding vehicle may vary from a traditional Limited Partnership property fund to a Special Purpose Vehicle set up as a Limited Company or PLC for the purpose. The form of the leasing arrangements with providers may also take on a wide range of different forms.

The key attractions of this approach are the ability to use such a vehicle to focus investment capital on the specific tenant group of interest, to create a proactive "champion" for this initiative in the sector as a catalyst for action, and to keep access to capital open to a very wide variety of providers, both large and small, across the country, in a relatively standardised form which they can easily take on (i.e. flexible lease obligations).

This approach needs to complement, as opposed to replicate, the specialist housing expertise that exists within the existing large-scale housing providers to the sector. The approach also needs to lease structures that are sufficiently robust to attract capital but sufficiently flexible to allow providers to manage their property portfolio over time.

Two examples of this structure are:

- Social property fund;
- Co-investment and bond vehicle.

b) Pooled Funding Arrangements Providing Flexible Lending to Providers

The common factor in these arrangements is the formation of a pooled funding vehicle, which raises investment, primarily in the form of debt, in order to on-lend to providers in the sector for their specific financing needs.

The form of the funding vehicle may vary but is most likely to be a Special Purpose Vehicle set up as a Limited Company or PLC for the purpose. The form of the lending to providers may also take on a wide range of different forms.

The key attractions of this approach are the ability to use such a vehicle to provide cheaper, longer term and more flexible terms on lending to (primarily housing) providers in the sector than are currently available to them from the mainstream financial markets. This in turn should allow housing providers to respond more effectively to the large capital needs to fund purchase of existing properties and development of new specialist properties which would arise from significant scaling up of provider activity to address this initiative.

The key issue associated with this approach is being confident that the access to more favourable lending terms by housing providers in the sector will provide the best way of ensuring capital is available to the specific needs of this initiative – concerns which would need to be addressed include:

- Whether cheaper debt would stimulate sufficient extra housing response from providers;
- Whether it would be focused on this issue or used to provide cheaper funding across the wider range of need served by these providers; and
- Whether it would be available to any but the largest of the housing providers, thereby excluding some smaller specialist housing providers who did not have sufficiently large balance sheets to raise large amounts of debt.

Two examples of this structure, which we consider briefly below, are:

- Bond aggregator;
- Layered debt fund

c) Direct Investment Arrangements

The common factor in these arrangements is that they do not rely on the formation of a pooled investment vehicle, but rather seek to create a more direct one-to-one "matching arrangement" between individual investors and investees in the sector.

The form of the investment could vary widely, depending on the preference of the individual investor and needs of the individual investee but the crucial distinction here is that the investor would have a direct investment relationship with the investee.

The key attractions of this approach are that it allows the maximum flexibility in matching investor and investee need. This could be on an individual deal basis, but with an eye to creating precedents and templates for deals, which could be replicated more widely across the sector.

The key issue associated with this approach is that it may either end up depending very heavily on meeting the needs of a single, large investor or arranging a large number of smaller bespoke deals, both of which carry significant transaction risk.

Two examples of this structure, which we consider briefly below, are:

- Single direct investor (pension fund / insurance company);
- Multiple direct investors.

d) Revenue Funding Arrangements

The common factor in these arrangements is that they focus primarily on providing working capital to allow service providers to increase staffing and other operational spend to deliver a significant scaling up of existing operations for the target tenant group, in contrast to the other funding mechanisms above which focus primarily on the provision of the property assets required.

The form of these arrangements could vary very widely, but the end result for service providers is likely to be some form of interest free loan, grant or fee for service which is closely linked to the costs of scaling up provision and the outcomes for individual beneficiaries.

The key attractions of this approach are that it directly addresses the revenue side of the equation which providers are struggling to cover at present through multi-lateral negotiations around specific projects with various interested agencies and funders (including NHS England, CCGs and LAs). It is likely therefore to be a necessary complement to the funding solutions above, which focus more on property asset financing.

The key issue associated with this approach is that it is likely to require some significant restructuring of existing commissioning arrangements and revenue flows, and it is therefore questionable whether it is feasible in anything other than a commissioning "reform" scenario, which may be complex, face structural barriers and take some considerable time to implement. A concern would therefore be to seek something here, which was relatively simple and quick to implement.

Two examples of this structure, which we consider briefly below are:

- 'Payment for Outcomes' Fund;
- Redirection of existing budgets.

6. Criteria for Assessment

Key Question:

What criteria should be used in assessing these options?

Key Conclusions:

Given the complexity of this issue and the number of stakeholders involved there are a very large number of views and interests which need to be taken into account. It is inevitable that not everyone will agree either on the subset of criteria focused on, or the priority and weighting given to them. We have tried to group the main criteria under four headings, which should hopefully all be recognized as important to delivering a preferred option, namely that it: a) Meets the needs of the sector to help individuals, b) Makes best use of Government support, c) Fits with reasonable investor requirements, d) Can be practically delivered.

6.1 Introduction

In this section we propose a number of assessment criteria, which can be applied to the various options for social investment set out in the previous section.

We have been asked to consider the analysis of solutions on the basis of two scenarios:

- "Business as usual" – particularly with respect to current commissioning arrangements;
- "Reform" – what would be possible with sensible changes to commissioning arrangements?

Whilst we have tried to follow that distinction, the reality is that almost all plausible solutions do require some element of Government action and changes to commissioning arrangements, even if incremental, so we have highlighted in the recommendations where those are necessary rather than developing two sets of recommendations.

6.2 Summary of Criteria

Given the complexity of this issue and the number of stakeholders involved there are a very large number of views and interests, which need to be taken into account. It is inevitable that not everyone will agree either on the subset of criteria focused on, or the priority and weighting given to them. We have tried to group the main criteria under four headings, which should hopefully all be recognized as important to delivering a preferred option, namely that it:

a) Meets the needs of the sector to help individuals;
b) Makes best use of Government support;
c) Fits with reasonable investor requirements;
d) Can be practically delivered.

We set out below a brief analysis of these criteria and the sub-issues, which we consider to be most relevant to each.

a) Meets the Needs of the Sector to Help Individuals
This is clearly the dominant issue. We believe assessment under this criterion can be informed by the analysis of the individual need and sector response set out in sections 3 and 4 of this report.

The question can be broken down into a number of sub-issues:

- Is it primarily capital for housing or for support that is needed? We believe that the primary need is for working capital to allow providers to scale up transition support, but that capital for housing may become a need if the sector begins to significantly scale up its response to the issue;
- In what form do sector providers want to receive capital? There are already a significant number of large housing providers with access to debt (and in some cases equity) markets, for whom there could be some benefit to marginal improvements in the terms of debt available (tenor, interest rate). However, many medium or small providers do not want to take on debt obligations or would not be able to do so due to their lack of balance sheet scale. For those that do, there are already a number of existing investment readiness programmes and debt raising platforms (e.g. for example, the Retail Charity Bond platform recently launched). From discussions, we believe that many providers would however be interested in using standardized, flexibly leased property as an option if asked to significantly scale up provision over a relatively short timeframe;

- Is it important that the solution is open to a diverse range of providers (both large and small, across the country)? From many discussions we believe that the answer to this is "yes", because the solution is often one in which local / regional service providers need to be involved and the needs of individuals require a "plurality of providers" to be encouraged. This is not necessarily inconsistent with investment structures, which involved a smaller number of lead providers to start an initiative, but are open to others to join over time on transparent criteria;
- Is the solution one that can scale to address the long term needs of the sector (even if it starts smaller)? It is important to address the immediate problem for individuals with learning disabilities in inpatient facilities in the context of the significant, and likely, growing need across the sector.

b) Makes Best Use of Government Support

Government is clearly a central player in practically all solutions, given that Government backed revenue streams inevitably underpin a significant proportion of the costs of caring for this group of individuals. Government is also represented in a number of different forms (DOH, NHSE, CCGs, LAs etc.).

The sub-issues for this criterion are:

- Does the structure rely critically on an additional form of Government support beyond the revenue streams already provided to the sector (e.g. investment, guarantee etc.)?
- If so, does that appear to be an efficient use of Government capital, and are certain forms more difficult than others to provide (e.g. it is assumed that wide ranging guarantees are difficult in the context of overall Government debt reduction initiatives, but that it may be easier to mobilise existing pools of resource which could be appropriate to address this issue – e.g. LIBOR fines, NHS property sale proceeds)?
- Does it require a restructuring of existing commissioning arrangements and therefore negotiation / agreement between different Government departments?

c) Fits with Reasonable Investor Requirements

Investor requirements should not drive the exercise, but are clearly another necessary condition to a successful solution.

Different structures address different (but potentially overlapping) sections of the overall investor universe. Each has some constraints around risk profile and return requirements, which need to be taken into account.

The sub-issues for this criterion are:

- Is the structure relatively familiar to investors?
- Can it deliver a commercial risk-adjusted return on the specific investment proposal, or is it requiring an investor to trade off return for social impact in a "blended return"?
- Will it address key investor concerns specific to social investment (including, importantly, on-going regulatory / policy risk in the sector)?
- Does it have the potential to address a relatively wide range of investors from different categories?

d) Can be Practically Delivered

This criterion is closely linked to the huge complexity of this situation, and the number of interest groups and stakeholders involved. It is therefore possible that there is a theoretically ideal solution which is however very costly, slow and risky to deliver in practice. It is also important to recognize that this is an issue, which demands quick action for the individuals involved, and a sector, which has considerable existing expertise and resource. It is therefore possible that a new intervention could have value as a "catalyst" for action, even if it did not initially address the entire problem.

