Evaluation of Building the Right Support

Phase 2 Case study findings report

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Executive Summary

This is the executive summary of a report produced as part of the evaluation of [Building the Right Support](#) (BRS). BRS aims to improve quality of life, care and outcomes for people with a learning disability, autism or both who display behaviour that challenges services. The evaluation is being undertaken by the [Strategy Unit](#), [ICF,](#) [BILD](#), and the [University of Birmingham](#).

In commissioning the evaluation, NHS England (NHSE) required an evaluation focused primarily on what is / not working in relation to BRS, and why. As a result, the evaluation aims to produce findings and support the process of translating them into improved practice. More information about the study, which began in December 2016 and ends in July 2019, can be found [here](#).

This report summarises the main findings from **ten case studies of local Transforming Care Partnerships (TCPs)** that bring together local authorities, NHS Clinical Commissioning Groups (CCGs) and other local stakeholders to implement BRS in their local areas. The ten case study areas were chosen in order to provide insights from TCPs with different characteristics from different parts of the country.

Visits to case study areas took place between December 2017 and April 2018. The evaluation team interviewed Senior Responsible Officers (SROs), programme staff, local stakeholders and practitioners, provider organisations, and held meetings with local self-advocacy groups. Key lines of enquiry covered:

■ Context and history of the TCP, including how it has built on existing partnerships, its structure and role in the local system, leadership, and the role of people with lived experience;

■ TCP priorities and actions, including stakeholders' understandings of the local challenges, how priorities were set, and the local 'model of change';

■ Implementation and progress in relation to the three main evaluation themes (described below), including changes made by the TCP since delivery began, what is going well or badly and why, outcomes that the TCP would expect to achieve;

■ Cross-cutting issues, such as progress with workforce, housing, and finance – as well as the interaction between the TCP and national partners in BRS; and

■ Examples of good practice, how they came about, and their results to date.

The evaluation team's contact with TCP case study areas is continuing, and we will be visiting them again later in 2018 to find out how they have progressed.

A separate report was produced for each TCP; this report draws from these 10 case studies. **Findings presented here are drawn solely from interviews and documentary analysis undertaken during the case study fieldwork**. Findings are presented firstly in relation to the three themes examined by the evaluation; then in relation to cross-cutting issues.

Community based support, prevention and early intervention

We looked at how improvements have been made to supporting people to live where and how they wish, and have a good and meaningful life. We examined TCPs' approaches towards developing more specialist, proactive and personalised care and support in the community. We found that:

■ Many TCPs have developed, or are developing, multidisciplinary intensive support teams or crisis accommodation so that people do not have not to be admitted to hospital if they

are in crisis and so that discharge planning locally is improved. Dorset, Outer NE London, Lincolnshire, Hertfordshire, and Surrey are examples of this.

■ Some TCPs are going further and attempting to build better relationships with local providers, share expertise between specialists and community teams, and remodel the local workforce. For example, local providers have been encouraged to work together as a network in Surrey to improve their skills and work in a more collegiate way. In Greater Manchester, stakeholders have used the infrastructure afforded by devolution to set up a common procurement framework.

■ In general however, there has been less emphasis on building up community support for wider – more 'upstream' – preventative activities, and most TCPs were just starting to think about how to approach the bigger picture. Making better links between TCPs and local strategies for children and young people was thought to be essential by many TCPs. For many this work was just starting.

■ Developing models that could support people with forensic needs were very much in the early stages. The publication by NHSE, ADASS and the LGA of a national service specification was often reported to be helpful, and furthermore some stakeholders said that working across TCP footprints would be a good idea for developing new models of care and support for people.

■ Most TCPs reported a lack of high quality local providers that are able to offer personalised support, with some identifying a lack of quality standards as an issue (and shared planning between providers and commissioners).

■ There are too few skilled commissioners with the experience to develop a collaborative provider market. Often, improvements revolved around key individuals who were able to build relationships and give providers credible information about the future needs of people 'coming through the system'.

■ There appears to be a great deal of variation in how community-based packages of support for people with complex needs are costed, and how they fit with ongoing support from specialist NHS teams in the community. Dialogue between commissioners and providers was generally not strong enough to resolve this.

■ Risk registers are seen as a valuable tool. TCPs' experience of using and implementing them have been varied. In most cases, they have been a first step to understanding population need. Most TCP case studies were still learning about how best to use risk registers to identify who might be at risk of admission and plan interventions around their needs.

■ Many professionals at the local level felt that in the face of rising demand and previously unmet need, maintaining current levels of hospital use ought to be counted as an achievement.

Quality of life, co-production and empowerment

We looked at how people and their families have more choice and control over how they live and whether people have a say in how commissioning decisions are made. We found that:

■ Co-production – in the sense of people, carers and professionals working together as equal partners – was highly varied across the 10 case study TCPs. In general, improving co-production was felt to be less of a priority than reducing the use of beds. Local stakeholders found it challenging to make a business case for investing in co-production relative to other priorities.

■ Co-production tended to be strongest in places that were already doing well and had built on earlier infrastructure from Valuing People e.g. learning disability or autism partnership boards. For example in Dorset, self-advocacy groups play a key role in setting the

agenda for their partnership boards, making decisions about what to invest in, lead on the development of ideas, and holding commissioners to account. TCPs where there was no previous history of working together struggled to develop a 'TCP-wide' approach to co-production.

■ TCPs reported that those voices that are less often heard include people with lived experience of ATUs, autistic people, people with very complex needs e.g. mental health needs, Black, Asian and Minority Ethnic (BAME) people, children and young people, and the growing number of people with a learning disability in later life.

■ Wider questions such as how could people with a learning disability be employed to deliver and develop services were rarely being addressed in a systemic way. There is good practice in some areas however, with Hertfordshire employing experts by experience as part of their multi-disciplinary teams (MDTs).

■ At the individual level, Care and Treatment Reviews (CTRs) and Care, Education and Treatment Reviews (CETRs) were reported as being one of the most valuable ways to personalise and plan future support. Local areas also recognise that results from these individual reviews are not feeding into strategic planning in the way they should. Some TCPs also reported that they needed to do more to understand their outcomes.

