National Mental Health
Development Unit

policy into practice into

Mental Health and Housing:
Resources for Commissioners and Providers

Mental Health and Housing
Housing on the Pathway to Recovery

Briefing

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EXECUTIVE SUMMARY

Recovery focused services are a central component to making health services fit for the twenty first century. At the heart of 'recovery' is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life[1].

Housing is generally recognised to be a central part of an effective recovery pathway. It provides the basis for individuals to recover, receive support and help and in many cases return to work or education. For all of us, housing is a critical part of our well-being; both physical and mental. However, accessing housing and being able to move through a pathway of care, to appropriate accommodation still requires service users to negotiate a range of obstacles.

As part of this programme we asked people what they perceived the advantages of a housing based service to be. Housing based services were perceived to bring a number of advantages:

>**Perception**
>Service users see a move out of statutory care as progress and their recovery is enhanced by moving away from the service where they were most unwell.

>**Principles**
>Healthcare providers have made great strides in introducing the recovery model and moving away from diagnose and treat. However, housing services were seen to 'live and breathe' recovery.

>**Price**
>Housing providers can lever in funding from other sources and currently unit prices are significantly lower than healthcare providers.

>**Risk**
>Clinical risk in the confines of statutory services is very different from community based risk. Some respondents believed that the supported housing sector has more experience in managing and mitigating community based risk. Some expressed concern that at discharge from the acute care pathway information pertaining to risk comes either from the point of admission or ward based risk which has less relevance in the community.

The downturn provides an impetus within the system to ensure that there is consistent implementation of best practice, the early adoption of innovation, the urgent delivery of productivity improvements and a more mutual relationship between the user and the system to enable them to make good choices about their own health. In mental health this means:

- reducing the number of acute admissions;

- reducing the number of people living in institutional care;

- reducing the numbers receiving treatment out of area.

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1   Shepherd G (2011) Making Recovery a Reality. SCMH : London

This requires the implementation of wider clinically owned and championed mental health pathways. These need to prioritise what users are really looking for, have the 'band-width' that reflects the whole of users' lived experience, offer a degree of choice and make best use of scarce resources. Broadly speaking this needs to be safe, offer a positive patient experience, be closer to home or in the home and offer a route to training or employment.

This will require co-operation between commissioners across the system to ensure that there is a strategic approach to commissioning that looks at need over the medium term. Otherwise the only option that will be available will be to place people out of area. In most cases this type of provision is more costly to local services and detrimental to the service user in terms of their longer-term recovery.

In order to achieve this a number of steps were identified:

1. The Joint Strategic Needs Assessment is instrumental in looking at the contribution that housing and support can make to health and social care agendas. Moving forward it could be a key mechanism for ensuring that these agendas are aligned to help do 'more for less'.

2. As part of the NHS reforms, the JSNA will be a key responsibility and joint commissioning vehicle for the new Health and Wellbeing Boards. The purpose of the JSNA and the influence that it has on commissioning intentions will be locally determined. The Health and Well-being Boards could be a 'bridge' between housing and social care investment decision makers.

3. A strategic approach to commissioning housing and support services needs to be taken to avoid out of area treatment being the only option at the point of someone's discharge. Their housing needs and options need to be considered at all stages of the pathway.

4. Users, commissioners and providers working together can arrive at good outcome measures and incentivise innovation in the way services are developed.

5. Providers will want to cooperate and develop new forms of integrated care across organisational and sectoral boundaries. They should develop long-term plans for reducing beds and Out of Area Treatments. They could be allowed to use their flexibilities to purchase property and pull together supply chains for delivery.

The Mental Health Strategy for England, No Health without Mental Health can only be delivered if we build a new and sustainable relationship with housing. The current changes in the health and social care environment offer a real opportunity to deliver levels of integration that have often been discussed but have been patchily implemented on the ground. The challenge will be to develop and promote a compelling narrative to commissioning in a way that allows providers to innovate and plan for the long term, to recognise the strengths of different professional groups and to create more integrated pathways to recovery.

PURPOSE OF THIS RESOURCE TOOL

This resource tool has been produced to support health, social care and housing commissioners and providers who are seeking to deliver a more therapeutic pathway to recovery at lower cost. Housing and housing related support services have a key role to play at each stage of someone's recovery. In this resource tool we will outline the evidence to support the inclusion of housing in the recovery pathway and the types of intervention that can contribute to Quality, Innovation, Productivity and Prevention (QIPP) in mental health.

It is designed to support the continued development of a more outcome-based approach to commissioning on the one hand and a more integrated approach to service provision on the other. Above all it is driven by a belief that in a downturn there is a responsibility on all of us to ensure that:

- scarce resources are targeted at things that users believe make a real difference for them;

- a whole system approach is taken for commissioning;

- the cost of the commissioning process and the burden on providers is kept to a minimum;

- users are enabled to do more themselves and to have more control over decisions;

- providers work in partnership to create innovative service models;

- finance is allowed to flow down to community providers.

The resource tool argues for a whole system approach to ensure that all the interventions that can contribute to someone's recovery are going to be considered. The commissioning process will acknowledge the whole system and encourage providers to come together to form a 'supply-chain' for delivery. By focusing early in the pathway on someone's housing circumstances they will be able to ensure that they only stay in institutional forms of care out of choice or real necessity.

The resource tool also includes a number of case studies of where people have made progress to include housing and housing related services to improve outcomes at lower cost. Contact details for each of the case studies have been included to make it possible to follow up on the examples to share learning.

SECTION TWO

SUMMARY OF CURRENT ISSUES

Policy Context

Mental Health Strategy
Good mental health and wellbeing is fundamental to all of us. The Coalition Government's mental health strategy, No Health without Mental Health sets out a two-track life-long approach that aims to:

- improve outcomes for people with mental ill health, and

- build individual and community resilience and wellbeing in order to prevent ill health.

The strategy is structured around a number of high-level mental health outcomes that are consistent with those set out in the NHS, social care and public health frameworks. These cover areas such as: better mental health care; better physical health for those with mental health problems; and better mental wellbeing in the population. An all-age, population-based mental health and well-being focus will be required across the NHS and Local Authority in order to create success. Such an approach should seek to include housing as a core component that can contribute to recovery and well-being.

The strategy is supported by a range of other documents including *The economic case for improving efficiency and quality in mental health*[2] which sets out five areas for intervention:

1 Early identification and intervention as soon as mental health problems emerge

2 The promotion of positive mental health and prevention of mental disorder in childhood and adolescence

3 The promotion of positive mental health and prevention of mental disorder in adults

4 Addressing the social determinants and consequences of mental health problems

5 Improving the quality and efficiency of current services

Commissioning
Commissioning is 'the cycle of assessing the needs of people in an area, designing and then securing appropriate service'. **The Health and Social Care Bill** followed the White Paper, *Equity and Excellence - Liberating the NHS*[3] and sets out the Coalition Government's plan for the NHS in England. Alongside the structural reform proposed, which includes the abolition of PCTs and SHAs, the Bill sets out a number of changes to the way in which health services in England are commissioned.

In mental health GP consortia will take on responsibility for planning and commissioning mental health services. Local Authorities will set up new Health & Well being Boards (HWB) that will join up the commissioning of local NHS services, social care and health improvement. These HWBs will promote integration and partnership working between the NHS, social care, public health and other local services and strategies; leading the Joint Strategic Needs Assessment and support joint commissioning arrangements as well as building partnerships for service change.

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2   www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123739
3   Equity and Excellence, Liberating the NHS Department of Health 2010

Public Health England will be responsible for Health Protection and will hold the system to account for a ring-fenced public health budget.   Guidance is expected to be coming out later this year (after the early implementers have been evaluated) and we know that this is likely to be very detailed. The likely end stage is that public health will look very much as it does now but with stronger central direction.

Managing the Market

Payment by Results (PbR) was introduced in the NHS in 2003/04 to improve the fairness and transparency of payments and to stimulate provider activity and efficiency. PbR means that providers are paid for the number and type of patients treated, in accordance with national rules and a national tariff. Work continues towards creating a national tariff for mental health services for working age adults and older people and mental health tariffs are expected to be introduced by 2013.[4] PbR in mental health thus far has involved the development of care packages against the new 'care clusters' and further developments in personal budgets.

Whilst the architecture for NHS providers will remain relatively unchanged, the market environment in the NHS and social care will expand to admit a far wider range and diversity of providers. This will be driven by the introduction of a system of **Any Willing Provider**. NHS trusts will find themselves in competition with independent and voluntary sector providers. This presents both opportunities and challenges for commissioners to seek ways of improving quality and productivity. They will have a far greater choice in the care provider market place, but may also need to ensure that the cost of market entry does not exclude specialist voluntary sector agencies whose services are often more acceptable and accessible, and no less effective, than those offered by larger agencies.