Sub-issues are:

- Cost and speed to get an initial version of the solution up and running;
- Ability to select an initial cohort of beneficiaries, initial commissioning partners, and initial framework of core providers to focus on demonstrating some material results which can then be rolled out further;
- Overall "transaction risk" of the solution proposed (e.g. to what extent does it depend on the actions of a single counterparty; could it be easily de-railed by next year's election etc.)?

6.3 Assessment of Options Against Criteria

In the table below we have attempted to summarise our analysis of the options against these criteria and draw some summary conclusions against each. In order to present a high level summary, the table is necessarily somewhat simplistic in assigning "tick or cross" values, but the rationale for each column is set out in more detail in an expanded analysis in Appendix 2.

Option	Criteria				Summary Conclusions		
	1. Needs	2. Govt	3. Investor	4. Delivery	Key attractions	Key issues	Overall
1A. Social property fund	✓?	✓	✓	✓	Quick to start, scalable and open to diverse providers. Helps providers respond to scaling up with a more standardized leased housing offer. Focus and catalyst for action.	May need 'Payment for Outcomes' Fund and/or revenue budget to pay for adaptations. Lease terms need to balance provider flexibility with investor certainty. Should complement not duplicate existing sector housing expertise.	**Good**, in scenario where sector is scaling up provision.
1B. Co-investment and bond vehicle	✓?	?	?	✓	Reasonably quick to start, scalable (if Govt. backed) and open to diverse providers	As for option 1 and/or depends more heavily on Govt. co-investment bond	**Ok**, but depends more heavily on Govt. support and bond finance
2A. Bond aggregator	?	x	✓	?	Reduces cost of debt to large housing providers	As for option 1 and/or depends entirely on Govt. guarantee; also likely limited to large housing providers who already have good access to capital markets.	**Limited**, to few large housing providers
2B. Layered debt fund	?	?	?	?	Reduces cost of debt to large housing providers	As for option 1 and/or depends entirely on Govt. junior debt (and other junior debt providers); also limited to large providers who already have good access to capital markets.	Limited to few large housing providers

Option	Criteria				Summary Conclusions		
	1. Needs	2. Govt	3. Investor	4. Delivery	Key attractions	Key issues	Overall
3A. Single direct investor	?	✗	✗	✗	Single counterparty, in theory, easier to negotiate; could set a template for further deals	Not clear major institutional investors would accept risk / return profile at this stage without onerous Govt. commitments; also likely limited to large providers	**Limited** to few large housing providers, **and risky**
3B. Multiple direct investors	?	✗	✗	✗	Flexible matching of different needs of various investors and providers	As for option 1 or 4 (depending on type of investor), and highly complex and inefficient to coordinate and deliver	**Complex and risky**
4A. 'Payment for Outcomes' Fund	✓	?	✓	?	Deals directly with adaptation, transition and care costs	Time and complexity of structuring 'Payment for Outcomes' contracts given initial starting conditions to free up savings (block contracts etc.)	**Good**, but time / new commissioning required
4B. Redirecting existing budgets	✓	?	-	?	Deals directly with adaptation, transition and care costs; possibly less complex than 'Payment for Outcomes'?	Not an investment solution – just redirects existing budget from inpatient facilities to local solutions, with expectation (but no guarantee) of savings over time	**Not an investment solution**

7. Preferred Option

Key Question:

Based on the criteria, what is the preferred option? How might the preferred option change if current commissioning arrangements changed?

Key Conclusions:

Based on the criteria, we recommend a hybrid approach which uses two linked investment structures in a complementary way: 1) A 'Payment for Outcomes' Fund to provide working capital funding to providers in order to scale up projects and staffing teams as well as specialist property adaptations, ultimately funded by longer term savings to health budgets, and financed by social investment. 2) A linked Social Property Fund to help providers respond to increased property needs if provision was significantly scaled, providing a more standardized leased housing option across the sector, promoting plurality of providers and localised housing / support choices for individuals, and acting as a focus and catalyst for action. Whilst the two structures could, in principle, be developed independently, and one could exist without the other, in practice we believe there are strong reasons to develop the two in a coordinated and complementary way.

Government seed investment / support is needed to kick-start this, providing leadership, confidence to investors and sector stakeholders and an acceleration of timelines. Better commissioning alone might in itself reduce net inflows to inpatient facilities but, without this investment impetus, constraints on providers will continue to imply thousands of individuals remaining in this situation for decades to come, and the likelihood of future "Winterbourne View" scenarios recurring.

7.1 Introduction

Given the criteria and options considered, we believe that the preferred option is a hybrid approach, which uses two linked investment structures in a complementary way:

a) A 'Payment for Outcomes' Fund

We believe that the primary sector need is for funding to providers enabling them to scale-up projects and staffing teams to address greater numbers of individuals transitioning out of inpatient facilities. A prerequisite to this is a clearer commissioning framework, which properly incentivizes longer term planning and commissioning behaviour for this activity. This could be significantly enhanced by a 'Payment for Outcomes' Fund structure, which is ultimately funded by longer term savings to health budgets, and financed by social investment. This Fund could also help pay for specialist property adaptations which were essential for adapting property to the needs of individual tenants but which did not add to the property's market value.

b) A Linked Social Property Fund

The sector does not appear to have major constraints on property provision under current levels of activity, with a large number of housing providers many of which have good access to capital markets. However, we believe that there is still strong merit to the creation of a social property fund focused on this area. This would help providers respond to increased property needs if provision in this area was significantly scaled up under this initiative. Its key contribution would be providing a more standardized leased housing option across the sector, promoting plurality of providers and localised housing / support choices for individuals. It could also act as a focus and catalyst for action.

We believe this approach addresses the two major capital needs for the sector but also has the merit of keeping the support element of provision, which may include some specialist property adaptations, separate from the pure property element (even if the same provider may in many cases provide both on an independent basis).

As noted in previous sections, we are not suggesting that social investment initiatives such as this can be seen in isolation from the need to significantly strengthen sector infrastructure in areas such as training, local emergency response teams, and investment / contract readiness support for providers. It is also likely that a significant

"push" factor will be needed in some form to galvanize action in moving individuals out of inpatient facilities, to complement the enhanced sector "pull" which could arise from these investment initiatives by third sector providers. Examples may be commissioning teams going into inpatient facilities directly to act as "discharge" teams; and/or deadlines set for closure of some "failing" facilities. The merits of these approaches are beyond the scope of this report.

Finally, we are not saying that other social investment structures proposed for the sector do not have any merit, or could not be of assistance to some sector participants. Our recommendations are simply for the two structures which we consider best meet the overall criteria, and for how those could be progressed, which may not exclude other social investment initiatives by intermediaries and providers. Critically, we feel these two structures are accessible to a wide range of providers independent of their operational size or balance sheets.

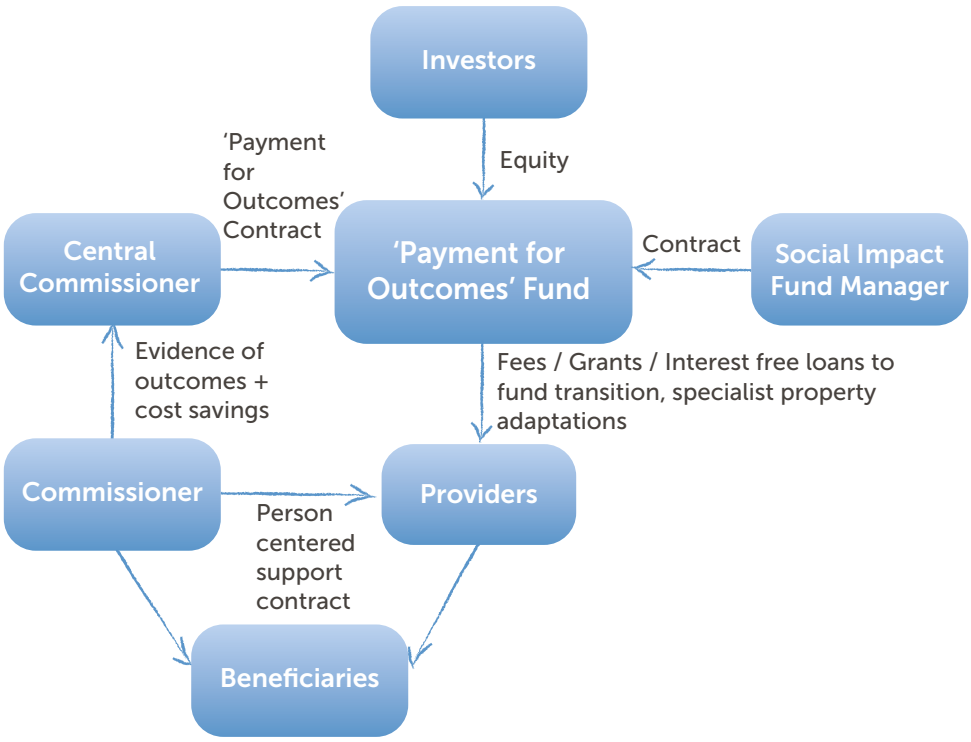
We analyse further each of the two elements of our recommended option below.

7.2 'Payment for Outcomes' Fund

The purpose of this element of the structure would be to help providers to fund the transitional costs of supporting a resident into their new home (advocacy/brokerage and staff mobilisation) and any required adaptations that are above and beyond a standard specification which can be economically provided by a housing provider (including a Social Property Fund) which may be necessary for some tenants but not others. Examples of this could be the conversion of a bedroom to a wet room, all room air conditioning, or significant strengthening to the fabric of a building.