■ Some TCPs had adopted tools such as individual life planning, individual service funds, and personal health budgets (PHBs). However, implementation is patchy; they are not yet being used in the widespread way that BRS envisaged.

Collaborative systems and partnership working

We looked at how organisations are working together to develop more personalised care and support, including the role of TCP and system leadership. We found that:

■ Local stakeholders generally report that TCPs have been a good way of bringing organisations together, and placing a specific focus on people with complex needs which was not always present previously. In some cases the added value of the TCP has been limited and existing partnerships at a more local level have pursued their own agenda and investment priorities.

■ TCPs have generated new linkages, particularly in the area of intensive / crisis support, admission avoidance, and housing. For example in relation to housing, there has been a steep learning curve as there was little prior experience of health and social care working together to obtain capital funding, identify potential sites, and work together to develop or redevelop homes suitable for people's needs. TCPs and the agenda set out in BRS have been a prompt and a catalyst for these actions. Surrey in particular have a well-developed housing programme that is adopting a more system-wide approach to identifying potential housing opportunities.

■ Training has also been helpful in facilitating and focusing new partnerships. For example, specialist forensic teams in hospitals have been training community teams. Some of the case study TCPs have taken this further by getting community-based providers to carry out 'in-reach' into hospitals to get to know the people and staff over a longer period of time, engaging in training delivery or simply fostering mutual understanding of what homes and support in the community can do. For example, in Nottinghamshire, support teams from community providers are regularly visiting locked rehabilitation facilities to learn more about people.

■ Pooling budgets and sharing risk is thought by most stakeholders to be essential for further driving integration, collaboration and better governance and decision making. Yet progress towards greater integration has not moved as quickly as many would have liked (and the policy would suggest). Pooled budgets usually focus on the 'BRS population' of

people leaving hospital, rather than bringing prevention and acute services for the wider population together.

- Funding has also been a particular strain on partnerships, with some social care stakeholders expressing concern that the net result of BRS has been an increase in the costs borne by social care relative to the NHS. Conversely, some NHS stakeholders made the argument that without more investment in prevention (in social care), people's behaviour escalates until it crosses a (too high) threshold for more intensive support. TCPs have found managing this dynamic challenging.

- Overall the programme is seen as being NHS led, with the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) being less visible (and less well resourced).

Cross-cutting issues

We also examined TCPs' approaches to dealing with a number of key topics that are relevant to all three of the evaluation themes identified above. These are: finance; workforce; housing; and, children and young people. Here, we found that:

Finance

- Feedback from local stakeholders suggests that they do not expect that meeting the goals of BRS will be cost-neutral. To date however, most of the evidence around this point has been anecdotal and there is a recognised need to identify more specific issues.

- One of the issues related to funding providers was that packages of care and support are not always fully costed to include all the aspects of personalised support, clinical input or quality assurance costs. They may not always take the added value of family or friends' support into account either. This relates to the need for both commissioners and providers to be working more closely together – and to consider the family and friends as a core part of a person's support 'workforce'.

Workforce

- Many local stakeholders reported the challenge of being able to recruit both specialist staff such as learning disability nurses as well as reliable and effective support workers. Recruiting support workers with the right values; having a workforce that is distributed between many organisations; low pay; geography; and Brexit were all cited as key difficulties.

- Many areas still commission on a person-by-person basis, making it difficult for commissioners or providers to establish a common understanding of the whole population for workforce planning purposes.

- The need to develop a specialist workforce in the community who are familiar with the needs of all people with behaviour that challenges or at risk was also noted. Many of the TCPs we looked at are just starting to think about the skills and competences required here; others are also starting to think about other ways to support the workforce such as apprenticeship or work experience schemes, setting enhanced pay rates or providing help with travel for support workers.

Housing

- The regional support put in place by the national programme (regional housing advisers), capital funding, and the requirement to develop housing plans were mostly seen by local stakeholders to be helpful in focusing attention on the need to work collaboratively on housing.

- At the outset of the programme, capital funding was often thought to be difficult to get (administratively complex, subject to tight or unrealistic deadlines for spending it), although it was acknowledged that NHSE had taken steps to address this more recently. Some TCPs had also accessed sources of capital funding other than NHSE, including Homes England and the Department of Health.

Children and young people

- Joining up BRS and Special Educational Needs and Disability (SEND) reforms locally, and ensuring that consistent, joined up approaches are taken to helping young people move through the transition from children's to adult services, is still in the early stages of planning – although some TCPs have plans to address this in 2018. In most case study TCPs education services seem peripheral to Transforming Care.

- Nevertheless there seems to be growing recognition that without prevention and upfront life planning many years in advance, demand will become overwhelming. TCPs recognised that children's and adults' health and social care, and local education services, therefore need to work more closely together. Suggestions from local stakeholders included networks that can support and train families, and providing a single point of contact that can help parents navigate assessments, Education, Health and Care Plans (EHCPs) and crisis / hospital support.

- Stakeholders reported that services are seeing more young people whose behaviour is rooted in complex social and mental health needs e.g. background of abuse combined with poor mental health and autism or a learning disability. The variation in approaches to / funding of child and adolescent mental health services (CAMHS) and children's social care across local authority boundaries is thought by many to be problematic because it makes it challenging to plan for young people's needs in a consistent way.

- Some of the case study TCPs are starting to address these issues: for example, Surrey is starting to develop intensive support for children and young people based on their BRS experience to date, as well as developing better support for families so that crisis can be prevented; while Dorset works with the local YMCA to ensure there is a more co-produced approach.

Conclusions and implications for national action

The evidence from the case studies to date reveals a complex picture where change has been far from uniform. Many local stakeholders thought that the overall Transforming Care programme had helped to give a sustained focus to local efforts and help set the agenda locally.

Beyond this, a range of factors all play an important part in whether progress has been made. These factors include: the way in which the spotlight in national policy helps to set priorities locally; the ability of local areas to take on support or access capital funding; previous history of partnership working; pre-exisiting structures to support co-production; and the strength and skill of local leaders. Many of these factors are historical and therefore hard to replicate.

The case studies also suggest that one of the most important success factors for making progress are skilled commissioners who are able to understand how to facilitate a shared understanding of the issues at a population level over the longer term.