Quality, innovation, productivity and prevention (**QIPP**) is the framework that the NHS, in partnership with local authority colleagues, is using to create the changes needed to commission and deliver health services in this period of financial constraint. It is intended to enable the NHS to drive up quality while improving productivity. It aims to make a £20bn saving that can be reinvested into the system.

The quality and productivity challenge for the NHS and the need to improve value for money in local authorities requires a double shift in investment involving a reduction in overall spend through increased productivity and moving upstream a proportion of the investment currently funding acute, specialist and other secondary care services   in order to reduce demand.

At the same time there will be a further push to give people more choice and control over their lives through **personalisation**. This goes beyond giving personal budgets for people to buy in their own care and support, or providing funding to purchase specific health care services. Councils in England are expected to have 30% of service users on personal budgets by March 2011, under targets agreed by the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Department of Health. The NHS also has a programme of pilots for the development of Personal Health Budgets. A personal health budget is an amount of money that is spent on meeting the health care and wellbeing needs of people, generally those with a long term illness or disability.[5]

Operating Context

The environment for commissioning and providing services in mental health is changing as new models for commissioning across the NHS, set out in the coalition Government's Health & Social Care Bill are developed to ensure that *"healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients."*[6] The mental health pathway is acknowledged to be one in which patients are actively involved in the

4   http://www.hsj.co.uk/5002882.article
5   www.personalhealthbudgets.dh.gov.uk/About/faqs/#item2
6   Equity & excellence: Liberating the NHS Department of Health July 2010

development and delivery of services. They have been at the forefront of multi-disciplinary working and in integrating care between secondary and community services.

The downturn provides an impetus within the system to ensure that there is consistent implementation of best practice, the early adoption of innovation, the urgent delivery of productivity improvements and a more mutual relationship between the user and the system to enable them to make good choices about their own health. Now as never before there is a need for integration and cooperation between housing, health and social care.

Adequate and appropriate housing is widely acknowledged to be a crucial underpinning of health and well-being. Inappropriate housing can significantly reduce the ability of people who have ill health or a disability to lead independent lives. They can often struggle to access preventive housing and related care and support services, which would allow them to participate in the community. This can often happen, for example, following discharge from hospital.[7]

The impact of poor housing on someone's health, their well-being and their quality of life is demonstrable and well evidenced. However, all too often it has been excluded from discussions about health and social care policy.[8] This had led to a disconnect in the commissioning of housing and housing related support and health based services. This lack of integration too often results in housing insecurity, lost productivity, poor use of resources, short term approaches to prevention and poor experiences of health and care services by people with mental health conditions.

In mental health the quality and productivity challenge means reducing the number of acute admissions, reducing the number of people living in institutional care and reducing the numbers receiving treatment out of area. This will require the implementation of wider clinically owned and championed mental health pathways. These need to prioritise what users are really looking for, have the 'band-width' that reflects the whole of users' lived experience, offer a degree of choice and make best use of scarce resources. Broadly speaking this needs to be safe, offer a positive patient experience, be closer to home or in the home and offer a route to training or employment.

The transition to GP led commissioning, coupled with the importance of improved outcomes and cost effectiveness, has led many to begin reconsidering the way in which services are commissioned and delivered by organisations both inside and outside the NHS. At the same time, the financial climate requires commissioners and providers to seek innovative ways of ensuring that high quality services can be delivered in the most cost effective and integrated way.

In mental health the trend has been for health commissioners to see housing as outside the traditional care pathway and something both provided and commissioned by others. What remains central to effective mental health commissioning, is that it must be a shared activity which is driven by an integrated approach involving all partners[9].

7   Connecting Housing to the Health & Social Care Agenda, Appleton, N. & Molyneux, P. DH Care Networks Sept 2007
8   ibid
9   The Commissioning Friend for Mental Health Services, Appleton, S. NMHDU/CSL Dec 2009

EVIDENCE BASE

Housing as a Factor in Mental Health

Housing and mental health are closely related and in policy terms have been afforded a good deal of consideration over the last decade. Those who experience mental health problems find that their illness can lead to the breakdown of a tenancy, loss of a job and hence the ability to pay a mortgage or rent which may lead to the loss of a family home. Being homeless, on the streets or insecurely housed can, of course, further exacerbate your mental health as well as your physical health.

It is fair to say that safe, secure and affordable housing is critical in enabling people to work and take part in community life.[10] Having settled housing and accommodation is known to have a positive impact on our mental health[11]. As we move towards a more personalised pattern of service, non-institutional services become more important and can save commissioning authorities a significant amount of money. Housing provides the basis for individuals to recover, receive support and help and in many cases return to work or training[12].

The impact on mental health of poor housing is well evidenced[13]. Compared with the general population, people with mental health conditions are one and a half times more likely to live in rented housing, with higher uncertainty about how long they can remain in their current home[14]. They are twice as likely as those without mental health conditions to be unhappy with their housing and four times as likely to say that it makes their health worse. Mental ill-health is frequently cited as a reason for tenancy breakdown[15]. Housing problems are frequently cited as a reason for a person being admitted or re-admitted to inpatient medical care[16].

Lack of housing can impede access to treatment, recovery and social inclusion and accessing mental health services and employment is more difficult for people who do not feel settled in their accommodation. So, housing is generally recognised to be a central part of an effective recovery pathway. It provides the basis for individuals to recover, receive support and help and in many cases return to work or education. For all of us, housing is a critical part of our well-being; both physical and mental.

However, accessing housing and being able to move through a pathway of care, to appropriate accommodation still requires service users to negotiate a range of obstacles. This was highlighted in the conclusions of *The Impact of Choice Based Lettings on the Access of Vulnerable Adults to Social Housing*. The report concluded that, "there is a need for support to be available to help people navigate the system and to provide advice and support"[17] and "there is a need to mainstream the "pathway approach" where there is a framework for enabling people to move from supported housing to mainstream housing and to plan for more than one move. This has the ability to address the needs of people from all vulnerable groups."[18]

Impact of Housing on Healthcare Costs

Unsuitable housing or a lack of suitable housing related support can also lead to an escalation in care needs and trigger admission to hospital or reduce an individual's or carer's confidence that they can live safely in the community. This increases the pressure for residential or other institutional care. It is often stated that at least one third of people in residential care do not need all the elements of care provided.[19] 9% of delayed discharges are estimated to be due to

10   New Horizons Department of Health December 2009
11   HM Government (2010) State of the nation re: poverty, worklessness and welfare dependency in the UK. London : Cabinet Office
12   Social Exclusion Unit (2004) Mental Health and Social Exclusion. London : Office of the Deputy Prime Minister.
13   Johnson R, Griffiths C and Nottingham T (2006) At home ? Mental Health issues arising in social housing. London " NIMHE.
14   ibid
15   Social Exclusion Unit (2004) Mental Health and Social Exclusion. London : Office of the Deputy Prime Minister.
16   Johnson R, Griffiths C, Nottingham T (2006) At Home ? Mental Health Issues Arising in Social Housing. London : NIMHE
17   The Impact of Choice Based Lettings on the Access of Vulnerable Adults to Social Housing, Appleton, N. & Molyneux, P. DH Housing LIN
        February 2009
18   ibid
19   Support Related Housing - bringing together housing, health and social care. Care Services Efficiency Delivery
        www.csed.dh.gov.uk/supportRelatedHousing/

a lack of suitable housing.[20] 23% are due to people awaiting places in registered care homes offering personal care.[21] Housing is clearly an issue in the first instance, and supported housing can provide a more cost effective solution for the latter.

A lack of appropriate accommodation can lead to people being placed out of the area, living in residential care or to delayed discharge. This can be an issue of supply, such as a lack of supported housing and other independent living options being available locally. It can also be due to a lack of appropriate and timely advice and support to service users who are in hospital as well as housing not being regarded as a key component of care planning.

This will require co-operation between commissioners across the system to ensure that there is a strategic approach to commissioning that looks at need over the medium term. Otherwise the only option that will be available will be to place people out of area. In most cases this type of provision is more costly to local services and detrimental to the service user in terms of their longer-term recovery. A toolkit has been developed by a range of partners to help reduce the use of out of area services[22].

Health and Well-being boards could act as a bridge between health investment on the one hand and housing investment on the other. Otherwise a lack of suitable housing will become a barrier to delivery. There will need to be considerable creativity to ensure that best use is made of existing buildings and that new ways of maximizing return on land that is held to deliver sustainable revenue streams.