This funding vehicle (which could take on a number of different legal forms, but is referred to simply below as the Special Purpose Vehicle or "SPV") would have a payment-for-outcomes contract with the NHS England (and other commissioners as they are willing) where payments would be triggered by clear delivery of sustained support and specific positive outcomes for individuals, which would be expected to be at a meaningfully reduced cost in the longer term compared with the inpatient facility.

4A: 'Payment for Outcomes' Fund



For example, if the expectation was that, in time, a resident could be supported at a cost of £1500pw in the community, compared with £2500pw in the inpatient facility, then a one-off payment of, say, 50% of this expected saving would be paid to the SPV in the event of the provider achieving the positive 'outcome' for the resident of successfully making this move. In this scenario, assuming a sharing of 50% of the expected saving over a 12 month period, a payment of £26,000 would be paid – an amount which could cover the specialist property adaptations, transitional cost of the provider and a financial return to investors in the 'Payment for Outcomes' Fund. It should be noted that at this stage all figures around expected savings are indicative and for illustration purposes only. However, we have seen anecdotal evidence of annual expected savings per individual of anywhere between £50 – 125k.

The generic structure of a 'Payment for Outcomes' Fund is set out on page 60.

We believe that this structure fits the assessment criteria well for the following key reasons:

a) Meets the needs of the sector to help individuals – based on our research, we believe that the immediate need is for providers to have the working capital and commissioning clarity to scale up provision from the relatively small numbers who are currently being transferred out of inpatient facilities. A 'Payment for Outcomes' Fund focuses on these two issues directly. It gives providers the data and contracting certainty to plan for scaling up activity, and the capital to do it, rather than simply attempting to respond to shorter term, ad hoc commissioner requests.

b) Makes best use of Government support – the main intervention from Government would be to ensure that an attractive 'Payment for Outcomes' contract could be offered. This might involve in the short term, some payments that were overlapping (e.g. if block contracts for inpatient beds could not be immediately unwound) but would ultimately be driving towards savings for Government in this area.

c) Fits with reasonable investor requirements - there is an increasingly developed market of investors who are interested in investing in these structures. For example, there is now an impact investment fund, which is dedicated to the purpose of investing into 'Payments for Outcomes' Funds (The Results Fund).

d) Can be practically delivered - 'Payments for Outcomes' Funds are still a relatively new investment innovation and can take a considerable time to develop. However, as the costs funded by the 'Payments for Outcomes' Fund would be approximately 8-12% of the property acquisition costs, initially a Fund of just £5-10m would be required to complement the first phase of the linked Social Property Fund discussed further below. This could focus on an initial cohort, and coalition of willing commissioners and providers, which could then be further expanded and replicated.

There are a number of more detailed issues which will need to be addressed in the next phase of development of such a structure, including:

- The form of the 'Payment for Outcomes' Fund – there are an increasing number of precedents now available for structuring 'Payment for Outcomes' Funds (sometimes also referred to as 'Social Impact Bonds') with advantages for different circumstances. These deal with the basis on which the fund vehicle is established with investors and on which it contracts with providers to share risk. For example, the Fund may provide any or all of (i) fee for service, (ii) grant or (iii) interest free loans to providers.

- The data necessary to structure the Fund – it will be necessary to obtain better data than has been available to date on the distribution and characteristics of the individuals affected and the potential cost savings and timings of those savings recognizing, for example, that it may be inappropriate to expect any cost savings for at least 6 months after transition out of inpatient facilities.

- At what point in the transition does the commissioning responsibility trigger a review of budget responsibility? Ordinarily this happens at the point of transition but in this specific case, as it is often a reason for the delay of transition, it may be best to defer this until a number of months post transition at which point the support need is better understood and the resident is more settled.

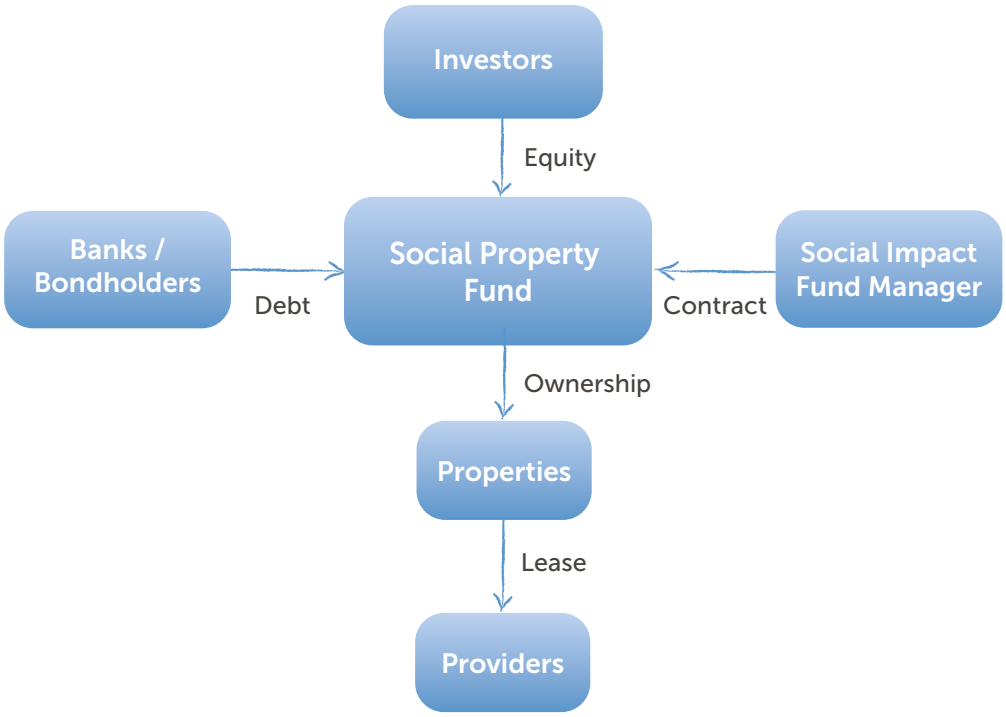
- The timing and roll-out of the initiative – as noted above, it may make sense to focus initially on a significant (not small scale) pilot for a specific cohort and grouping of commissioners / providers who are already actively engaged in these issues. Given the likely time to fully structure a SIB (12 months) and the urgent need in this case, it would also be worth exploring the transitional arrangements for a SIB and whether any transitions out of inpatient facilities can begin even whilst the longer-term incentive mechanism is being put in place.

7.3 Social Property Fund

The purpose of this element of the structure would be to give further impetus to the supply of specialized housing, in a scenario where providers were significantly scaling up activity from current levels.

The fund would acquire properties, and cover all acquisition costs and any refurbishment to bring them up to an agreed specification as set out in a Framework Agreement, but not very specialist adaptations necessary for individual tenants, which would be separately covered by the 'Payments for Outcomes' Fund described above. The fund would lease the properties it acquired to an initially small but inclusive group of approved providers with the relationship managed through the Framework Agreement. The financial return to investors would be based on the fund being paid Local Housing Allowance rates (or variations thereon) for rental but would also include capital gain on the property (if any).

1A: Social Property Fund



We believe that this structure fits the assessment criteria well for the following key reasons:

a) Meets the needs of the sector to help individuals – One theme from our discussion has been a general unwillingness or inability from many providers to take on significant levels of debt. Another recurring theme is that complete reliance on a pure private capital model for housing may drive provision models back to the scale and perverse incentives that have arguably helped create the "Winterbourne View problem". It is therefore necessary to think towards a social investment structure which bridges this gap.

A property fund makes a clear distinction between the providers of investment capital to fund property assets, the users of those assets, and the providers of support (even if the last two may be the same in many cases). It is also an inherently "open" structure which can provide a diverse range of housing and support providers with access to those assets on appropriate terms.

b) Makes best use of Government support – a fund structure should not require government guarantees of the investment vehicle or additional subsidies. It would seek to offer investors a risk adjusted return

on their investment as a market based solution to the capital need of this initiative. However, it could be seeded by initial investment from identified Government funding sources which would provide initial impetus and encourage private sector investment.

c) Fits with reasonable investor requirements – a property fund is a transparent and recognizable structure for investors. It can take initial "seed" investment from a small number of initial founding investors (including Government) and use this to attract further investment, potentially up to large amounts (£100-300m) which would be very difficult for individual service providers to raise on their own balance sheets.

d) Can be practically delivered – there are established models for property funds which can be delivered within reasonable budgets and timing, and which can move from initial smaller scale structures to larger scale structures in due course, as discussed in more detail below. By avoiding direct Government guarantees and subsidy, and by dealing with specialist property adaptations through the linked 'Payment for Outcomes Fund', it is also inherently scalable to address large scale capital needs for the sector.

There are a number of more detailed issues which will need to be addressed in the next phase of development of such a structure, including:

- **Scope of Activity**

We believe it will be important that the fund has a clear focus for its activity, centred on financing of housing for those with learning disabilities transitioning out of inpatient facilities. However, there are a number of natural extensions to this activity, including preventative housing schemes being developed by providers for those with learning disabilities leaving residential schools, and potentially further "upstream" to financing of property related educational facilities which promote the transition to independent but supported living.

A fund could provide capital for both targeted purchase and refurbishment of existing housing stock, and a proportion of its capital could also be used for development schemes. It may also be helpful for a fund to be a guaranteed purchaser and long term holder of property assets for which the development risk (and return) is taken by a specialized private developer, which would enable good practitioners in this area to recycle capital into new developments. Another extension of the fund's use could be as a vehicle to provide a "sale and leaseback" solution to existing housing providers in the sector, who could likewise use proceeds generated as financing for new developments.