The reports produced for the individual TCP case studies suggest a series of lessons for local practice. Here we therefore focus on key messages for national policy makers; they are that:

- There is a need for ongoing national support (funding, coordination and expertise) to embed change and make it sustainable – including access to resources and ongoing capital funding. The aims and service model set out in BRS are not yet fully or consistently implemented. Further efforts are required;

- There is a need to re-emphasise the broader aims of BRS. To make more sustainable change there also needs to be a focus on prevention, as well as on reducing the use of hospital facilities;

- The development of Sustainability and Transformation Partnerships (STPs) / Integrated Care Systems (ICS)) changes the context for delivery of the programme. While TCPs illustrate a similar kind of multi-agency, system-wide, collaboration, the place of 'BRS' in these new arrangements must be carefully articulated to avoid confusion;

- There is both a local and national need for taking provider development further so that investment can go into provision that can meet people's needs, and providers who understand this market and who are prepared to collaborate. National efforts can help to provide a coordinated overview of this market – over and above local commissioners' efforts – that might develop and refine the provider base;

- The reported lack of skilled commissioners needs national emphasis e.g. better describing what good commissioning looks like, providing assessment frameworks and pointing to tools and training to support improvement. Some changes are already in train nationally;

- There are many challenges in recruiting, retaining and upskilling the wider workforce; part of the solution lies in making sure that families too are given support and training. The national programme should aim to incentivise TCPs (and STPs/ICS) to provide a viable career pathway for support workers and foster collaboration between commissioners and providers;

- Better alignment between BRS and key stakeholders such as Department for Education for children and young people, and the Ministry of Justice, will help to address gaps in stakeholder linkages at the local level by providing a more integrated policy direction;

- Local areas need to know (and be held to account for) high standards in relation to co-production that they are expected to meet – backed up by resources and support to enable better co-production to happen locally. It is important to emphasise the value of the process of co-production in and of itself (rather than for narrow instrumental benefits);

- More needs to be done to understand the financial model underpinning the policy shift from hospital-based to community-based care; and

- Further work also needs to be done to understand the nature and scale of gaps in support for autistic children and adults, so that both generalist and specialist mental health services are better equipped to better meet their needs.

1 Introduction to this report

This report has been produced as part of the evaluation of Building the Right Support (BRS). BRS aims to improve quality of life, care and outcomes for people with a learning disability, autism or both who display behaviour that challenges services – and ensuring that support and care is closer to home. It was published in 2015 by NHS England (NHSE), the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS).

The evaluation is being undertaken by the Strategy Unit, ICF, BILD, and the University of Birmingham. The evaluation was commissioned by NHSE. The specification for the study set out a requirement for an evaluation focused primarily on the implementation of BRS: to examine what is / not working and why. As a result, the evaluation aims to take findings and support the process of translating them into improving practice. More information about the study, which began in December 2016 and ends in July 2019, can be found here.

The evaluation began with a scoping phase. The aim here was to understand BRS' purpose and ambitions, structures for delivery, history and context. This could then be used to focus the evaluation. Results from this work are contained in the 'Early Findings and Evaluation Framework' report (July 2017). That report identified three **priority themes** for the evaluation:

1. Community based support, prevention and early intervention;
2. Quality of life, co-production and empowerment; and
3. Collaborative systems and partnership working.

As well as establishing a thematic focus, the scoping phase of the study also set out the main approaches to evidence gathering. In summary, these approaches included:

■ Case studies of ten Transforming Care Partnerships (TCPs);

■ An eSurvey of all TCPs;

■ Engagement with national groups to support co-production of the evaluation; and

■ Interviews with national and regional stakeholders to BRS.

Each of these is being repeated over time, allowing the evaluation to track change.

1.1 Report structure; method used

One of the key tasks for the evaluation has been to carry out ten **case studies** of local TCPs that bring together local authorities, NHS Clinical Commissioning Groups (CCGs) and other local stakeholders to implement BRS in their local areas.

This report summarises findings from those ten case studies to date. It looks at each of the three priority themes outlined above in turn (focusing on the main challenges and good practices identified) followed by a section on conclusions for national policy makers. **Findings presented here are drawn solely from interviews and documentary analysis undertaken during the case study fieldwork**.

The case study areas were chosen in order to provide insights from both 'fast-track' and other TCPs; areas with different challenges such as a high use of Assessment

and Treatment Unit (ATU) beds or hospitals far from home; differing performance as defined by NHSE's ratings; different organisational boundaries and structures (e.g. TCPs coterminous with a single local authority area or CCG to those with multiple commissioner organisations); and 'soft intelligence' from national stakeholders across the Transforming Care programme. The case study areas are:

■ Greater Manchester;

■ South Yorkshire and North East Lincolnshire;

■ Lincolnshire;

■ Nottinghamshire;

■ Hertfordshire;

■ Outer North East London;

■ Suffolk;

■ Surrey;

■ Dorset; and

■ Devon.

Case studies included interviews with Senior Responsible Officers (SROs), programme staff, local stakeholders and practitioners, provider organisations, and meetings with local self-advocacy groups. Visits to case study areas took place between December 2017 and April 2018. Our contact with case study areas is continuing, and we will be visiting them again later in 2018 to find out how they have progressed, in order to produce final case study reports at the end of the Transforming Care programme. **A short, standalone case study report is available for all ten TCP case studies; readers wanting more local detail are therefore referred to these reports**.

The same key lines of enquiry were used with interviewed stakeholders in each TCP. In summary, we asked about:

■ Context and history of the TCP, including how it has built on existing partnerships, its structure and role in the local system, leadership, and the role of people with lived experience;

■ TCP priorities and actions, including stakeholders' understandings of the local challenges, how priorities were set, and the local 'model of change';

■ Implementation and progress in relation to the three themes outline above, including changes made by the TCP since delivery began, what is going well or badly and why, outcomes that the TCP would expect to achieve;

■ Cross-cutting issues, such as progress with workforce, housing, and finance – as well as the interaction between the TCP and national partners in BRS; and

■ Examples of good practice, how they came about, and their results to date.