Conclusion

Although QIPP is an NHS process, similar approaches in local authorities to delivering efficiency and value for money are intended to enable commissioners to drive up quality while improving productivity. A strong argument exists for housing featuring strongly in QIPP particularly when looking at out of area treatments, the use of residential care and tackling delayed discharge. However, much of this has been demonstrated through demonstration projects and has not transferred into mainstream practice. The current financial pressures allow us the opportunity to make this part of the mainstream[23]. This is what we will look at in the next section.

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20   SITREPS (Situation reports) data is collected by NHS Trusts on delayed discharges. It records information about who is responsible for the delay and the reason for the delay, such as a lack of suitable housing.

21   ibid

22   In sight and in mind: A toolkit to reduce the use of out of area mental health services, http://www.rcpsych.ac.uk/policy/policyandparliamentary/oatstoolkit.aspx

23   tAppleton N and Appleton S (2011) Housing and housing support in mental health and learning disabilities - its role in QIPP. NMHDU : London

SECTION THREE

HOUSING AND QIPP

The NHS is seeking to achieve efficiency savings of £20bn over the next three years. As we have seen, to achieve this the NHS has adopted an approach to implementing quality innovation, productivity and prevention or QIPP. This will require everyone on mental health to ensure that examples of good practice are consistently adopted and that radical service redesign will be required[24]. Only by capitalising on examples of good practice, such as those provided by housing related support providers, can the NHS hope to achieve the necessary savings whilst continuing to deliver improvements in service quality. In mental health, No Health Without Mental Health[25] emphasises the importance of prevention, patient empowerment and quality. Housing services have a key role to play in this. In this section we will look at the possible contribution of housing to the acute care pathway and to the PbR Clusters.

Housing in the Acute Care Pathway

Care Pathways were developed 20 years ago and are used widely in many areas of health care across the world. There is an extensive evidence base for their effectiveness in improving the care provided to patients. Care Pathways aim to improve the continuity and co-ordination of care across different disciplines and sectors. Care Pathways can be viewed as algorithms that offer, in a flow chart format, the decisions to be made and the care to be provided for a patient with a given condition. Care Pathways have four main components:

- a timeline;

- the categories of care with preferred interventions;

- short, intermediate and long term outcome criteria;

- and a record of any permitted deviations and variations.

In mental health the acute care pathway starts when an individual is first referred to the crisis resolution and home treatment (CRHT) team. The end of the care pathway is then defined as being when responsibility for the individual's care is transferred to another team, or when the individual is discharged from services after the acute phase or episode.

This pathway has been driven by a set of values associated with the recovery approach. These are about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. it emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life[26].

A lot of work has gone into establishing how recovery principles can best be incorporated into routine practice in mental health through a focus on the changes that will be needed in the practices of mental health workers, the types of services provided and the culture of organisations[27]. As part of the implementation of QIPP in mental health the Audit Commission has a staged model for reviewing the acute care pathway and in particular bed utilisation.

24   Cotton R (2011) Efficiency in Mental Health Services : Supporting Improvements in the Mental Health Acute Care Pathway. NHS Confederation / NMHDU / Audit Commission.
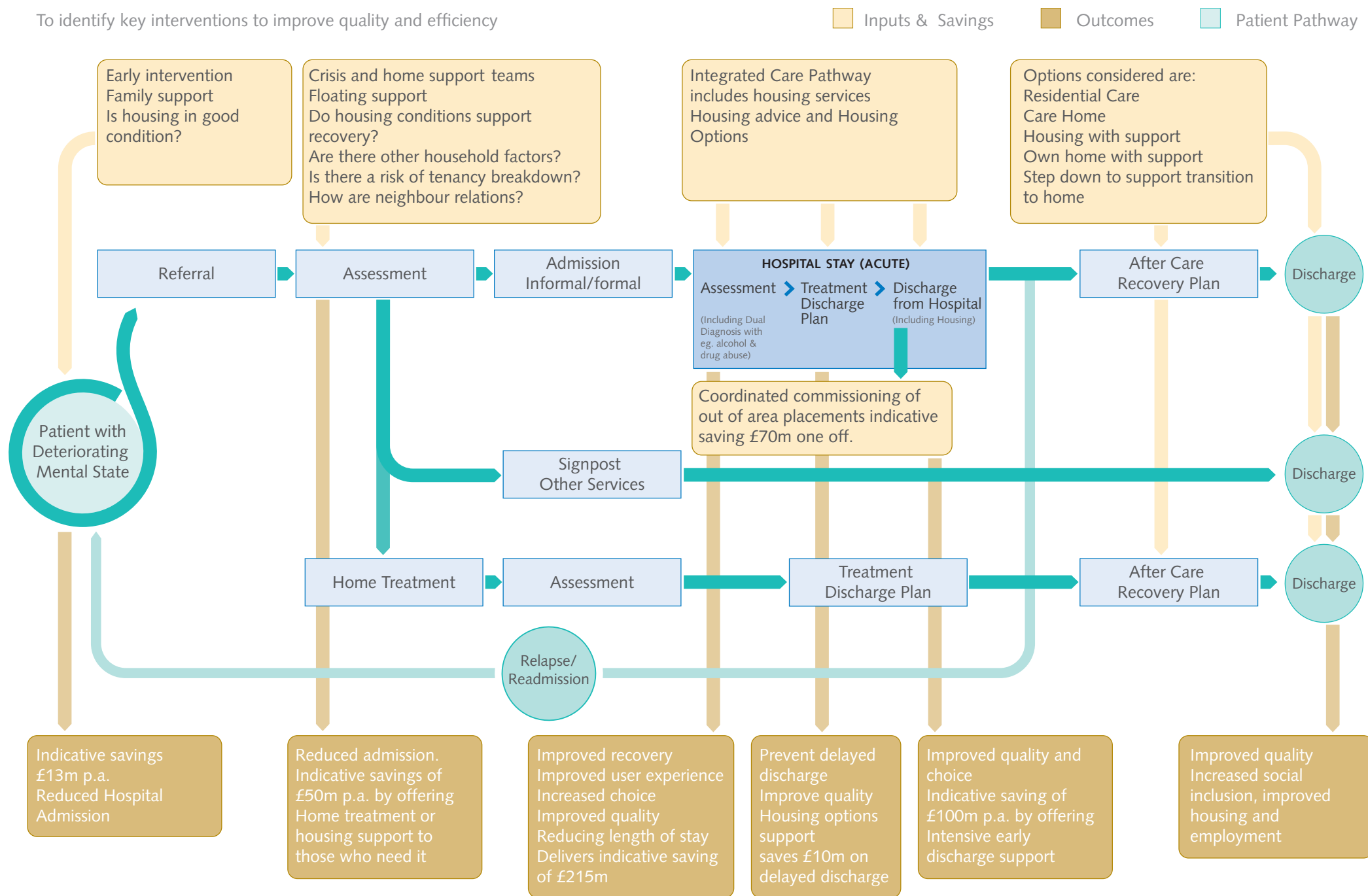25   DH (2011) No Health Without Mental Health : a cross-government mental health outcomes strategy for people of all ages. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf
26   Shepherd G (2011) Making Recovery a Reality. SCMH : London
27   Shepherd G (2010) Implementing Recovery : A New Framework for Organisational Change. Centre for Mental Health : London

Figure 1: The Acute Care Pathway

To identify key interventions to improve quality and efficiency

Inputs & Savings   Outcomes   Patient Pathway

Early intervention
Family support
Is housing in good
condition?

Crisis and home support teams
Floating support
Do housing conditions support
recovery?
Are there other household factors?
Is there a risk of tenancy breakdown?
How are neighbour relations?

Integrated Care Pathway
includes housing services
Housing advice and Housing
Options

Options considered are:
Residential Care
Care Home
Housing with support
Own home with support
Step down to support transition
to home

Referral

Assessment

Admission
Informal/formal

HOSPITAL STAY (ACUTE)
Assessment > Treatment
Discharge
Plan
> Discharge
from Hospital
(Including Housing)
(Including Dual
Diagnosis with
eg. alcohol &
drug abuse)

After Care
Recovery Plan

Discharge

Patient with
Deteriorating
Mental State

Coordinated commissioning of
out of area placements indicative
saving £70m one off.

Signpost
Other Services

Discharge

Home Treatment

Assessment

Treatment
Discharge Plan

After Care
Recovery Plan

Discharge

Relapse/
Readmission

Indicative savings
£13m p.a.
Reduced Hospital
Admission

Reduced admission.
Indicative savings of
£50m p.a. by offering
Home treatment or
housing support to
those who need it

Improved recovery
Improved user experience
Increased choice
Improved quality
Reducing length of stay
Delivers indicative saving
of £215m

Prevent delayed
discharge
Improve quality
Housing options
support
saves £10m on
delayed discharge

Improved quality and
choice
Indicative saving of
£100m p.a. by offering
Intensive early
discharge support

Improved quality
Increased social
inclusion, improved
housing and
employment

In Figure 1 we have set out an example of the acute care pathway taken from the NMHDU. What each of the "inputs" shows is the possible contribution that housing and housing related support services can make to improving the success of the pathway in delivering recovery. It argues for a consideration of someone's housing circumstances, their housing options and alternatives to institutional forms of provision.