- **Structure of Fund**

The fund would need to be able to guarantee security of tenure to the individual underlying tenants. This means it would be inappropriate to have a fixed term fund which required a sale of the property with vacant possession at a fixed date in the future. The options would therefore either be a fixed term fund which would need to sell properties with tenants in place to a defined universe of acceptable buyers or, more likely, a fund which did not have a fixed term.

Ideally this fund would take the structure of a Real Estate Investment Trust (REIT) or Property Alternative Investment Fund (PAIF), which are perpetual property investment structures where investors obtain liquidity either through the sale of listed shares (for a REIT) or other liquidity mechanisms for the redemption of their investment (for a PAIF). However, given their relatively high setup and operational costs, these structures require an initial scale of at least £100m and an existing asset base of at least £50m. It is therefore more likely that a fund would initially be structured as a Limited Partnership or Public Limited Company, without fixed term, with the intention of converting it into a REIT or PAIF when it reached greater scale. This would require initial investors to take a degree of liquidity risk on the investment.

- **Interaction with Providers**

It would be necessary for the fund to have a Framework Agreement with an initial group of providers and other sector participants, but which was flexible enough to allow new providers and participants to join who could demonstrate sufficient financial health (not necessarily scale) and quality of provision.

Providers could either approach the fund with a defined property need for existing property, or an identified property which needs to be acquired, or a development proposal which has reached a defined stage of development. Specialist developers could approach the fund, alongside a partner provider, with a development in need of guaranteed purchase at the end of construction (subject to some evidence of demand for this new property from a commissioner). Existing specialist housing providers could do either of the above, or approach the fund with a sale and leaseback proposal to free up development capital.

Operational responsibility for refurbishment of existing property could be dealt with in a number of ways, but financed by the fund. Payment for adaptations, which did

not add market value to the property would be separately covered by the 'Payment for Outcomes' Fund discussed above or directly by the provider or commissioner.

It would be important for the fund not to replicate the extensive specialist housing expertise which exists in the sector. It may be therefore appropriate for the fund to have a specific (independent) sector sponsor from amongst the industry organizations which cover the sector, to complement the activity of a specialist impact investment fund manager.

One of the key benefits of the fund would be to provide a relatively standardized lease option to providers under the Framework Agreement. The lease would need to reflect a balance between flexibility for providers and certainty and risk insulation for investors. It is clear that whilst institutional investors would like 25 year CPI linked contracts, this is too inflexible for providers, so it is likely that the leases would at least need break clauses at some point between 5-10 years, and some linkage back to the underlying rental stream (LHA or variants thereon). Risks would need to be allocated to those best placed to take them – that would likely involve on-going maintenance risk being taken by the provider (albeit in some cases subcontracted) but void risks might be shared between the provider and Local Authority.

- **Market Positioning with Investors**

The fund would be a residential property social impact fund, aiming to deliver commercial risk-adjusted returns and a focused impact in the area of Learning Disability, particularly around the issue of supporting move-on from inappropriate, institutional settings to a community-based, "supported living"[19] environment of choice for the individual.

Its social impact focus would be clearly defined around the specific issue of Learning Disability, allowing it to specialize (with appropriate sector partners) in this complex area, and also demonstrate a measurable social impact on this issue to investors over time. This would distinguish it from more generic "social" property funds.

Its headline return targets would not necessarily match the highest claimed by private equity property funds, but it would seek to reduce risk to investors to compensate for this and to thereby offer a more cost effective housing solution to providers in the sector who were skilled at managing the specific risks of this tenant group.[20]

Returns would be primarily in the form of income yield generated by leases to providers, with the potential for capital gain in the portfolio. The realization of capital gains would depend on an assumption of some turnover in portfolio but, for a large enough fund with flexible lease arrangements with providers, there would be an ability to statistically predict this element over time.

Given these dual impact and return elements, the fund would be of initial interest to a wide range of investors already interested in the impact investment space, including large endowed charitable trusts, high net worth individuals and family offices, wholesale impact investors (including Big Society Capital), larger Housing Associations who did not want to cover this issue in their core business model but for whom impact investment of surpluses in this area was mission-aligned, and potentially Local Authorities (where they have to invest directly in housing now, and this could provide a better use of capital).

Longer term, as it achieved scale and demonstrated track record for its model, the fund would have the potential to attract larger scale institutional investment, and also potentially be opened to ordinary retail investment (through transition to a REIT or PAIF structure). As noted above, initial seed funding by Government could provide an important first step in launching that process, and a strong signal of Government support.

[19]In its broad sense, which might most often follow a Supported Living revenue model, but could also be flexible to incorporate good providers under the Registered Care Home revenue model.

[20]Further analysis would be required as to whether the fund should be geared with additional debt, which could potentially enhance returns to investors but also expose them to greater volatility in returns if rental or capital values moved adversely.

7.4 Linkage Between the Two Structures

Whilst the two structures described above could, in principle, be developed independently, and one could exist without the other, in practice we believe there are strong reasons to develop the two in a coordinated and complementary way.

a) It would be possible for a Social Property Fund to exist without a related 'Payment for Outcomes' Fund to cover adaptation costs (and this is the current model adopted by many housing providers). However we believe that to scale a property fund of this nature requires a simple and recognizable structure so that institutional and individual investors can quickly see what they are buying into. In addition, such a structure would be less dependent on some of the complex rent subsidy arrangements in the sector which provide premiums to standard LHA rates, but which are potentially open to on-going policy risk.

b) The rationale for a Social Property Fund could exist independently, but is strongest in a scenario where the sector is being asked to significantly scale up provision in response to a clearer and more incentivizing commissioning framework (such as a 'Payment for Outcomes' Fund). Having said that, in could be that a Social Property Fund begins in parallel with a first localized (but not small scale) trial of a 'Payment for Outcomes' Fund rather than needing a 'Payment for Outcomes' model to pre-exist across the entire sector.

c) The "Social Property Fund + 'Payment for Outcomes' Fund" approach also enables the project to be more inclusive of small providers which may be under capitalized themselves and might naturally be excluded if there was not a separate 'Payment for Outcomes' Fund to fund the additional costs. Including smaller providers would add a diversity of provision that would strengthen the sector and the choice to individuals.

8. Roadmap

Key Question:

What could the next steps be to implement the preferred option(s)?

Key Conclusions:

There are some "quick wins" that can be achieved and, if possible, some resource should be released immediately to pilot parts of the strategy which will enable the fine tuning of operational relationships. We therefore propose that a new Community Interest Company (CIC) is set up with a £20m equity investment from NHS England and/or Department of Health. The purpose of this entity would be to channel existing capital funds available now and also in the future when capital is released if some public sector run inpatient facilities are ultimately closed. These funds would be deployed by the CIC into a variety of capital projects that relate to increasing the capacity of supported living in the community, including the two funds recommended in this report as well as some of the capital elements of the wider sector infrastructure needed. A further £10m of Government funding should be used for strengthening sector infrastructure as outlined further in this report.

8.1 Introduction

Establishing investment funds takes time and resources. There is much willingness across participants but there needs to be a clear sponsor of this exercise. NHS England appear to be best placed for this, but leadership and especially commitment to provide access to key commissioners and decision makers needs to be provided from both the Local Government Association (LGA) and sector bodies.

There is a particular window of opportunity to work closely with the Joint Improvement Programme (JIP), funded until the end of March 2015, to develop an investment framework that is accessible to some Local Government Commissioners.

The focus of this group is to provide intelligence to enable a social investment intermediary to be able to construct a source of finance, as outlined in this report, that can inject some of the necessary resource to build on the existing momentum and willingness and to accelerate the good work that is already underway.

We need to avoid a need for absolute consensus or to make the framework to benefit from investment so prescriptive that it is no longer useful. The investment structures need to be "additive" to the ways in which the sector is working, not the only way of working

8.2 Proposal for Immediate Action

There are some "quick wins" that can be achieved and, if possible, some resource should be released immediately to pilot parts of the strategy, which will enable the fine tuning of operational relationships.

We therefore propose that a new Community Interest Company (CIC) is set up with a £20m equity investment from NHS England and Department of Health. The specific purpose of this entity would be to channel existing capital funds available now and also in the future when capital is released if some public sector run inpatient facilities are ultimately closed. These funds would be deployed by the CIC into a variety of capital projects that relate to increasing the capacity of supported living in the community, including the two funds recommended in this report.

The CIC could be a wholly owned subsidiary of NHS England and Department of Health, a shell company with no operational costs, but as an asset locked body 65% of profits would always remain for the benefit of the learning disability community, ring fenced and unable to be re-channeled to another purpose. A volunteer board would be appointed by the shareholders to channel the capital in the best way deemed fit, under the guidelines above.