The report is one of several from the evaluation. Readers wanting further information are therefore referred to the other evaluation reports produced to date:

■ The ten individual TCP case study reports;

■ A stakeholder interviews report (July 2018); and

■ Findings from the survey of all TCPs (February 2018).

Later outputs from the evaluation will also bring together all the findings of these different reports. These will include accessible outputs.

2 Community based support, prevention and early intervention

This theme looks at how improvements have been made to supporting people to live where and how they wish, and have a good and meaningful life. The case study research examined TCPs' approaches towards developing more specialist, proactive and personalised care and support in the community.

2.1 Progress to date

Developing better services and support in the community has been a focus in all ten case study TCPs. In general, emphasis has been placed on developing support that can prevent people being admitted to hospital in the event of a crisis. For example, TCPs have developed multidisciplinary intensive support teams or crisis accommodation, or have remodelled their local ATU provision so that people who have no other option than hospital can remain at least closer to home, and have better access to local discharge planning from the beginning of a hospital stay.

In most of the case studies, these developments are taking place in the context of linked efforts to remodel or upskill the wider workforce in health and social care (moving expertise out of the ATUs into community settings), use co-production to shape the support being developed, and improve the relationships between community providers and commissioners.

However, there has been lesser emphasis on wider support needs (e.g. looking at whether the whole local housing stock is able to meet need) or preventative approaches before crisis.

In some of the case study areas, there is evidence of more systemic approaches – in line with the aspirations set out in BRS – to understanding current and future need across the TCP, building trusted relationships and working in partnership with a range of providers to plan out how those needs will be met over a longer horizon than the year ahead. Some TCPs have also invested in prevention and wider support services to make support more resilient. Those TCPs that had taken such steps very much felt that they were at the start of a journey, and that these efforts were not yet embedded as 'business as usual'. If anything, they reported that the process of developing better community support revealed more challenges (such as the need to upskill the whole provider and commissioner workforce, join up commissioning budgets, develop support for autistic people with complex needs, or think about the processes that might help to re-enable people rather than simply 'sustaining' them in the community).

The more advanced TCP case studies place equal emphasis on improving the support that is commissioned with reference to the needs of the whole population with behaviour that challenges (whether in hospital or in the community). However, many are still at the start of taking the next step towards thinking about how mainstream services might be improved, or how families might be better supported.

Although some areas had made efforts to address the wider aspects of BRS that aim to improve early intervention and the access of people with a learning disability or autism to health services (e.g. increasing the number of health checks), stakeholders in most case study areas felt that the wider agenda was less of a priority for TCPs than facilitating discharges and avoiding admissions.

Lastly, while some TCP areas were developing new models of intensive support for young people, in most cases these were in the early stages of idea development. In

general, thinking about how adults' and children's commissioners could develop more comprehensive, joined up approaches to meeting the ambitions of BRS had been a lesser priority for all TCPs. Transforming Care was largely seen as a programme for adults and reducing adult in-patient beds. The development of new models for delivering community forensic services that were suitable for people under Ministry of Justice (MoJ) restrictions were also in the early stages.

2.2　Challenges to delivery

The most significant challenge identified by local stakeholders was a lack of high quality local providers. Some areas reported having providers with the 'right' values that take a creative and thoughtful approach to working with people with complex needs, their families and commissioners (e.g. Beyond Limits in Devon). However, it was generally thought that there are far from enough skilled and resilient providers that are able to provide such personalised support.

It was also reported that there is a lack of detailed quality standards that could be used to assure the quality of support in the community, or standards for what high quality commissioning looks like for people with complex needs. Some TCPs such as Dorset (Bournemouth and Poole) or groups of providers (e.g. in Surrey) are therefore developing their own.

There also appears to be a great deal of variation in how packages of support for people with complex needs are costed, and how they fit with ongoing support from specialist NHS teams in the community (discussed later in this report). Some local commissioners thought that this was a particular issue when people are placed out of their area.

Related to this, the case studies also showed that there are too few skilled commissioners with the experience, knowledge and credibility to develop the collaborative provider market that can deliver personalised support for people with complex needs. It was widely recognised that TCP or future efforts across a health and social care footprint, however defined, needed to focus on broader market shaping rather than case-by-case procurement. However, the pressures of day-to-day work and fragmented commissioning prevented progress from happening as quickly as many frontline professionals would like.

TCPs' experience and use of risk registers are mixed. Risk registers are widely seen as a valuable tool and the requirement to develop them was seen as a good first step for TCPs to start thinking about population need (rather than case-by-case commissioning) and so likely future service requirements. In many cases it proved challenging to pull lists of people together from different sources – especially if several local authorities were involved – and to update these as more became known about the scope of the programme (i.e. all people with behaviour that challenges and a learning disability or autism, no matter where they are). Most TCP case studies were going through a learning process about how best to use risk registers to identify who might be at risk of admission and plan interventions around their needs (e.g. in regular multidisciplinary team (MDT) meetings).

The whole programme has been taking place within a context of a rise in demand that is both perceived (commissioners having to think about people who have traditionally been out of scope for local learning disability services e.g. people in prison, people who have severe mental health conditions) – as well as a rise in demand that is real (increasing numbers of younger people with complex needs who require NHS support, more people diagnosed on the autism spectrum). As well as discharging people who have been in hospital for a long period of time,

there are many more people and families who need the kind of personalised, holistic support that BRS aspires to deliver. Many professionals at the local level felt that in the face of this rising demand, maintaining current levels of hospital use ought to be counted as an achievement.

TCPs also reported gaps in services for adults that are autistic and have developed behaviour that challenges, with most starting to recognise that their needs are poorly met by current NHS community learning disability teams. Such people may not have met thresholds for local authority support in adulthood, but nevertheless develop needs that can then only be met with NHS involvement. There were further reported gaps in provision (and upfront prevention) across case study TCPs for people with a learning disability or autistic people also experiencing complex mental health conditions (for example, there is a lack of understanding of what services and providers might be required for a reportedly growing number of women who have experienced abuse or trauma).