There are a number of examples of where mental health commissioners and providers are working to co-produce a whole systems approach and to agree local outcome targets. By asking "how independently someone can live" they are planning to close up to 50% of beds over a five year period. Key to this is the management of risk. In a number of trusts the management of the pathway into the community was seen as essential but to support this it was also necessary to either i) have a team managing the transition or ii) a good relationship with a provider of housing related support who was trusted to manage the shared risk. So that at each stage of the process there is a positive contribution to be made from a partnership with housing.

Housing's contribution to the PbR Clusters

The development of care clusters and the introduction of tariffs provides the opportunity to provide financial incentives that further drive innovation and the seamless delivery of care. Against each of the clusters it is possible to identify a range of community based service options that reflect users' aspirations. These then need to be procured in a way that specifies the desired outcomes that can only be delivered in partnership.

As part of this programme we asked people what they perceived the advantages of a housing based service to be. Housing based services were perceived to bring a number of advantages:

Perception
Service users see a move out of statutory care as progress and their recovery is enhanced by moving away from the service where they were most unwell.

Principles
Healthcare providers have made great strides in introducing the recovery model and moving away from diagnose and treat. However, housing services were seen as living and breathing recovery.

Price
Housing providers can lever in funding from other sources and currently unit prices are significantly lower than healthcare providers.

Risk
Clinical risk in the confines of statutory services is very different from community based risk. Some respondents believed that the supported housing sector has more experience in managing community based risk and has a better frameworks to assess and manage that risk. Some expressed concern that at discharge from the acute care pathway information pertaining to risk comes either from the point of admission or ward based risk which has less relevance in the community.

GOOD PRACTICE CASE EXAMPLE

Housing's Contribution to the Clusters – London Cyrenians Housing

INTRODUCTION

Clustering was introduced to help support Payment by Results for NHS mental health services. It links payment to activity by grouping together people with relatively similar diagnosis or care needs and rationalises resource allocations accordingly.

The 21 clusters developed by the Care Pathways and Packages Project are laid out with associated scoring profiles to enable results to be measured. Currently this payment by outcomes system is specific to the NHS but could have a wider application for housing and community mental health support solutions.

AIM

To establish a results based payment system for the voluntary and independent sector and to create a single accountable system that unifies approaches and expectations across the entire mental health pathway.

OBJECTIVES

- To ensure housing is an integrated and integral part of peoples' mental health recovery pathway.

- To provide a preliminary platform for the introduction of PBR across the voluntary and independent sector.

- To move away from hours based commissioning and towards outcome focussed contracts.

- To align statutory and non-statutory services by adopting a single payment system

- To create a publicly accountable system and improve the quality of care and support for people with mental health needs.

HOUSING / COMMUNITY PATHWAYS FOR PEOPLE SUPPORTED THROUGH MENTAL HEALTH CLUSTERS

Universal offer - All clusters will be offered access to housing advice, housing options and advocacy.

Cluster 1

- Formal enquiry about living housing circumstances and living condition and social stressors
- Access to relevant computerised support programmes

Cluster 2

- Formal enquiry about living housing circumstances and living condition and social stressors
- Access to relevant computerised support programmes

Cluster 3

- Peer support
- Befriending
- Mentoring

Cluster 4

Floating Support – time limited (up to 6 months) Low intensity (up to 5 hours per week)

Cluster 5

Floating Support – time limited (up to 6 months) Low intensity (up to 5 hours per week)

Cluster 6

Floating Support – time limited (up to 1 year) Moderate intensity (5-10 hours per week)

Cluster 7

- Floating support time limited (up to 18 months) intensive (10 hours plus per week)
- Accommodation based - medium support
- Therapeutic Community

Cluster 8

- Outreach support
- Therapeutic Community
- Accommodation based - medium support
- Recovery Centre

Cluster 9

N/A

Cluster 10

- Floating support – up to 7 hours pw
- Outreach – up to 7 hours pw

Cluster 11

- As above up to 5 hours pw
- Peer support
- Befriending

Cluster 12

- Group home – longer term
- Floating support – high intensity 15 hours plus pw
- An Accommodation based option

Cluster 13

- Group home – longer term
- Floating support – high intensity 15 hours plus pw
- An Accommodation based option

Cluster 14

- Recovery Centre
- High support ABS
- Therapeutic Community
- Crisis House

Cluster 15

- Recovery Centre
- High support ABS
- Therapeutic Community
- Crisis House

Cluster 16

- Therapeutic Community
- Complex needs ABS
- Intensive floating support

Cluster 17

- Recovery Centre
- Complex needs ABS
- Assertive outreach

CLUSTER AND PBR TABLES

NUMBER	CLUSTER	HOUSING/COMMUNITY PATHWAYS	SKILLS SET	TARIFF
Cluster 1	Common Mental Health Problems (Low)	• * • Formal enquiry about living housing circumstances and living conditions and social stressors. • Access to relevant computerised support programmes.	• Questionnaire • Signpost • Leaflets	
Cluster 2	Common Mental Health Problems (Low & Greater Severity)	• Formal enquiry about living housing circumstances and living conditions and social stressors. • Access to relevant computerised support programmes.	• Questionnaire • Signpost • Leaflets	
Cluster 3	Non-psychotic (Moderate)	• Peer support • Befriending • Mentoring	• Lived experience • Training • CRB • CV Support	Vouchers up to £10
Cluster 4	Non-psychotic (Severe)	• Floating Support – time limited (up to 6 months) Low intensity (up to 5 hours per week)	• Complete skills for care induction • Good communication skills • Transferable life skills and experience	£8.50 - £10.00 per hour
Cluster 5	Non-psychotic Disorders (Very Severe)	• Floating Support – time limited (up to 1 year) Moderate intensity (5-10 hours per week)	• Complete Skills for Care induction • Understanding of mental health issues • Good communication skills • 6 months relevant experience	£10.50 - £12.00 per hour

NUMBER	CLUSTER	HOUSING/COMMUNITY PATHWAYS	SKILLS SET	TARIFF
Cluster 6	Non-psychotic Disorder of overvalued ideas	• Floating Support – time limited (up to 1 year) Moderate intensity (5-10 hours per week)	• Complete Skills for Care induction • Understanding of mental health issues • Good communication skills • 6 months relevant experience	£10.50 - £12.00 per hour
Cluster 7	Enduring non-psychotic Disorders (High Disability)	• Floating support time limited (up to 18 months) intensive (10 hours plus per week)	• Skills for Care induction • Mental health recovery training • mental health access course • 1 years experience or a relevant degree	£12.00 - £18.50 per hour
		• Accommodation based - medium support		£14.00 - £16.00 per hour
		• Therapeutic Community		£19.00 - £22.00 per hour
Cluster 8	Non-psychotic Chaotic and Challenging Disorder	• Outreach support	• Understanding of Assertive Model of Engagement	£14.00 - £16.00 per hour
		• Therapeutic Community	• Proactive approach to domestic skills and activities	£19.00 - £22.00 per hour
		• Accommodation based - medium support	• An understanding of mental health recovery	£14.00 – £16.00 per hour
		• Recovery Centre		£14.00 - £16.00 per hour
Cluster 9	Blank	N/A		
Cluster 10	First Episode Psychosis	• Floating support – up to 7 hours pw	• Complete skills for care induction • Good communication skills	£8.50 - £10.00 per hour
		• Outreach – up to 7 hours pw	• Transferable life skills and experience	£14.00 - £16.00 per hour