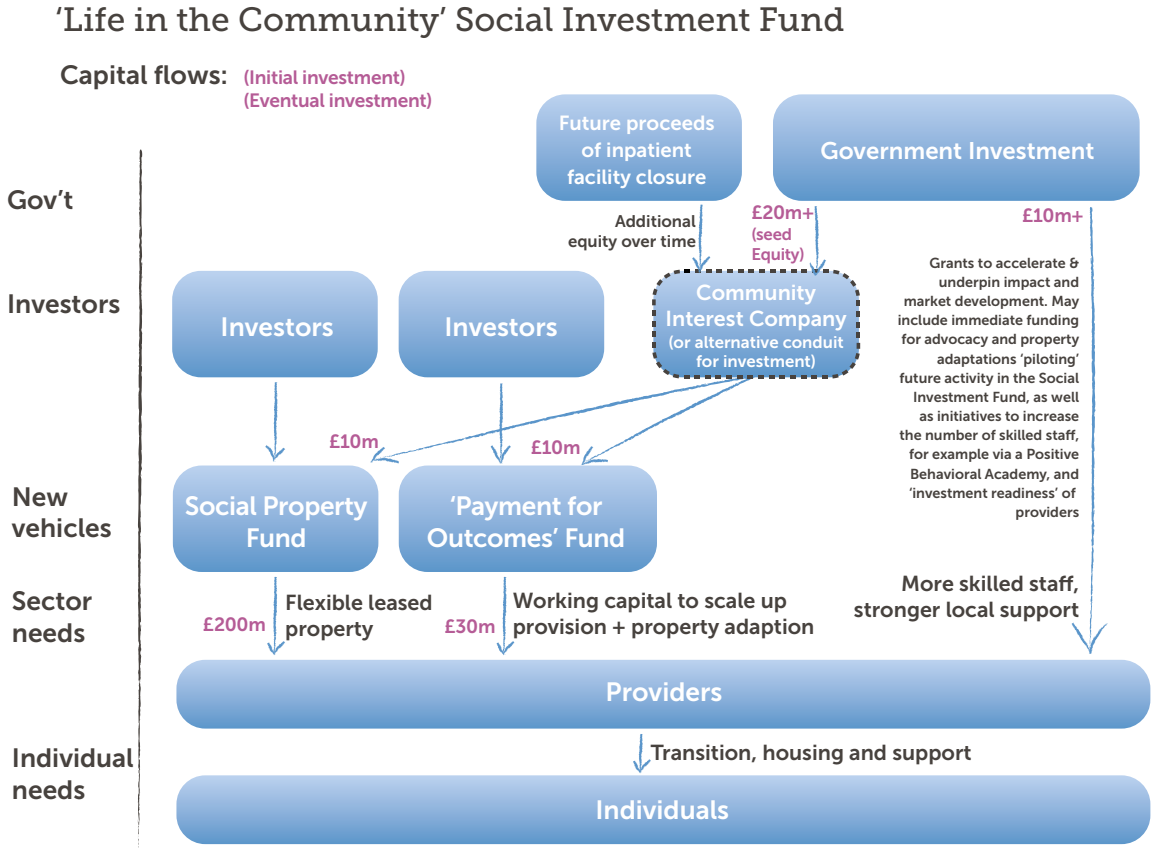
Additionally, either through this Community Interest Company, or directly we believe that a further £10m should be allocated to further strengthening of the wider sector infrastructure, including as priorities:

a) Pump priming a new Positive Behaviour Support Academy dedicated to training the anticipated 4,000 new support staff needed to support the 2,000 people moving out of inpatient facilities over the next 3-4 years.

b) Piloting customized adaptations for existing housing providers housing people moving out of inpatient facilities in the next 12 months, prior to a 'Payment for Outcomes' Fund being available for this element.

c) Funding some immediate advocacy and brokerage activity and to further train individuals, sharing best practice and begin to build capacity and acceptance of this essential function within existing and new organizations. These early activities will inform the pricing and running costs of a 'Payment for Outcomes' Fund, which is essential in building investor and commissioner confidence alike.

This approach, of an immediate CIC followed by the two investment structures proposed in this report, and the capital flows that would result are shown in the diagram below:



8.3 Roadmap to Social Impact Bond

We envisage an immediate application by NHS England to the Cabinet Office / Big Lottery Fund's jointly run Commissioning Better Outcomes and the Social Outcomes Fund with a Social Investment Finance Intermediary. This would enable the financing of the detailed structure of a 'Payment for Outcomes' Fund and, importantly, contribute up to 20% of the outcomes payment on delivery of the desired result.

For maximum effect other leading commissioners will need to be included, however as NHS England are by far the largest commissioner of inpatients beds, it makes most sense for NHS England to be the applicant. The development will need to draw from the wide group of stakeholders, but we anticipate this being a small group of sector representatives picked for their ability to contribute capacity and access to decision makers. The development process will naturally be iterative and each stage will need to be 'road tested' against future participants.

Initially the majority of detailed work would be to clearly target specific cohorts of people in order to have a way of prioritizing where to focus attention in the first instance.

The next priority would be to describe the desired positive outcomes for individuals and understand how these align with commissioner, provider, families and regulator priorities. This would form the basis of a set of framework agreements between the 'Payment for Outcomes' Fund vehicle, the Commissioners and the Providers.

With this sketched, the financial modelling can be designed such that the 'Payment for Outcomes' Fund can advance funds to the providers to prepare for an identified individual to move out of an inpatient facility and be repaid by savings to the commissioner after a period of time. This sharing of savings will also have to finance the operational costs of the 'Payment for Outcomes' Fund and generate a risk adjusted return for investors.

With strong commitment and a favourable decision from the Cabinet Office/Big Lottery, we anticipate that this work will be able to commence by December 2014 and result in a structured investment opportunity by end of April 2015. It is difficult to predict how long capital raising would take but we would expect the first funding to be available to providers from September 2015.

8.4 Roadmap to Social Property Fund

We envisage a two-stage launch for a Social Property Fund initiative. Initially the plan would be to commence operating with an open ended but unlisted vehicle seed funded by Government and a relatively small number of "founder" investors. A minimum viable fund might be as little as £20m with Government providing at least £10m corner stone investment either directly or through the CIC described above. However, if additional amounts of Government investment were available from specific funding pools (e.g. LIBOR fines, NHS property sales) then the structure could be scaled more quickly.

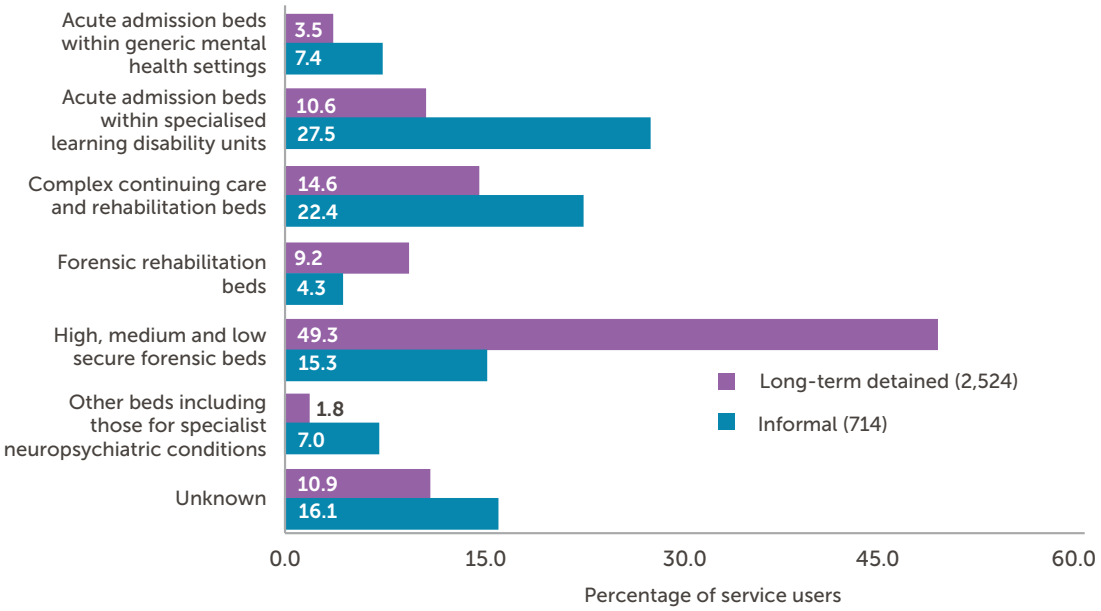
Otherwise, the fund could raise additional funds from impact investors over the first two years to circa £50m with a second stage launch listing the fund as a Real Estate Investment Trust (or equivalent) in order to scale to £100m-£300m.

Initial investors would most likely be a range of charitable foundations and existing impact investors, but following at least one full year of successful trading and eventual listing, the fund would become attractive to both institutional investors and ordinary retail investors.

As with the 'Payment for Outcomes' Fund, with strong commitment from Government in the form of anchor investment, we anticipate that this work will be able to commence by December 2014 and result in a structured investment opportunity by end of April 2015. If a small number of founder investors could be found to match Government investment then the property fund could launch immediately after April 2015, and make capital available to providers from that point onwards. Subsequent investment rounds for the fund would then increase the available capital to providers over time.