In all these areas, a lack of joined up community assessment and support for families at an earlier stage appears to lead to more complex needs appearing in services 'down the line'. Several TCPs noted that finding solutions requires a more fundamental rethink of the skills, workforce, and ways of working between local health and social care agencies – which many stakeholders recognised was necessary, but that they usually felt ill-equipped to initiate. Issues described by stakeholders included: a lack of commissioning skills and able leadership to deal with problems that straddle health and social care; working effectively with local providers (specialist or community); bridging the gap between adults' and children's services; and difficulties in planning for the longer term because of uncertainties in relation to resources and policy, as well as the need to focus on dealing with immediate demand.

Challenges specific to housing are discussed in section 5.3 below.

2.3 Emerging good practice

A number of TCPs (e.g. Dorset, Outer NE London, Nottinghamshire) have been developing crisis provision (sometimes referred to as 'intermediate', 'step-down / step-up' or 'respite' provision – the terms used vary) that has successfully prevented admissions or allowed people to be supported by intensive support teams in the community. These services are generally focused on building support that can follow people through, and enable commissioners to get longer term support in place. If admission to an ATU is required, they enable discharge planning to be in place from the start – thus avoiding longer term admissions. Setting up such provision has not always been straightforward for some TCPs – with workforce and staffing issues reported as being a barrier to implementing this kind of intensive support.

The case studies provided some examples of longer term efforts to build trust between local providers and commissioners, and establish a stable footing for planning what 'good looks like' in terms of support for people with complex needs. For example:

■ Greater Manchester have used the infrastructure afforded by devolution to set up a common procurement framework;

■ Devon is moving towards a more outcomes-based approach to community provision (e.g. it is part of the Integrated Personal Commissioning national programme); and

- In Surrey, a provider framework exercise provided the starting point for the development of a collaborative and collegiate provider network that has enabled better engagement with local commissioners, and which takes ownership of initiatives to improve quality and training. In parallel, commissioners feel more able have regular, longer-term discussions with their specialist providers.

The overall result of such initiatives is a sense across both providers and commissioners that risk is being shared and that decisions are made drawing on the respective expertise of each. This ultimately lessens the risk of 'placement breakdown' because both providers and commissioners enter arrangements with better knowledge about the needs and aspirations of individuals, as well as about the characteristics of the broader population that are living locally or awaiting discharge. In addition, they have relationships that allow providers to change course if things don't work. In the longer term, the intention is that commissioners and providers will be able to effectively share information about people's future needs, apply for capital funding together, and jointly plan investments.

There are also good examples in the case study TCPs of planning for or establishing a MDT that brings together professionals from different agencies to meet the needs of people with behaviour that challenges or at risk. These join together different forms of expertise to provide specialised support in the community (Lincolnshire and Hertfordshire).

Lastly, in relation to people with forensic needs (people who have come into contact with, or who are at risk of coming into contact with the criminal justice system), some TCPs are starting to work with the MoJ. Progress here has been slow and policy is not always clear; but these TCPs reported that there is at least the recognition that much more work with prisons should be happening. Community forensic services are mostly at the planning stage (exploring extent of need) or thought to need an overhaul where they exist; success depends on sharing expertise across settings that are not historically used to close partnership working. Some stakeholders suggested that cross-TCP working may be needed to make any new services viable at scale (since they are high-cost, high-expertise, low-volume). The publication by NHSE, ADASS and the LGA of a national service specification for this group was often reported to be a helpful starting point for discussions about the support to be commissioned in future.

3 Quality of life, co-production and empowerment

This theme looks at how people and their families have more choice and control over how they live and examines whether support has become more person-centred. We also looked at whether people have a say in how commissioning decisions are made, and the local evidence for improvement in people's quality of life, including approaches to measuring the impact of re-enabling people in the community.

3.1 Progress to date

Practices of co-production – in the sense of people, carers and professionals working together as equal partners – were highly varied across the 10 case study TCPs. Broadly speaking, there is a sense that co-production at the individual level is more developed (and more obviously fruitful) than co-production at the strategic level.

All TCPs were engaging or consulting people with a learning disability through some means; but, in general, improving co-production was felt to be less of a priority than reducing the use of beds. Even in those areas where significant efforts had been made to give local people, families and self-advocacy groups a meaningful say in shaping and prioritising new forms of community support, local stakeholders felt that they had to make a very strong case for it.

Co-production tended to be strongest in places that were already doing well and had already built on earlier infrastructure from Valuing People or campus closure programmes, such as learning disability or autism partnership boards. Likewise, TCPs where there was no previous history of working together struggled to develop a 'TCP-wide' approach to co-production. Each TCP has focused on different methods of co-production; there is no common understanding of what the new models of community support would be like if they were delivered in a co-productive way – for example, how could people with a learning disability be employed to deliver services?

Where effective co-production is in place, it is recognised that developing trust and good relationships takes time and resources – with a mix of different approaches at different points in service development. It was also recognised that the results of investments in work to improve co-production are not always immediate, or easily measurable.

At the strategic level, forms of co-production that are inclusive of a wide range of perspectives, give local self-advocacy groups the resources and skills to engage, and trust people to 'own' the development of new ideas were seen to give the greatest value. For example, common actions taken by TCPs such as increasing the number of 'easy reads' or using an expert by experience on the TCP board may be meaningful or not depending on the context for that engagement.

At the individual level, Care and Treatment Reviews (CTRs) and Care, Education and Treatment Reviews (CETRs) are seen as a useful tool and were reported as being one of the most valuable ways to personalise and plan future support. However, local stakeholders also recognise they are not feeding into strategic planning in the way they should, and none of the TCP areas (to our knowledge) had yet reviewed the outcomes that had resulted from them or used them to collate intelligence about the needs of the broader population. The effectiveness of CTRs

in helping get people into appropriate community support is also thought to vary in some places, with the views of people with lived experience – including families – not always carrying an equal weight.

To differing extents, the case study TCPs had also adopted various tools for personalising support – including individual life planning, individual service funds, and personal health budgets (PHBs).

3.2   Challenges to delivery

Ensuring the inclusion of those people most affected by the programme, as well as people from groups that are usually overlooked among the wider population with a learning disability and autism, was thought to be challenging. It requires resources, time and advance planning – as well as a willingness to prioritise working in this way.