NUMBER	CLUSTER	HOUSING/COMMUNITY PATHWAYS	SKILLS SET	TARIFF
Cluster 11	Nmf nhmf qdbt qdmf Orxbgnrhr (Low)	¶ Ekn'shmf rt oonqs fl t o sn 4 gnt qr ov ¶ Ntsqd'bg fl t o sn 4 gnt qr ov ¶ Oddqrt oonqs ¶ Adepdmchmf	¶ Khudc dwoddpdmbd ¶ Sq hmhmf ¶ BQA ¶ B U Rt oonqs	¢7-4/ , ¢0/-// odqgnt q ¢03-// , ¢05-// odqgnt q Unt bgdq t o sn ¢0/
Cluster 12	Nmf nhmf nqqdbt qqdmt Orxbgnrhr 'Ghfg Chr'ahltsx(	¶ F qnt o gnl d fl knmf dqsdq ¶ Ekn'shmf rt oonqs fl ghfg hmsdmrhsx 04 gnt qr olt r ov ¶ @m@bbnl l nc'shmma'rdc option	¶ Orxbgnrnbh kilhsdqudmshnmr. B AS Sq hmhmf ¶ 1 xd'qr dwoddpdmbd ¶ @mt mcdqs'mchmf nel dms'k health recovery	¢03-// , ¢05-// odqgnt q ¢01-// , ¢02-4/ odqgnt q ¢03-// , ¢05-// odqgnt q
Cluster 13	Nmf nhmf nqqdbt qqdmt Orxbgnrhr 'Ghfg Rxl osnl %Chr'ahltsx(	¶ F qnt o gnl d fl knmf dqsdq ¶ Ekn'shmf rt oonqs fl ghfg hmsdmrhsx 04 gnt qr olt r ov ¶ @m@bbnl l nc'shmma'rdc option	¶ Fnnc hmsdqdqrnm krj hlkr ¶ Oqn'bshud 'ooq'bg sn cnl drshb rt oonqs 'mc activities ¶ Gnt rhmf Noshnmr	¢04-// , ¢06-// odqgnt q ¢01-// , ¢02-4/ odqgnt q ¢03-// , ¢05-// odqgnt q
Cluster 14	Psychotic Crisis	¶ Qdbnudqx Bdmsqd ¶ Ghfg rt oonqs @AR ¶ Sgdq odt sho Bnl l t mhsx ¶ Bqhrhr Gnt rd	¶ Orxbgnrnbh kilhsdqudmshnmr. B AS Sq hmhmf ¶ 2 xd'qr dwoddpdmbd nqqdkdu'mt cdf qdd ¶ @v 'qdmdrr nerhfmr 'mc rxl osnl r nel dms'kilkmdrr	¢07-// , ¢10-// odqgnt q ¢07-// , ¢10-// odqgnt q ¢08-// , ¢11-// odqgnt q

NUMBER	CLUSTER	HOUSING/COMMUNITY PATHWAYS	SKILLS SET	TARIFF
Cluster 15	Severe Psychotic Depression	¶ Qdbnudqx Bdmsqd	¶ Orxbgnrnbhk Hmsdqudmshnmr. BAS Sqhmhmf	¢07-// , ¢10-// odqgnt q
		¶ Ghfg rt oonqs @AR	¶ 2 xd'qr dwoddhdmbd nqqdldu'ms cdfqdd	¢07-// , ¢10-// odqgnt q
		¶ Sgdq odtsho Bnl l t mhsx	¶ @v 'qdmdrr ne rhf mr 'md rxl osnl r nel dms'khkmdrr	¢08-// , ¢11-// odqgnt q
		¶ Bdrhr Gnt rd	¶ @fqdd $ put'kh dc rs'ee	
Cluster 16	Ct 'kCh f mnrhr	¶ Sgdq odtsho Bnl l t mhsx	¶ L t kh,chrbhokhm qx sd'l ¶ Bnt mrdkkhmf	¢08-// , ¢11-// odqgnt q
		¶ Bnl okdwmddcr @AR	¶ BAS Sqhmhmf ¶ Sgdq odtsho Bnl l t mhsx Model	¢1/-// fl ¢12-// odqgnt q
		¶ Hmsdmrhud fnn'shmf rt oonqs		¢01-// , ¢07-// odqgnt q
Cluster 17	Orxbgnrhr 'md @eedbshud Chrnqcdq , Chp bt ls sn Dmf 'f d	¶ Qdbnudqx Bdmsqd	¶ Orxbgnrnbhk Hmsdqudmshnmr. BAS Sqhmhmf	¢07-// , ¢10-// odqgnt q
		¶ Bnl okdwmddcr @AR	¶ 3 xd'qr dwoddhdmbd nqqdldu'ms cdfqdd	¢1/-// , ¢12-// odqgnt q
		¶ @rrdqshud nt sqd'bh	¶ Oqnedrrhnm kpt'kh b'shnm+ ¶ @v 'qdmdrr ne rhf mr 'md rxl osnl r nel dms'khkmdrr ¶ @fqdd $ nt qrhmf	¢03-// , ¢05-// odqgnt q

Joint Strategic Needs Assessment

As part of the Coalition Government's reform agenda the Joint Strategic Needs Assessment will be a key responsibility of the new Health and Well-being Boards. The integration of housing and support information is key if the needs of vulnerable groups are going to be properly reflected in local planning and commissioning frameworks and the translation of these into commissioning intentions.[28]

The integration of housing and support information has been identified as a key weakness of the JSNA[29]. Further work is needed to ensure that all information about the housing and support needs of marginalised groups is included in the JSNA and other local planning and commissioning frameworks. Specific attention needs to be given to strengthening the translation of the JSNA assessment into joint commissioning conversations and decisions.

A series of case studies has been published by the LGID as part of their Communities of Practice[30]. A review undertaken as part of the Healthy Communities Programme indicated a number of steps that would need to be considered if the needs of vulnerable adults were to be accurately reflected In the JSNA – and hence in commissioning intentions.

As part of the NHS reforms, the JSNA will be a key responsibility and joint commissioning vehicle for the new Health and Wellbeing Boards. The purpose of the JSNA and the influence that it has on commissioning intentions will be locally determined. From previous work on the development of the JSNA it is possible to distill some key messages as the JSNA transfers to the Health and Wellbeing Boards:

- There is a real overlap between clients across health, housing and social care and the whole system needs to be engaged in the process of gathering data;

- There is a need to appreciate the different funding, regulatory, governance, decision-making and legal frameworks that partners are working to;

- Good partnership working builds on what is already in place;

- Leadership is required to join up the actions that are required to further join up intelligence and actions across health, social care and housing;

- Need to recognise the contribution that housing and related support services make to health and well-being agendas;

- There need to be clear mechanisms for how people 'fit' into the development and analysis of the JSNA locally.

Some areas have already seen the JSNA as being instrumental in looking at the contribution that housing and support can make to health and social care agendas and as a key determinant of health. Moving forward it could be a key mechanism for ensuring that these agendas are aligned to help do 'more for less'.

GOOD PRACTICE CASE EXAMPLE

East of England

Aligning Joint Strategic Needs Assessments and Strategic Housing Market Assessments

In 2009 / 2010 partners in the East of England worked together to ensure that there was an alignment between the Joint Strategic Needs Assessment and the Strategic Housing Market Assessment and they could both inform investment decisions. This was to ensure that they were taking a long term strategic approach to the provision of services and the housing strategy that would be needed to support it.

They wanted to follow up on recommendations in Housing, Care and Support: A Guide to Integrating Housing-Related Support at a Regional Level. These align local assessments of the need for housing related support to allow for aggregation at a regional level and between different outcomes frameworks so that services include housing and housing related support.

It recommended that Supporting People Commissioning Bodies take responsibility for producing robust assessments of need and that the JSNA should include an assessment of future needs for housing related support for vulnerable adults. This should then feed into the SHMA. The key messages were :-

- An integrated JSNA ca read across into different sets of needs assessments and demonstrate links to determining the quantity of affordable, adapted and supported housing;

- Local Authorities are building greater capacity through representing the needs of vulnerable adults in the JSNA;

- There are very different across the worlds of housing and health with supported housing bridging the gap.

It was decided to give consideration to the amount of revenue funding being made available for the Supporting People Programme. An increase in households will proportionally lead to an increase in the number of vulnerable households. With the reduction in real terms to the Supporting People revenue, there were concerns that there would be a stretching of resources beyond the limit of adequate delivery.

It was therefore decided to develop a prioritisation matrix to ensure that capital investments were aligned with the SP programme. This includes information pulled together by the housing authority, a scoring from the Supporting People Core Commissioning Groups and an assessment by the Housing Corporation (Homes and Communities Agency).

This has required sub-regions to be very explicit about their priorities and to ensure that they have been agreed before the bidding round begins. It has made for a more efficient process and, not withstanding the need to train staff, one that makes better use of staff time – which is the primary cost.

28   http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097
29   Rollinson J (2010) Joint Strategic Needs Assessment : Vulnerable Adults, housing and support. London : LGID
30   www.communities.idea.gov.uk

SETTING OUTCOMES FOR THE WHOLE SYSTEM

There are perceived to be a number of benefits of an Outcome Based Approach to commissioning[31]. It should mean a better service for the end user avoiding the trap of delivering service volumes, in the manner agreed, at the right time, to high quality standards, but still not achieve the desired outcomes. It enables the commissioner to focus on exactly what they want the provider to achieve and why. This may be of particular help where services are to be jointly commissioned. Given that both sides need to understand the rationale behind the desired outcomes, to understand what success would look like and to identify the evidence based practice that will deliver measurable results.