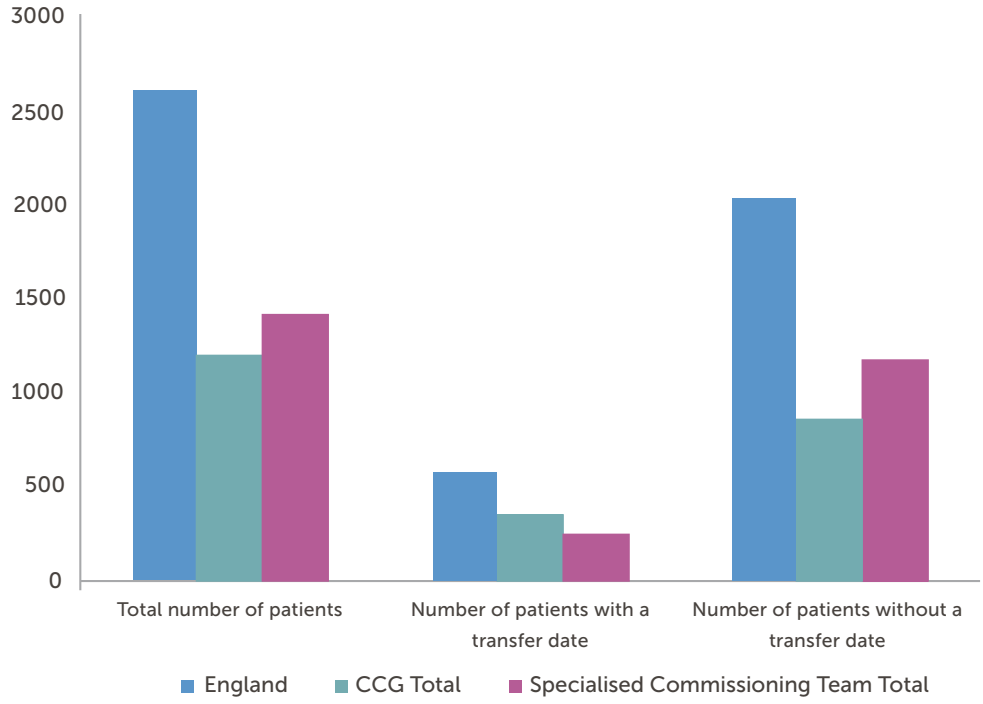
Appendix 1: Service Users & LA Data

1A: Service Users by Legal Status and by Ward Type



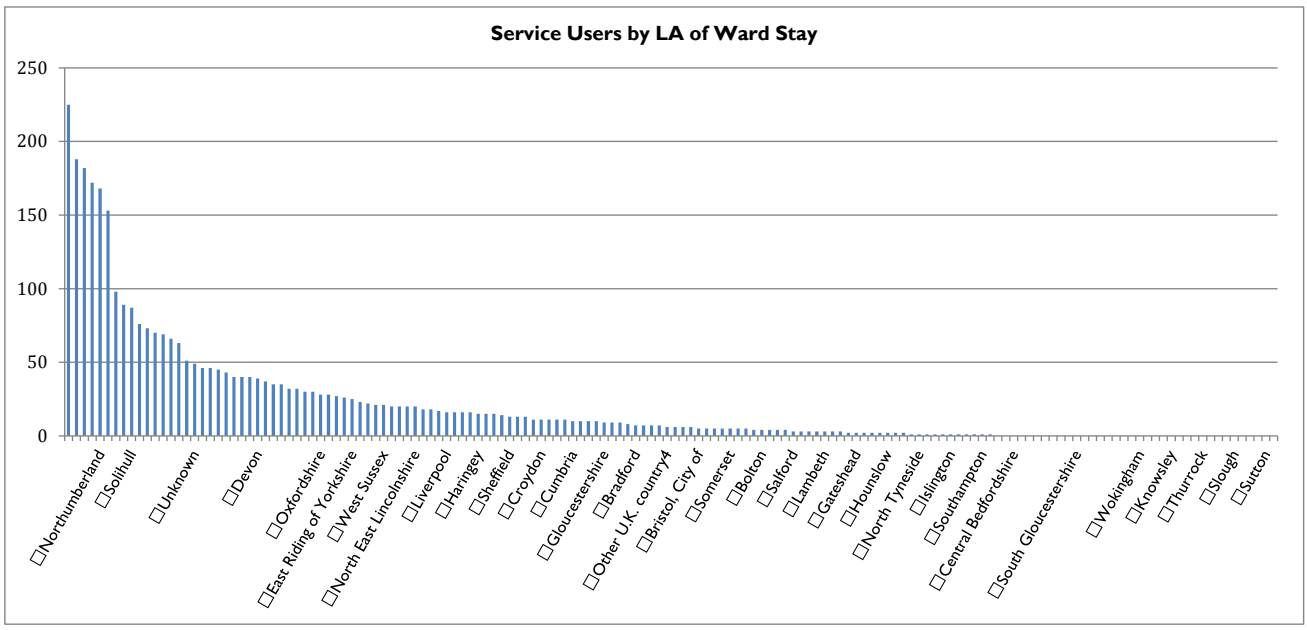
Base: 3,238
Data source: Table 10b of the reference data tables, Learning Disabilities Census Report 2013 (further analysis)

1B: Number of People Without a Transfer[21]



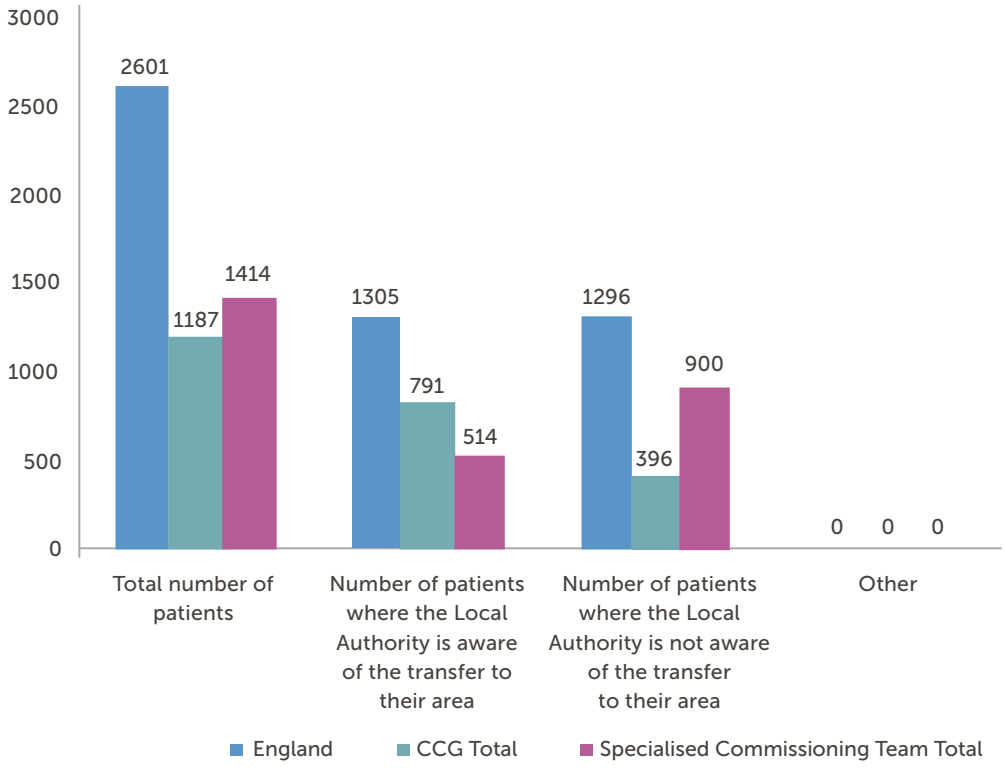
[21]Assuring Transformation: Meeting the Winterbourne View Concordat Commitments, NHS England, June 2014.

1C: Service Users by LA of Ward Stay



1D: Shown overleaf on page 72

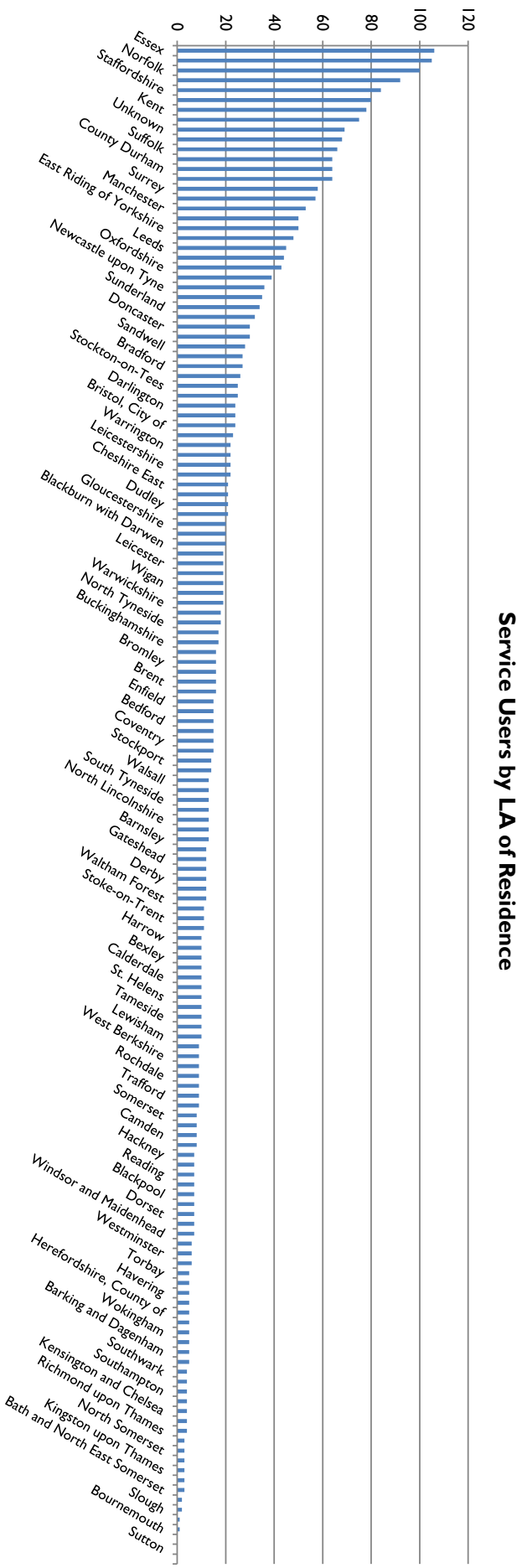
1E: Awareness of Local Authorities of Agreed Transfer Dates[22]



[22]Assuring Transformation: Meeting the Winterbourne View Concordat Commitments, NHS England, June 2014.