TCPs reported that those voices that are less often heard include people with lived experience of ATUs, autistic people, people with very complex needs e.g. mental health needs, Black, Asian and Minority Ethnic (BAME) people, children and young people, and the growing number of people with a learning disability in later life.

At the strategic level, doing co-production well was thought to be both time- and resource-intensive – but some TCPs recognised that this was necessary in order to build trust and reduce adversarial relationships. However, local stakeholders found it challenging to make a business case for investing in this relative to other priorities.

At the individual level, there were some reported tensions between the expectations of people and families for more personalised services close to home, and what was thought by commissioners to be the most realistic affordable option. It is difficult to say to what extent this is because commissioners and providers are being insufficiently creative or flexible in the support that they offer, or whether this reflects the view of many local stakeholders that support in the community can be more expensive than ATUs (discussed later in this report).

3.3   Emerging good practice

There are a number of examples of the inclusion of people with lived experience in strategic decision making such as the 'confirm and challenge' model adopted in Greater Manchester, or involving local self-advocacy groups in the design of new support in Dorset. In Dorset (Bournemouth and Poole), local groups have taken the lead role in drawing up ideas and specifications for new services via their Learning Disability Partnership Board, and are delivering them – for example, a witness support worker that aims to support people who have been victims of hate crime or so-called 'mate crime' in court, enabling people to have access to justice and be safer. At partnership board meetings, people have the chance to develop and ask questions in advance, and prepare their responses to agenda items, as well as taking a vote on proposals, allowing for a better quality of discussion.

Some TCPs (e.g. Greater Manchester) are also supporting families by training them in positive behavioural support (PBS). Experts by experience may also be part of specialist Transforming Care teams, helping to support people who are being discharged from hospital, as in the case of Hertfordshire. Hertfordshire also has a 'service finder' role who aims to match providers and different forms of personalised support with people and families.

There are also good examples of cross-regional work, such as a professional expert co-production group across the North where 'experts on tour' have been showing their perspective to hospital staff and have started to tackle inappropriate use of medication and restraint, and encourage more individual approaches to planning support that take wider life needs into account.

4   Collaborative systems and partnership working

This theme looks at how organisations are working together to develop more personalised care and support, including the role of TCP and system leadership. We looked at whether TCPs have fostered new ways of working, encouraged more creative approaches from their local provider market, and enabled partners to improve the flow of stable investment into the community to transform care faster and more effectively than they would have done without the TCP in place.

4.1   Progress to date

Local stakeholders generally think that TCPs have been a good way of bringing organisations together, and placing a specific focus on people with complex needs which was not always present previously.

Where there is a local history of collaboration – with effective partnerships between NHS commissioners, local authorities and (sometimes) NHS and social care providers, TCPs have generally moved faster, as they have built on existing operational links. Where TCPs did not reflect any previous collaborative links, progress has been slower and time has been spent mapping out how organisations might collaborate. However, in some cases (e.g. South Yorkshire) existing partnerships at a more local level have seemingly continued to set their own agenda and investment priorities. Elsewhere, constraints such as local CCGs being in financial special measures have limited the scope to collaborate as much as stakeholders would have liked to do (e.g. Outer North East London).

TCPs have also generated new linkages, particularly in the area of intensive / crisis support, admission avoidance, and housing. With respect to housing (see below) both NHS and social care commissioners, and providers, need to work closely with a range of stakeholders including people and families, adult social care, housing associations, planning officers, and architects – and in most cases there has been a steep learning curve as there was little prior experience of working together to obtain capital funding, identify potential sites, and work together to develop or redevelop homes suitable for people's needs. TCPs and the agenda set out in BRS have been a prompt and a catalyst for these actions.

Some areas (e.g. Lincolnshire) have been able to pool budgets between health and social care – initially around meeting the needs of people being discharged from hospital, but some areas such as Surrey are also looking at more ambitious plans to pool budgets around the whole population identified on their risk register. Stakeholder feedback indicates that while pooling budgets requires a great deal of local leadership and strategic alignment to put in place, there are clear benefits in terms of further driving integration, collaboration and better governance and decision making. However, progress has been slower than expected.

4.2   Challenges to delivery

One of the most significant challenges for some TCPs has been overcoming the sometimes adversarial or distant relationships between commissioners and providers, and building trust and a shared understanding of longer term goals (as already discussed).

Funding has also been a particular strain on partnerships, with some social care stakeholders expressing concern that the net result of BRS has been an increase in the costs borne by social care (a sector under greater funding pressure than the

NHS); conversely, some NHS stakeholders make the argument that without more investment in prevention (in social care), people's behaviour escalates until it crosses a (too high) threshold for more intensive support. While some TCPs have established more durable ways to manage such challenges and plan out future costs, others have found this process challenging.

Lastly, most stakeholders thought that at the national level, more could be done to encourage education providers and the MoJ to act in support of the agenda set out in BRS; at the local level, these relationships are just starting to be established.

Much also depends on the relationships between local TCPs and specialised commissioning; among some, there is a sense that the national programme gives out conflicting messages on what to prioritise, although the support provided is generally valued. Overall the programme is seen as very much NHS led, with ADASS and the LGA being relatively less visible (and resourced).

4.3   Emerging good practice

There are many good examples of partnerships and collaboration that are prompted by the objectives of BRS. For example in Surrey, the risk register is used to guide meetings and frame discussions at the operational level, with a multidisciplinary Transforming Care group meeting weekly to discuss concerns and decide on actions.

Where multidisciplinary teams (including adults' social workers and experts by experience) have a clear involvement in CTRs, they can help to bring new perspectives to how community care need not replicate hospital-based models. This has been the case in Lincolnshire.

Training has also been helpful in facilitating and focusing new partnerships. For example, specialist forensic teams in hospitals have been training community teams. Some of the case study TCPs have taken this further by getting providers to carry out 'in-reach' into hospitals to get to know the people and staff over a longer period of time, engaging in training delivery or simply fostering mutual understanding of what homes and support in the community can do. For example, in Nottinghamshire, support teams from community providers are regularly visiting locked rehabilitation facilities to learn more about people.