Commissioners and providers working together to arrive at good quality measures can be a beneficial approach to both raising the quality of the service and for enhancing working relationships. In this section we will look at the ways in which outcomes are set and then the available mechanism for delivering them.

Outcomes framework for the NHS, Social Care and Public Health

The current outcomes sit in different places across the system, for example, housing sits with local authorities and employment with the NHS. Hence there is a need to develop outcomes at a local level that work across public health, the local authority and the NHS. Outcomes that reflect the lived experience of the user and that require the whole system to come together to deliver them.

The Coalition Government has published new outcomes frameworks for the NHS and Social Care. Public Health outcomes are in draft form at the time of writing. Mental health will be accorded equal importance to physical health outcomes as a measure of effectiveness. The importance of settled accommodation has been recognised in the frameworks for Social Care and draft frameworks for Public Health. This takes forward the legacy from the previous government's approach to Public Service Agreements.

The NHS outcomes framework describes a set of outcomes measures that are intended to drive up quality and enable the Secretary of State to hold the NHS Commissioning Board for England to account and for them, in turn, to receive assurance from the Health and Well-being Boards for delivery. Some of the NHS outcomes framework domains have been given a mental health specific indicator. Others do not have a specific indicator that relates to mental health but will still have direct relevance to mental health service commissioning and provision.

The NHS Outcomes Framework includes :

Domain 1 : Preventing people from Dying Prematurely

- Mortality from causes considered amenable to healthcare.

- Mental health indicator: Under 75 mortality rate in people with long term mental illness.

Domain 2 : Enhancing quality of life for people with long term conditions

- Health related quality of life for people with long term conditions.

- Mental health indicator: employment of people with mental illness.

Domain 4 : Ensuring people have a positive experience of care

- Overarching indicators: Patient experience of primary care. Patient experience of hospital care.

- Improving experience of healthcare for people with mental illness.

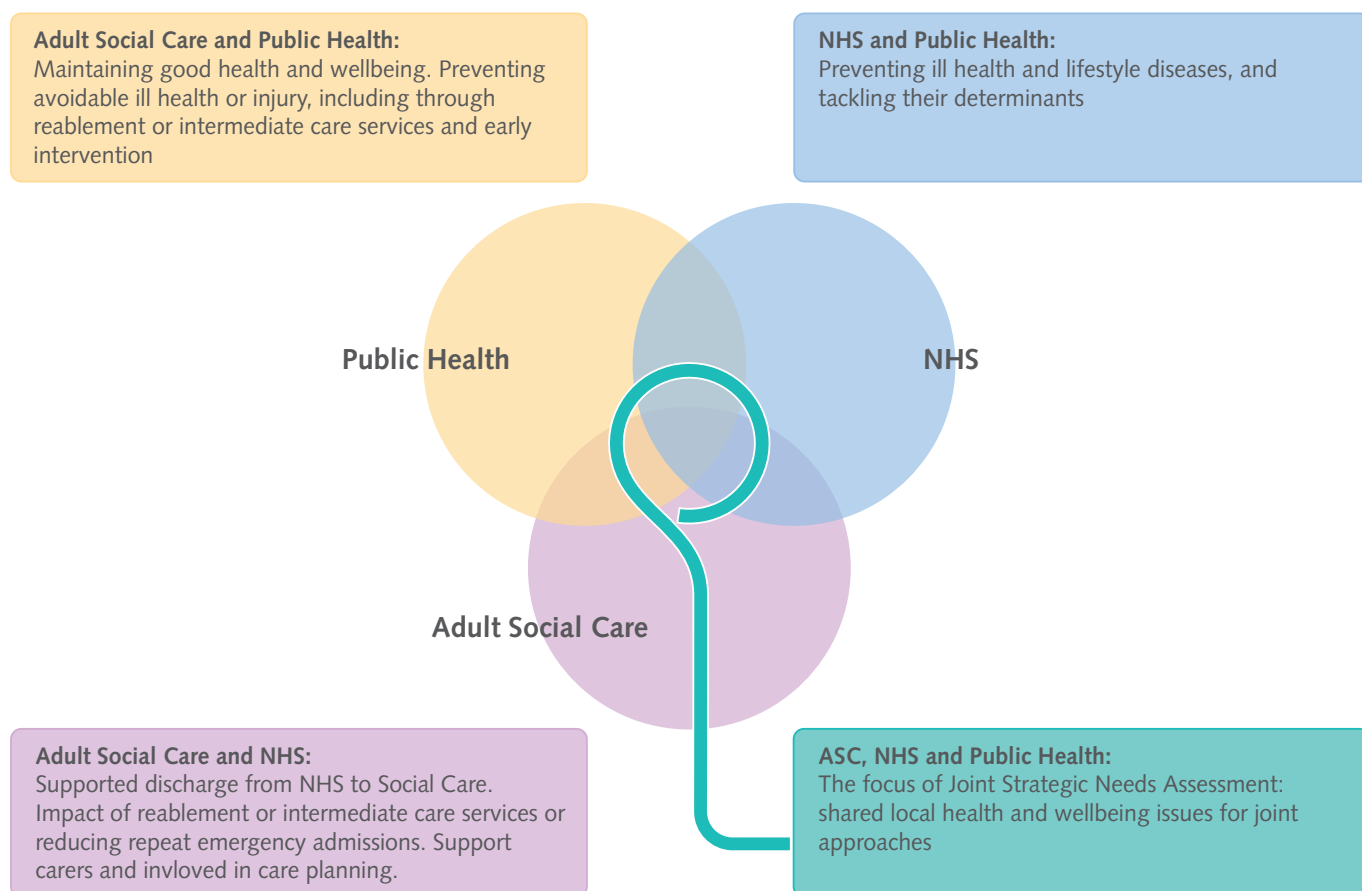- Mental health indicator: Patient experience of community mental health services.

Domain 5 : Treating and caring for people in a safe environment and protecting them from avoidable harm

- Overarching indicators: Patient safety incident reporting; Severity of harm. Number of similar incidents

There are a number of ways in which these have implication for collaborative work across health, housing and social care. These are:

- Domain 1 could encourage actions around suicide prevention and lifestyle risk management;

- Domain 2 could apply directly to enhancing quality of life for people with long-term severe mental illnesses and the contribution of mental health services to those with physical long-term conditions such as diabetes;

- Domain 3 could apply to recovery from episodes of severe mental ill health. This would need to reflect the aspirations of clients for education, training and employment support, housing, social networks and attention to wider social care and skills development issues;

- Domain 4 might encompass people's experience of mental health care, treatment and support, including their ability to exercise choice, personalisation, peer support, involvement in developing care plans, decisions about care and treatment, and use of recognised measures such as Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs);

- Domain 5 is about safeguarding people's wellbeing when accessing mental health care and treatment, including clinical safety, informed by PROMS, NICE Quality Standards, and Care Quality Commission inspections of the care environment and standards of practice[32].

Figure 2

Adult Social Care and Public Health:
Maintaining good health and wellbeing. Preventing avoidable ill health or injury, including through reablement or intermediate care services and early intervention

NHS and Public Health:
Preventing ill health and lifestyle diseases, and tackling their determinants

Public Health

NHS

Adult Social Care

Adult Social Care and NHS:
Supported discharge from NHS to Social Care. Impact of reablement or intermediate care services or reducing repeat emergency admissions. Support carers and invloved in care planning.

ASC, NHS and Public Health:
The focus of Joint Strategic Needs Assessment: shared local health and wellbeing issues for joint approaches

Source: Practical Mental Health Commissioning - Bennett, A. Appleton, S. Jackson, C. March 2011

The Social Care Outcomes Framework[33] includes:

Domain 1 : Enhancing quality of life for people with care and support

- The proportion of adults in contact with secondary mental health services living independently, with or without support.

Although this is subject to consultation, the proposed Public Health outcomes framework[34] includes:

Domain 2 : Tackling the wider determinants of ill health: tackling factors which affect health and wellbeing

- Housing overcrowding

- Proportion of people with mental illness and disability in settled accommodation

- Statutory homeless households

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32   Bennett, A. Appleton, S. Jackson, C. (2011) Practical Mental Health Commissioning. London : NMHDU.

The Coalition Government has made clear that it expects social care services to work not just with the NHS and Public Health England towards these outcomes but also, just as importantly, with partners in local government and with local independent, mutual and voluntary and community organisations. Figure 2 illustrates the way in which the different outcomes frameworks could come together.

Patient Driven Innovation

The key focus of recovery is the service user. Relationships between healthcare professionals and people using services are undergoing a profound change, "professionals need to move from being "on top" to being "on tap" says Jerome Carson, a consultant clinical psychologist in a South London and the Maudsley (SLaM) community mental health team based in Streatham in South London. SLAM has developed an approach with users that uses the talent that exists within the patient population and using multi-channel delivery to reach the wider population.

