Dear Harriet,

Thank you for your letter dated 9th January regarding the Joint Committee on Human Rights meeting on Assessment and Treatment Units and people with learning disability or autism.

You raise a concern about whether different funding sources create barriers to the development of appropriate community based care. I entirely understand this concern, which has existed since the foundation of the NHS. The question is how best to manage the boundary. I can confirm that we have actions underway to mitigate any issues regarding the distinction between NHS and local authority funding. In accordance with the Funding Transfer Agreement process, each Transforming Care Partnership (TCP) should have in place a Risk Share Agreement governing the key funding transfer principles shared and agreed between the local CCGs, local authorities and NHS specialised commissioning function operating in the area. This Agreement should address issues such as how additional care and support costs for individual patients might be met.

NHS England supports CCGs, NHS England Specialised Commissioning and local authorities to put in place governance and financial mechanisms to align or pool resources and to manage financial risk. Dowries are also paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of discharge. This is of course in addition to the fundamental duty on local authorities under the Care Act 2014 to assess and meet any eligible care needs. Local authorities must work in partnership with eligible individuals to plan their care and support and offer a range of options regarding how their care and support is secured.

You also raise a question about whether private providers might have a vested interest in keeping people in hospital. This has been discussed in the media extensively. Clearly, we have to guard against any potential vested interest that acts against patients’ interests.
We have a range of safeguards in place to prevent gaming of the system at the patient’s expense. The key process to determining discharge or treatment plans, are the Care and Treatment Reviews (CTRs) which are undertaken by an independent panel of people, including an expert by experience, a clinical expert and the commissioner who pays for the person’s care. Decisions on continuing hospital treatment are therefore not made in isolation by a resident clinician.

Providers are monitored by the Care Quality Commission, and doctors subject to rigorous professional registration. We have asked the CQC to undertake a full thematic review of the use of segregation and seclusion across health and social care and to look at other restrictive interventions in settings specific to learning disability, autism or mental health, including private providers, to ensure that whilst they are inpatients, people are not subject to unnecessary restrictive intervention.

There are also statutory provisions to allow people access to advocacy support. The Mental Capacity Act (2005) gives people who have an impairment, injury or disability, who have no one able to support or represent them, and who lack capacity, the right to independent support and representation.

Under the Mental Health Act (2007), you have the right to be referred to an independent mental health advocate (IMHA) if you are detained under most sections of the Mental Health Act, whether you are in hospital or on a community treatment order. Staff in the NHS or a local authority, for example, doctors, care managers and social workers, all have a duty to instruct an IMHA where the eligibility criteria are met.

I hope this response is helpful. I am very concerned that the support we give for people with learning disabilities and autism must improve. I would be very interested in your views on how best to do that, and would be keen to work with you on this vital agenda.

Yours ever,

MATT HANCOCK