Other examples of good practice include a common assessment process being developed in Lincolnshire, and the PBS Support Network in Surrey, a collaborative initiative owned by the local specialist providers who have been developing training, quality standards and ways of exchanging knowledge between providers for wider benefit.

5 Cross-cutting issues

We also examined TCPs' approaches to dealing with a number of key topics that are relevant to all three of the evaluation themes identified above. These are: finance; workforce; housing; and, children and young people. Examples of good practice are described briefly under each sub-heading below.

5.1 Finance

Some TCPs reported that providing high quality homes, a life in the community and packages of support to meet complex needs might be more expensive than hospital, especially where people are coming home to high cost areas. Feedback from local stakeholders suggests that they do not expect the overall outcome of meeting the goals of BRS to be cost-neutral (one of the assumptions in the national funding model), pointing to the cost of individual arrangements where costs of supporting people in the community are much greater than places in hospital.

While it is broadly recognised that increasing independence improves lives and reduces risk (i.e. is seen as 'the right thing to do'), stakeholders also reported that savings arising from re-enablement have not yet been realised – and that expectations of savings have not for the most part been factored into long term planning.

A related issue is that supportive ways of moving funding into the community such as 'dowries' and funding transfer agreements are not always functioning as they should. In the view of some local stakeholders this was not only because beds must be decommissioned before savings can be realised, but because they do not take account of the work that TCPs have done to reduce admissions among people who would previously have gone into ATUs. Many TCPs reported that they were investing in community support to avoid admissions and meeting demand from previously unmet / unidentified needs, which was not related to the release of resources from closing beds.

One of the issues related to funding providers was that packages of care and support are not always fully costed to include all the aspects of personalised support, clinical input or quality assurance costs. Conversely, they may not always take the added value of family or friends' support into account. This relates to the need for both commissioners and providers to be working more closely together and understanding each other's perspectives on what is needed to sustain living in the community – and to consider the family and friends as a core part of a person's support 'workforce'.

5.2 Workforce

Many local stakeholders acknowledged the challenge of being able to recruit both specialist staff such as learning disability nurses as well as reliable and effective support workers. Recruiting support workers with the right values and commitment was cited as challenging. Having a workforce that is distributed between many organisations; low pay; geography; and Brexit were all cited as key difficulties.

Many areas still commission on a person-by-person basis, making it difficult for commissioners or providers to establish the common understanding of the whole population for workforce planning. However, some TCPs were starting to use market position statements or working more collaboratively with groups of specialist

providers to plan investments such as training, or agreeing pay premiums for support workers for people with complex needs.

The need to develop a specialist staff workforce that are familiar with the needs of all people with behaviour that challenges or at risk was also noted. Many of the TCPs we looked at are starting to think about the skills and competences required to support people with complex needs living in the community (e.g. crisis support / blue light, medication review, occupational therapy support, psychiatry, forensic support, and above all ability to work effectively with people and families and 'think personal' when delivering care and support).

Some TCPs are starting to think about apprenticeship or work experience schemes, or setting enhanced pay rates or providing help with travel for support workers that help people with complex needs, working with providers to try and address some of the workforce issues.

Multi-agency training and new roles were also being implemented. However, many stakeholders felt that they lacked the skills to support people with severe mental health needs or autism in the community, pointing to a need to think more fundamentally about what these people will need.

5.3 Housing

The regional support put in place by the national programme (regional housing advisers), capital funding, and the requirement to develop housing plans were mostly seen by local stakeholders to be helpful in focusing attention on the need to work collaboratively on housing. At the outset of the programme, capital funding was often thought to be difficult to get (administratively complex, subject to tight or unrealistic deadlines for spending it), although it was acknowledged that NHSE had taken steps to address this more recently.

Some TCPs are starting to develop a more strategic approach to developing housing, for instance by working with local partners (housing associations, NHS, local authorities) to produce lists of all their local housing assets and thinking about how best to develop them, by mapping provision to likely future needs of people on their risk registers. They then work with partners to design houses that would be suitable for more than one individual or one supported living arrangement. In general, it is thought to be harder to develop those properties subject to the NHS capital charge, although some areas (e.g. Surrey) had successfully done so. Some TCPs had also accessed sources of capital funding other than NHSE, including Homes England and the Department of Health.

5.4 Children and young people

Joining up BRS and Special Educational Needs and Disability (SEND) reforms locally, and ensuring that consistent, joined up approaches are taken to helping young people move through the transition from children's to adult services, is still in the early stages. In most case study TCPs, education services often seem peripheral to Transforming Care.

More widely, some stakeholders thought that the focus of national education policy – on attainment and measurable results – resulted in a culture that was less responsive to issues such as access, inclusion and making reasonable adjustments for those children and young people with highly complex needs and vulnerabilities (that could result in behaviour that challenges services).

Nevertheless there seems to be growing recognition that without prevention and upfront life planning many years in advance, demand will become overwhelming – so children's and adults' health and social care, and local education services, need to work more closely together.

Suggestions from local stakeholders included networks that can support and train families, and providing a single point of contact that can help parents navigate assessments, Education, Health and Care Plans (EHCPs) and crisis / hospital support. Some stakeholders did not have a good overview of EHCPs and whether information about young people's health and support needs translated into (for example) effective reasonable adjustments or interventions to reduce behaviour that challenges services, before a crisis point is reached. They thought that more needed to be done to ensure that health needs and wider life goals were featured more prominently in these plans. Without a clear understanding of these, stakeholders reported that it remained difficult to plan for future demand effectively.

Services are seeing more young people whose behaviour is rooted in complex social and mental health needs e.g. background of abuse combined with poor mental health and autism or a learning disability. The variation in approaches to / funding of child and adolescent mental health services (CAMHS) and children's social care across local authority boundaries is thought by many to be problematic because it makes it challenging to plan for young people's needs in a consistent way. Some of the case study TCPs are starting to address these issues: for example, Surrey is starting to develop intensive support for children and young people based on their BRS experience to date, as well as developing better support for families so that crisis can be prevented; while Dorset works with the local YMCA to ensure there is a more co-produced approach.