1D: Service Users by LA of Residence

Service Users by LA of Residence	
LA	Number
Essex	106
Hertfordshire	105
Norfolk	100
Lancashire	92
Staffordshire	84
Nottinghamshire	80
Kent	78
Birmingham	75
Lincolnshire	68
Suffolk	66
Northumberland	64
County Durham	64
Surrey	58
Worcestershire	57
Manchester	53
Hampshire	50
East Riding of Yorkshire	50

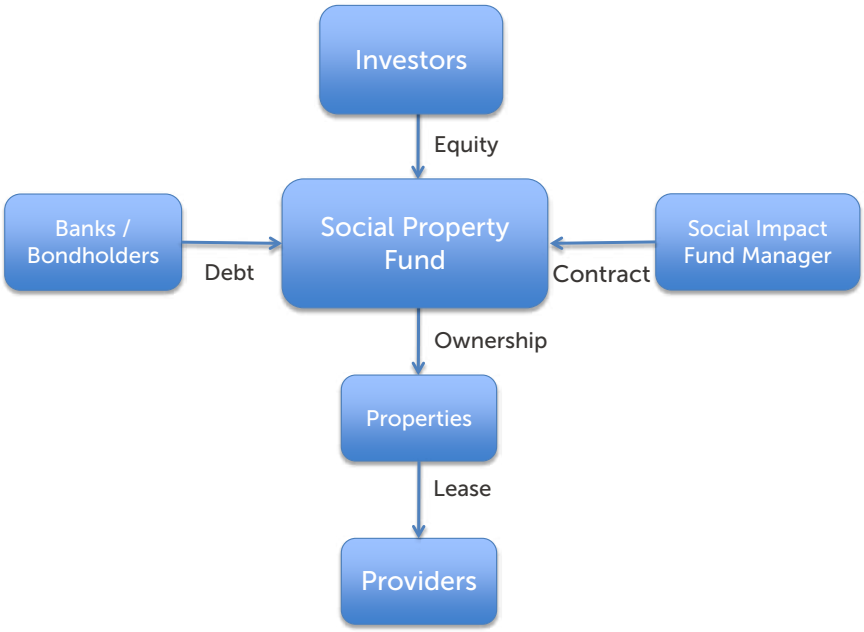


Appendix 2

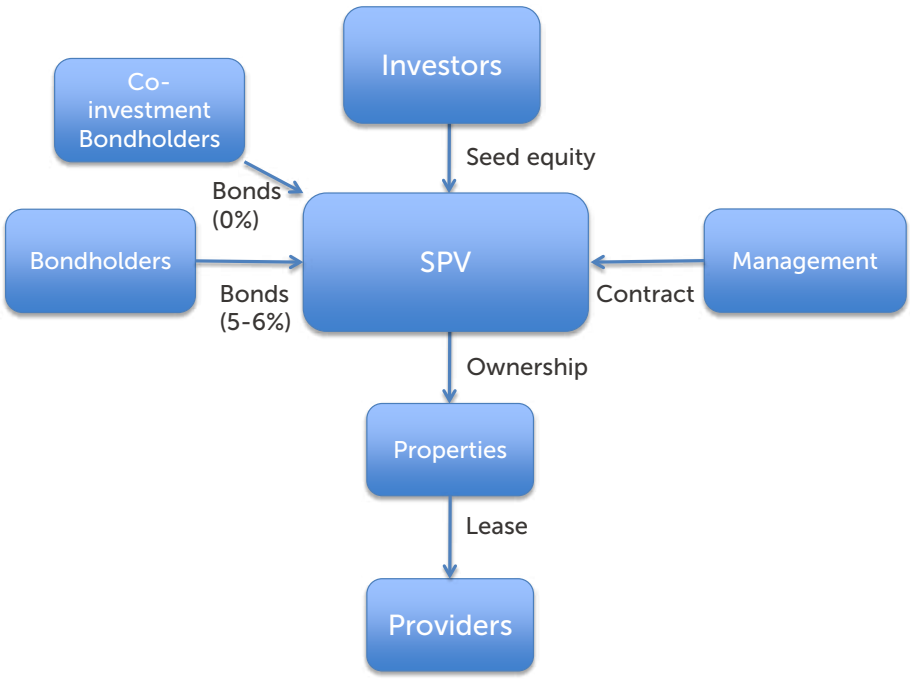
Expanded Analysis of Social Investment Options										
Option	1. Meets Needs of Sector to Help Individuals				2. Best Use of Govt Support	3. Fits Investor Requirements	4. Practical to Deliver	Summary Conclusions		
	Benefit to Provider	Housing, Support or Both ?	Open to Diverse Providers	Scalable				Key Attractions	Key Issues	Overall
1A. Social property fund	Properties under lease	Mainly housing (maybe some support)	Yes	Yes	Not critical, but very helpful (seed investor)	Possible (but more likely needs 'Payment for Outcomes' Fund and/or revenue budget for adaptations, transition and care)	Yes (maybe in 2 steps – LP/PLC first then REIT)	Quick to start, scalable and open to diverse providers. Helps providers respond to scaling up with a more standardized leased housing offer. Focus and catalyst for action.	May need 'Payment for Outcomes' Fund and/or revenue budget to pay for adaptations, transition and care. Lease terms need to balance provider flexibility with investor certainty. Should complement not duplicate existing sector housing expertise.	**Good**, in scenario where sector is scaling up provision.
1B. Co-investment and bond vehicle	Properties under lease	Mainly housing (maybe some support)	Yes	Yes (but heavily dependent on Govt. co-invest)	Critical (seed investor / coinvestment bond at 0%)	Maybe (but only if heavily subsidized by Govt coinvestment bond at 0%)	Yes (if bank facility before bonds)	Reasonably quick to start, scaleable (if Govt backed) and open to diverse providers	As for option 1 and/or depends more heavily on Govt. co-investment bond	**Ok,** but depends more heavily on Govt support and bond finance
2A. Bond aggregator	Cheaper and longer term debt	Housing	No	Yes (but totally dependent on Govt guarantee)	Guarantee (100%)	Yes, but only with Government guarantee	Maybe	Reduces cost of debt to large housing providers	As for option 1 and/or depends entirely on Govt guarantee; also likely limited to large housing providers who already have good access to capital markets.	**Limited**, to few large housing providers
2B. Layered debt fund	Cheaper and longer term debt	Housing	No	Yes	Junior debt	Maybe, but only if heavily subsidized by Govt junior debt position	Maybe	Reduces cost of debt to large housing providers	As for option 1 and/or depends entirely on Govt junior debt (and other junior debt providers); also limited to large providers who already have good access to capital markets.	**Limited** to few large housing providers
3A. Single direct investor (pension fund / insurance)	Depends – longer term debt most likely	Housing	Highly unlikely	Maybe (if can be replicated)	Guarantee ?	Unlikely (govt guarantee may derisk, but will still need commercial return)	Risky (depends on one counterparty)	Single counterparty, in theory, easier to negotiate; could set a template for further deals	Not clear major institutional investors would accept risk / return profile at this stage without onerous Govt commitments; also likely limited to large providers	**Limited** to few large housing providers, **and risky**
3B. Multiple direct investors	Depends – debt, equity or leased property	Mainly housing (maybe some support)	Maybe	Difficult	Guarantee ??	Mixed (may be a few social investors who will take lower return for impact)	Very risky (complicated process)	Flexible matching of different needs of various investors and providers	As for option 1 or 4 (depending on type of investor), and highly complex and inefficient to coordinate and deliver	**Complex and risky**
4A. 'Payment for Outcomes' Fund	Fee for service, grant, or possibly loan	Support (but maybe including housing adaptation)	Yes	Yes (if 'Payment for Outcomes' contracts can be expanded)	'Payment for Outcomes' Contract	Yes, if 'Payment for Outcomes' contract sufficiently attractive	Ok, but takes time for 'Payment for Outcomes' contract	Deals directly with adaptation, transition and care costs	Time and complexity of structuring 'Payment for Outcomes' contract given initial starting conditions to free up savings (block contracts etc)	**Good**, but time / new commissioning required
4B. Redirecting existing budgets	Fee for service, grant, or possibly loan	Support (but maybe including housing adaptation)	Yes	Yes (limited by budget size)	Initially same cost for Govt but may reduce over time	n/a	Ok, but may take time to get money to follow individual	Deals directly with adaptation, transition and care costs; possibly less complex than 'Payment for Outcomes' Fund?	Not an investment solution – just redirects existing budget from inpatient facility to local solutions, with expectation (but no guarantee) of savings over time	**Not an investment solution**