An example of this approach is a Trust publication, entitled Recovery Journeys: Stories of coping with mental health problems, a 20-minute Recovery film that features four service users talking about their life experiences – but was also directed by a SLaM service user. The film is available to download from the Trust's website and on YouTube[35].

There is a recognition across many mental health organisations that the approach to recovery has to be driven by users with the recovery pathway stretching out into the community. At SLAM they have supported this through a Community Links Programme that helps people manage the transition to community living and to manage the risks successfully – as well as supporting the implementation of the Trust's Social Inclusion, Recovery and Rehabilitation Strategy.

There are increasingly good links to supported housing projects and a recognition that there are good teams within these organisations and that they have become more professional. Increasingly, providers are collaborating to manage risk, to ensure that people move between clusters (in a positive direction) and to share training and skills development.

A Framework for Outcome Based Commissioning

It is unclear (at this moment in time) how, and who, is in the best position to support GP consortia and Health and Well-being Boards to address the control and complexity of a 'whole system' approach to commissioning. GP Commissioners will not have the resources to design the detailed specifications that were used by PCTs. Instead they will need to take responsibility for health outcomes that would assume proper control of service planning, development and the commissioning process[36].

The King's Fund have argued that to make a significant impact towards achieving the five domains of the NHS Outcomes Framework there needs to be, not only a large enough footprint to commission, but also a real understanding and responsibility to achieve the best and most cost-efficient outcomes. By adopting an outcomes based approach there is a greater opportunity to ensure that scare resources are being allocated where they can have best effect[37].

33   Department of Health (2010). Transparency in outcomes: a framework for adult social care. A consultation on proposals. London: Department of Health.

34   Department of Health (2010). Healthy lives, healthy people: transparency in outcomes. Proposals for a public health outcomes framework. A consultation document. London: Department of Health.

NHS Liverpool developed an outcome-based approach to commissioning services which they have described as the ABC approach to commissioning for outcomes. This model helps to develop, define, implement and monitor outcome measures and as supporting the QIPP Plan and the wider quality agenda. The ABC approach to commissioning for outcomes focuses on:

- **A**ssessment of need and delivery of the PCT's strategic **A**ims

- The use of the **B**est evidence to inform what we do

- The review of **C**urrent practice and a formal **C**ritique of the evidence.

- The **D**evelopment of meaningful and measurable outcomes

- The **E**valuation of services

- Ensuring that we **F**ormulate the right data sets to assess the impact.

As such it brings together the commissioning cycle, the required national competencies for commissioning, evaluation and the principles of evidence-based care delivery.

The Health and Social Care Bill requires commissioning organisations to become more outcome-focused. In developing outcomes NHS Liverpool suggest that it necessary to ask the following simple questions:

- What should be measured?

- How should it be measured?

- When should it be measured?

- What do we expect to happen?

- What are the most powerful measures to detect a [clinically] significant change and are these a measure of therapeutic impact?

NHS Liverpool believe by synthesising these principles and the elements of the 'ABC' model, they have developed a framework where key functions within the organisation are influencing and supporting each other in a structured way and one which will not only survive the vicissitudes of structural change but be better suited to the new landscape.

35   www.slam.nhs.uk/patients/recovery.aspx
36   Smith, J., Curry, N., Mays, N., Dixon, J., (2010) Where next for commissioning in the English NHS?. The Nuffield Trust and The Kings Fund. London.
37   Devlin, N., Appleby, J. (2010). Getting the most out of PROMs: Putting health outcomes at the heart of NHS decision-making. The Kings Fund. London

GOOD PRACTICE CASE EXAMPLE

LOOK AHEAD: TOWER HAMLETS

Personalising block contracts in supported housing

London Borough of Tower Hamlets, NHS Tower Hamlets and Look Ahead Housing and Care.

Introduction

Look Ahead Housing and Care, working in partnership with the London Borough of Tower Hamlets and NHS Tower Hamlets have piloted an innovative model to commissioning and delivering personalisation in a block contract supported housing scheme for people with mental health conditions. The pilot developed a core and flexi approach to offering personalised supported housing services.

Coventry Road

Coventry Road is a high needs mental health accommodation-based service that has self-contained flats for 20 people. Customers are referred into the project by the CMHT, have a range of complex needs, and are subject to the Care Programme Approach. Customers are mixed in terms of age, gender, ethnicity and background. Staff are on site 24 hours a day and the full staff team is made up of ten support workers, one manager and one deputy manager. Coventry Road is commissioned by the London Borough of Tower Hamlets (25%) and NHS Tower Hamlets (75%). LBTH are a member of the In Control Total Transformation Programme. Commissioning takes place through the Supporting People arrangements.

The Core and Flexi Approach

The 'core' refers to a fixed range of support required by all customers in order to run an accommodation-based service, while the 'flexi' refers to individual support that enables the service to be more tailored to the needs of, wishes and interests of the customers.

The model was established around some well-established principles of clarity and control developed by In Control around personal budgets. The intention was to personalise the service in its entirety. It was decided that of the available block contract: 74% would be the core, funding two staff for 24 hour cover; 26% would be flexi, offering 3.5 support hours (18%) and £40 (8%) per week to be decided by the customer. The cash allocation was achieved by freezing two support worker posts when they became vacant.

By implementing Person Centred Planning, the customer could not only decide how to spend the £40 to meet their outcomes (this could also be rolled-up or saved over a number of weeks), they could also decide which support worker would support them in their 3.5 hours of activity.

Key outcomes and learning

The development of the pilot has been transformational for the organisation and the customers. Many customers have adapted enthusiastically to the offer of more personalised services. Although it is early days in measuring longer term impact, customers have: opened up to person-centred thinking, validated talents and abilities and sparked interest in old hobbies and skills; feel they have taken control of their lives; maintained focus and motivation;

built confidence; and managed cash and used it responsibly. As one customer said "I have a focus in my life. Something to look forward to and get excited about".

For the provider, the trial has highlighted the importance of: preparation – introducing a preparation programme, identifying what level of control customers have, addressing how resources are allocated, involving external partners and scrutinising policies, procedures and practices; workforce – managing and leading culture change, revisiting terms and conditions, looking at recruitment and retention, redesigning rotas; and central services – understanding the wider change and impact the approach has on the organisation.

For the commissioners, this pilot has demonstrated how, in partnership with providers, they can personalise block contracts and demonstrate a clear commitment to self-direct support and personalised prevention services, as well as increase knowledge for local commissioning. Some of the key ingredients to the success of this pilot were: the relationship between the commissioners and the provider; clarity of purpose that the trial would not be a backdoor route to cutting the contract value; recognising customer priorities; being prepared to agree contractual deviation.

Concluding remarks

The Core and Flexi model in accommodation based services can offer a package of safety and progression combined with genuine customer control over designing and purchasing elements of care and support. Look Ahead believes it has the potential to be adapted to range of needs and services. It is only one approach and demonstrates what can be achieved when providers and commissioners work together to achieve change and transformation.

Further information and summary of the learning to date can be found on the Look Ahead website: www.lookahead.org.uk

Commissioning Processes

There are significant local variations in the way mental health commissioning is delivered. Arguably mental health commissioning has not been as well resourced and have not always managed to establish the same level of authority over the provider market as in   other areas of commissioning. This is often characterised by one large mental health provider informing the commissioner of what they needed to see in their block contract.

However, the market in mental health is already well developed and is arguably more mature than other parts of the health and social care market. Third Sector providers have played a significant role in the development of IAPT and other community services. They are also very visible in the provision of specialist services and rehabilitation services. There are three main ways in which mental health commissioners shape the market, ensure choice, improve quality and safety and increase effectiveness. These are:

> i) contract negotiations;
>
> ii) Competitive Dialogue;
>
> iii) Tendering.

Contract Negotiations

Most mental health services have continued to be commissioned by use of a standard mental health block contract. Increasingly Commissioners have been encouraged to use the lever of the contract as a way of securing new innovation and greater value for money. The contracting round was seen as a key lever in the World Class Commissioning process. This approach is attractive to commissioners who want to drive forward improvements without destabilising existing providers.

Competitive Dialogue

This procedure replaced competitive negotiated procedures as the routine choice for such complex contracts. The essential difference between the competitive dialogue procedure and the competitive negotiated procedure is that under the new procedure 'final tenders' which are submitted after conclusion of the dialogue with candidates 'shall contain all elements necessary for the performance of the project'. Competitive Dialogue is a favoured method for projects that involve a complex supply chain and where provider driven innovation is a requirement of the project. The new primary care service in Earl's Court is being procured by this method.