6 Conclusions and summary

6.1 What have been the catalysts for change?

The evidence from the case studies to date reveals a complex picture where the interaction between a national programme and local implementation is far from the traditional model of 'national says, local does'. Change has been far from uniform. Rather, a range of factors – the way in which the spotlight in national policy helps to set priorities locally; the ability of local areas to take on support or access capital funding; previous history of partnership working (particularly in relation to campus closure programmes and whether infrastructure from policies such as Valuing People and the Autism Act are still in place); relationships with Specialist Commissioning; and the strength and skill of local leaders - all play an important part. Many of these factors are historical and therefore hard to replicate.

Yet overall, BRS and the Transforming Care programme have given a sustained and concentrated focus to local efforts. There have also been helpful and specific pieces of guidance (e.g. service specifications, CTRs) or initiatives (Stopping over medication of people with a learning disability, autism or both (STOMP), risk registers, developing housing plans) that have informed and influenced these efforts. Likewise, while the focus of national reporting was often likened to "feeding the beast" (overly complex, too frequent, subject to regular change), some acknowledged that this had also helped to keep a focus on improving local care and support throughout. In sum, these national efforts have developed local practice beyond what is likely to have occurred without BRS.

The case studies also suggest that one of the most important success factors for making progress are skilled commissioners who are able to understand how to facilitate a shared understanding of the issues at a population level over the longer term. Then providers and commissioners alike can develop trusted relationships that help to develop providers' specialism in supporting people with complex needs and their families, and unlock investment in terms of time and funding.

6.2 How can national action address the challenges identified?

The variety in local contexts and local practice makes it very difficult to make recommendations at that level. So here we concentrate on messages for national policy and the national programme infrastructure. At this level, the emerging evidence from the local case studies suggests the following:

- There is an ongoing need for national action. The agenda set out in BRS has not yet been fully implemented. This, allied to the sense in which the national programme has helped set a more consistent framework for local collaboration, policy direction and service development, backed by performance management and support, suggests a need for ongoing national support (funding, coordination and expertise) to embed change and make it sustainable.

- There is a need to re-emphasise the broader aims set out in BRS. For a series of understandable reasons, TCPs have focused on the 'sharp end' of moving people out of hospital. To make more sustainable change there also needs to be a 'downstream' focus on prevention.

- The broader policy environment (notably the move towards more integrated and place-based models of care, such as Sustainability and Transformation

Partnerships (STPs) / Integrated Care Systems (ICS)) changes the context for delivery of the programme. In some ways, TCPs are well placed: they illustrate the kind of multi-agency, system-wide, commissioners-providers collaboration desired by this policy direction. Yet the place of 'BRS' in these new arrangements must be carefully articulated to avoid confusion. Opportunities created by the development of STPs/ICS – notably the opportunity to aggregate and specialise scarce commissioning skills and provider engagement – should form part of this description;

■ More effort could go into provider development and systematically building providers that understand this market and who are prepared to collaborate. While primarily a local task (any provision will be commissioned and provided locally) there is a national role to support, encourage, exemplify and highlight good local practice (and to name names). Efforts at both levels will increase provider confidence (that 'the market' is there for them) and guide the development of their services (knowing what commissioners will want);

■ Continue providing access to capital funding, as well as continued support to local commissioners to improve both skills and experience for developing personalised housing – both elements are essential to improving the supply of housing and improving the way that housing is planned in strategic way, to meet the varied needs of people with a learning disability, autism or both;

■ There is an apparent lack of skilled commissioners – allied to a lack of codification as to what 'good commissioning' might mean in this context. This can be addressed nationally by describing what good looks like, providing assessment frameworks and pointing to tools and training to support improvement. There are helpful broader developments – notably the increasing prominence of population health management – that should aid these efforts. One of the main tasks of a good commissioner will be to understand current and likely future needs at a population level (rather than reacting to individual cases and carrying out spot purchases). Providing specific tools to help with this task would therefore be a helpful national action. This might include guidance on how to bring together currently disparate data sources – such as how to aggregate information on outcomes from CTRs;

■ There are many challenges too in recruiting, retaining and upskilling the direct support worker workforce with the right values and competencies to support people and families. Part of the solution lies in making sure that families too are given support and training, and more widely, placing more emphasis on implementing the tools developed by Skills for Care, Skills for Health and Health Education England (e.g. *Care Roles to Deliver the Transforming Care Programme - Building the Right Support*). The national programme should aim to incentivise TCPs to provide a viable career pathway for support workers, develop models for enhanced payments for workers supporting those people with the most complex needs, and encourage providers and commissioners to collaborate on training and development programmes;

■ There is a reported clash in policy directions between educational policy (broadly reported as unhelpful to efforts around inclusion) and BRS. Likewise, there also appears to be scope for bringing together MoJ policy and the BRS agenda, so that there is more certainty for local partners on how people under MoJ restrictions can live in the community, and a shared understanding of how risks can be managed and reduced through the provision of high quality community support (that does not replicate institutional approaches in the community). These issues cash out at local level but can only be remedied

nationally. The national programme should therefore set out what an ideal policy would be to achieve the aims of BRS, and ensure that this is raised with DfE and MoJ with the aim of developing a more coordinated policy response to local challenges;

■ Develop a vision and guidance / specific approaches for co-production so that local areas know the standard that they are expected to meet, and provide the resources and support to enable that to happen locally. It is important to emphasise the value of the process of co-production in and of itself; focusing too narrowly on immediate and instrumental benefits (e.g. revising service specifications or challenging strategic planning) would count against taking a longer-term view and embracing broader benefits such as changing mindsets;

■ More needs to be done to understand the financial model underpinning the policy shift from hospital-based to community-based care. The simplifying assumption of the programme – that one would cost broadly the same as the other – is questioned at the local level. There is significant subtlety to the issues described here: What is the nature and scale of implied shifts in cost – from national to local; between health and social care? At some point of complexity care will cost more in a community setting, but what might that point be? What are the dynamics of these costs – is there an in-built early price for risk that then diminishes? Does closer commissioner-provider working reduce the cost of risk? (etc);

■ Further work also needs to be done to understand the nature and scale of gaps in support for autistic children and adults, so that local approaches to commissioning and providing support are built around holistic, inclusive and proactive approach to preventing future crises and ensuring that both generalist and specialist mental health services are better equipped to better meet their needs.