Appendix 3 : Investment Structure Options

1A: Social Property Fund

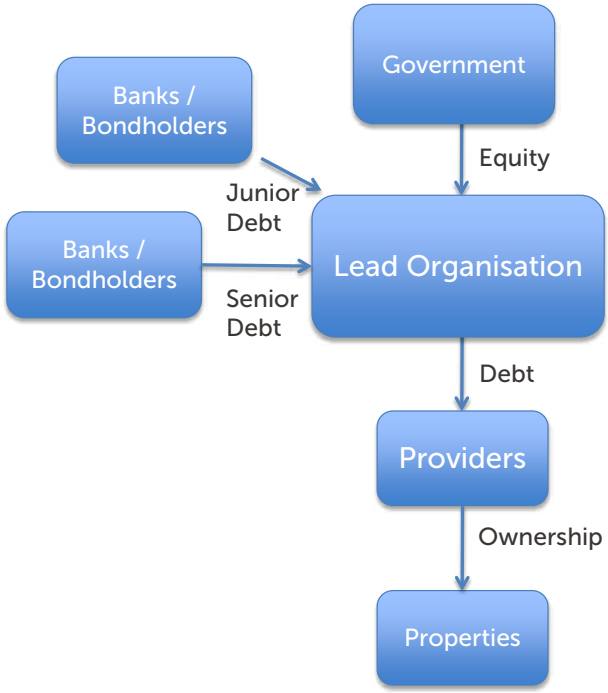


1B: Co-Investment & Bond Vehicle

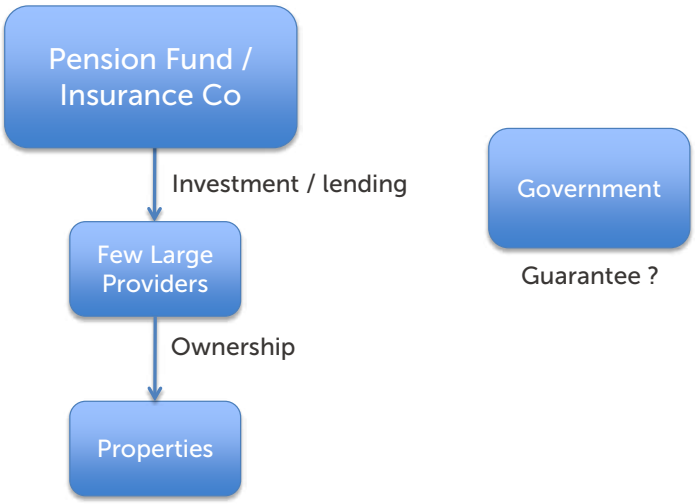


2A. Bond Aggregator

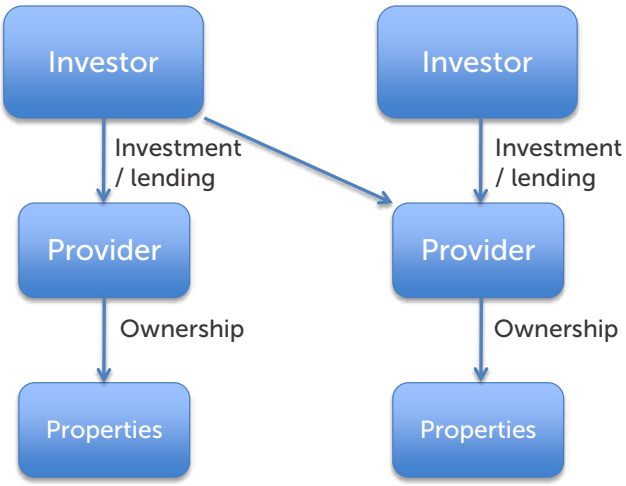
2B. Layered Debt Fund



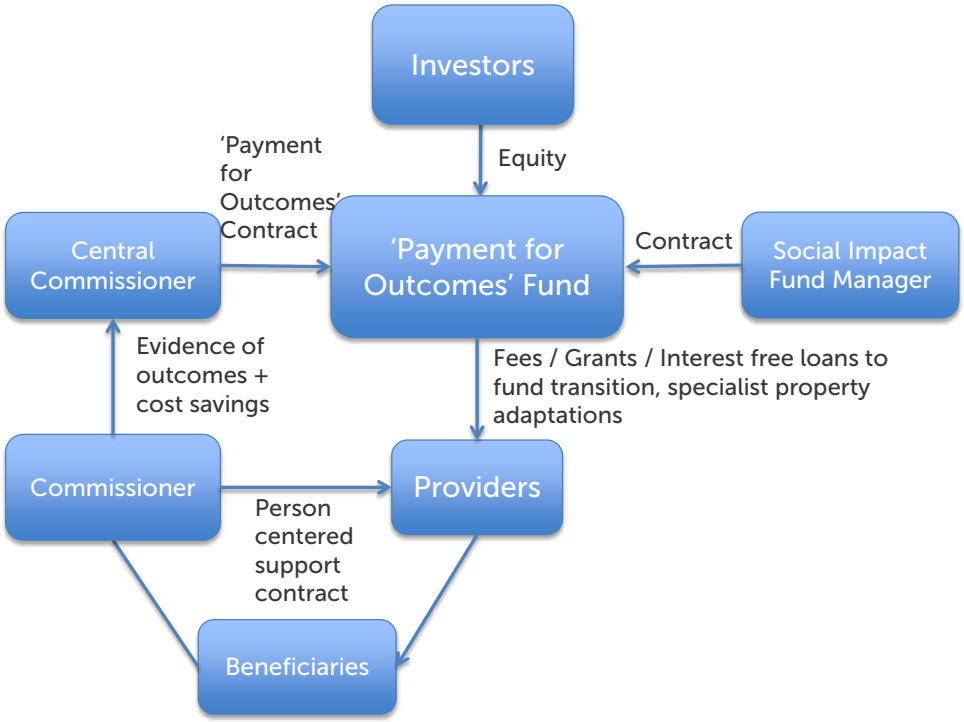
3A. Single Direct Investor



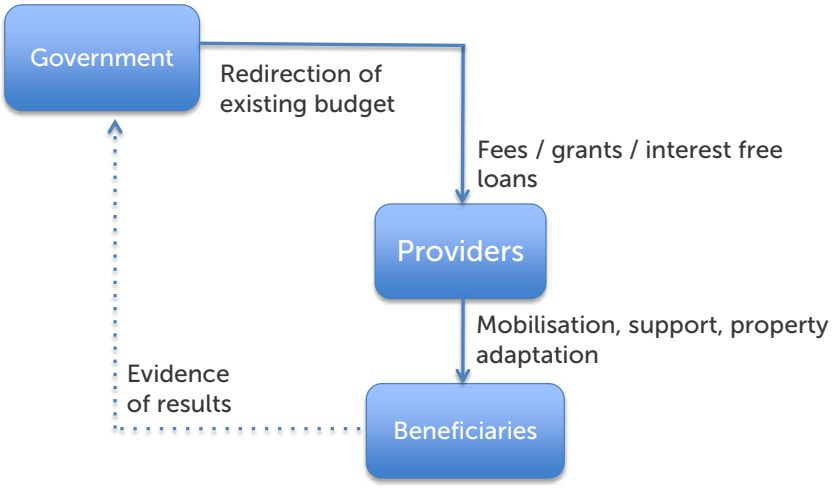
3B. Multiple Direct Investors



4A: 'Payment for Outcomes' Fund



4B: Redirection of Existing Budgets



Appendix 4: Organizations We Worked With

The following is a list of the organizations with whom we have interacted in the production of this report. Due to the short timeframe for the report it has not been possible to have a comprehensive consultation with each of the very large number of organizations involved in this area, however we believe that we have been able to achieve a representative sample of good practice in the main relevant areas. This has been achieved through a combination of interviews, questionnaires and working group sessions. Not all of the organizations listed below have had input through all of these means. It should also be stressed that the views expressed in this report, in whole or in part, do not necessarily correspond will all of the organizations with whom we have consulted below. Inevitably, there is a diversity of view and healthy debate as to the best approaches. The conclusions drawn in this report are therefore those of Resonance, under the guidelines for the research that we have been commissioned to conduct.

1	ACEVO	
2	Advance	Housing & Support Provider
3	Allia	
4	Ashley House	Housing Provider
5	Avenues	Support Provider
6	Bates Wells Braithwaite	
7	BATIAS	Advocacy
8	Bespoke Supportive Tenancies Ltd	Housing Provider
9	BeyondAutism	Support Provider
10	Beyond Limits	Support Provider
11	Big Society Capital	
12	Brandon Trust	Support Provider
13	Cabinet Office	
14	Cameron Trust	Housing & Support Provider
15	Care Quality Commission	
16	Care solutions group	Housing & Support Provider
17	Challenging Behaviour Foundation	Advocacy
18	Charity Bank	
19	Choice Care Group	Support Provider
20	Choice Support	Support Provider
21	Classic Care Solutions	Support Provider
22	Department of Health	
23	Dimensions	Housing & Support Provider
24	Emerald care services	Support Provider
25	Family Mosaic	Housing & Support Provider
26	Golden Lane Housing	Housing Provider
27	Grace Eyre Foundation	Housing & Support Provider
28	HFT	Housing & Support Provider
29	Housing & Support Alliance	
30	Investing for Good	

31	Joint Improvement Programme	
32	K & K Ambler	Support Provider
33	L'Arche	Housing & Support Provider
34	MacIntyre	Support Provider
35	Mcch	Housing & Support Provider
36	MENCAP	Support Provider
37	Michael Batt Foundation	Support Provider
38	MySafeHome Limited	Housing & Support Provider
39	Natwest	
40	NHS England	
41	Positive Support in Tees CIC	Support Provider
42	Radian Support	Support Provider
43	Reside Housing Assoc	Housing Provider
44	Shared Lives Plus	Housing & Support Provider
45	Social & Sustainable Capital	
46	Social Care	Support Provider
47	Social Finance	
48	Social Investment Business	
49	Southdown Housing	Housing & Support Provider
50	Specialist Autism Services	Support Provider
51	St. Christopher's Trust Redcourt	Housing & Support Provider
52	Star Wards	
53	Team Kenny	Support Provider
54	The Kent Autistic Trust	Housing & Support Provider
55	Triodos	
56	Turning Point	Housing & Support Provider
57	UKEvolve	Support Provider
58	United Response	Housing & Support Provider
59	Waymarks	Support Provider

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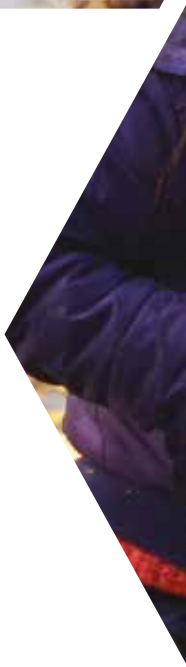

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