Tendering

There are a number of reasons that a PCT or down the line a GP Led Commissioning Consortia will decide to tender services. These fall into three categories i) EU Law, ii) NHS Principles and Rules for Cooperation and Competition and iii) an organisations own standing orders.

I) **EU Law**
All procurement is governed by EU law under the Public Contracts Regulations. This divides services into two types. The first are Part A services which include services such as IT and these can be challenged if they are not tendered. There are then Part B services which is designed to be a light touch regime which includes health and social care services. These are not required to be tendered. However, they may be subject to the NHS Principles and Rules of Competition and Co-operation.

ii) **Principles and Rules of Competition and Co-operation**
The PRCC require PCTs to undertake an advertised competitive process when contracting for clinical services. If services fall naturally within the remit of an existing block contract or can be shown to be the natural extension of a block contract then there is no need to tender. This can be challenged by other providers by appealing to the Competition and Cooperation Panel. In some circumstances the PCT may manage the risk of a challenge by asking the holder of the block contract to undertake a market making exercise.

iii) **Standing Orders**
A PCT seeking to extend a contract can normally do so – although it may need to tweak its Section 75 agreements. Any FT seeking to innovate will argue that all its services are Part B services and the PRCC do not apply to them. It will have to have regard to its own standing orders and terms of business with the regulator. However, it may undertake a market making exercise to help the PCT manage its responsibilities under the PRCC.

Provider-led Innovation

However, commissioners decide to shape the market providers will want to cooperate and develop new forms of integrated care across organisational and sectoral boundaries. They should develop long-term plans for reducing beds and OATs. They could be allowed to use their flexibilities to purchase property and pull together supply chains for delivery.

One organisation form that has been explored in this situation is that of an Integrated Care Organisation or ICO. Integrated care organisations (ICOs) are seen as a means of achieving improved coordination of care, delivering better services between secondary, primary and social care, and providing improved overall care for patients more economically. Indeed there are those who consider that GP Led Commissioning Consortia may be a staging posts on the way to the creation of more ICOs in which participating clinicians receive a global fully capitated annual payment for each patient on their list, and assume responsibility for ensuring access to all necessary care (except highly specialist services).

In Figure 3 we show how a supply chain might be pulled together to reflect the whole of a person's pathway to recovery through co-operation with providers, outcome based commissioning and personal / individual budgets. It illustrates the 'band-width' that is required and the need for patient / user feedback to ensure that investment is targeted effectively.

Figure 3: Supply Chain
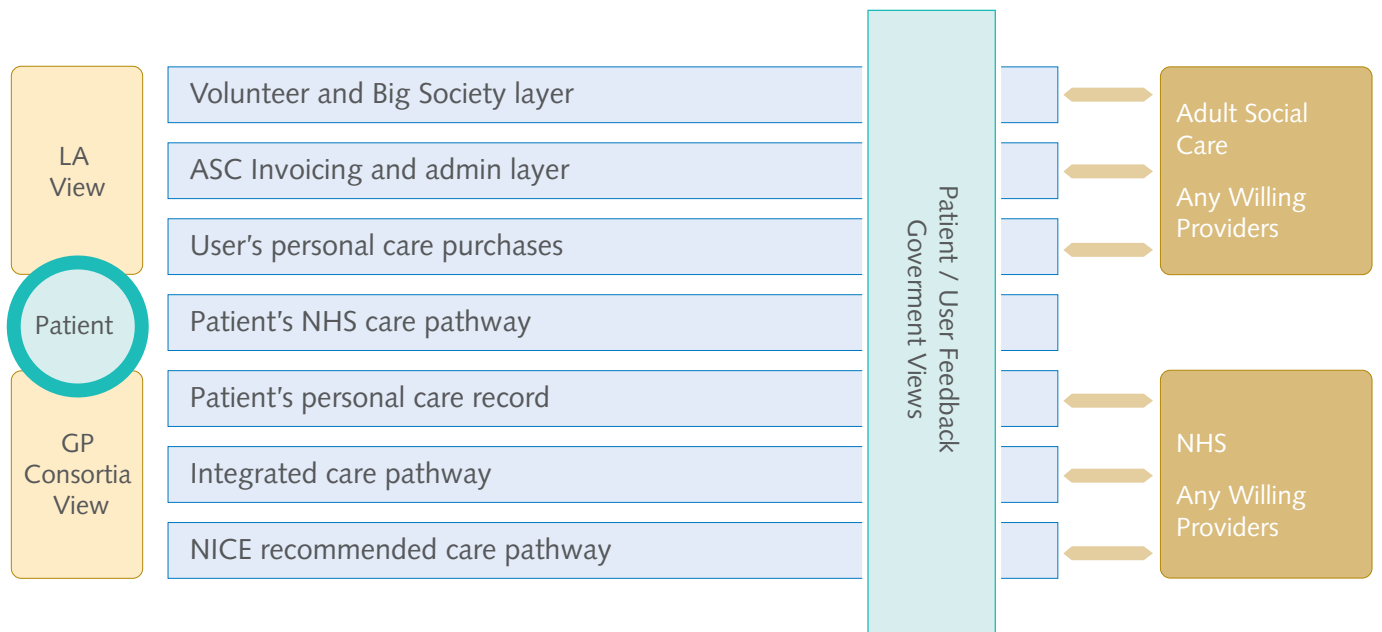
GOOD PRACTICE CASE EXAMPLE

MIDLAND HEART & 2GETHER

Midland Heart recognised that commissioners were issuing invitations to tender that encompassed a broader range of services and in some cases asked for groups of providers to come together to deliver a set of specified outcomes. They recognised that they were only in a position to deliver the housing and housing related support elements of the proposed response. However, commissioners were looking to create one contract.

2gether had worked to ensure that recovery was the focus of all the organisation's activities. They recognised that this required them to further develop the role of users within the organisation and to form new relationships with agencies that had different skills. In particular, they knew that they did not wish to manage housing.

Midland Heart and 2gether began to explore the possibility of forming a partnership. Both organisations invested a significant amount of time in developing a shared vision and shared values. This was to ensure that relationships were built between staff groups at different levels of the organisation so that they could understand their respective strengths. This had two main advantages:

      i) an understanding of each other's skills built trust and a willingness to share risk and an understanding of the need to manage risk differently in different settings;

      ii) when a tender came up there was already a trust and a willingness to work together.

There was an understanding that if it was desirable to adopt the social model of recovery then there was a need to bring into the pathway a range of skills including housing options advice, floating support, life skilling and independent living.

An opportunity arose when Herefordshire Council issued an invitation to tender for £30m of services over three years. They opted to use a competitive dialogue process to procure this. They are credited with being open and transparent about the outcomes they were looking for and the resources they had available to commit to them. On this basis Competitive Dialogue was seen to have been a good process to use as it enables everyone to be open and constructive.

The downside is that it is very time consuming. It can be difficult to keep people motivated and it can take time before there is a return on investment. However, the quality of relationship and the understanding can help to manage risk and deliver a more therapeutic pathway to recovery.

DEFINITIONS

Over the years a number of terms have come into use either because they are used in policy, in clinical practice or amongst different professional groups. Throughout this paper a number of these terms are used. A number of them are defined below.

Acute care pathway	The person's journey through acute psychiatric inpatient care and crisis / home treatment.
Block contract	An agreement, renewed annually, between a commissioner and a contractor to provide a complete programme or service for a set amount of money over a set amount of time
Care pathway	The person's journey (and that of their carer) through the mental health system setting out the planned care and treatment at each stage, what should be provided, by whom, how, when and where, and which indicators of quality improvement and clinical and social care outcomes should be used to demonstrate return on investment
Cluster	A group of people with a recognisable shared set of symptoms and signs of illness
Common mental illness	Mental health conditions with a mild to moderate and/ or time-limited impact on the person (often depression or anxiety)
Contract	A legally binding agreement between a commissioner (the contract owner) and a provider (the contractor) to deliver a product to an agreed specification (quality and outcome) for a specific amount of money over a set period of time
Crisis House	Traditionally provided by the statutory and voluntary sector to provide a rapid response residential service to people experiencing acute mental distress. It will usually include a range of structured support sessions and clinical interventions, a safe diversion from hospital inpatient facilities, an alternative where home treatment is not suitable and a short term haven from daily issues
Floating Support	A model of service delivered by the voluntary sector, housing associations and statutory services that it provides practical support to people in their own homes focussing on building domestic skills, home management, money management and mental health recovery, support with CPA requirements and fixed term support with a view that the support will "floated off" when no longer required
Housing Advice	Usually provided by statutory and third sector agencies e.g. Shelter, CAB, and legal firms, to support vulnerable people to sustain their tenure.
Housing Options	Usually provided by the Local Authority or the Third Sector and supports people to identify suitable local accommodation.

Outcomes	The effect or result of commissioning process (ie. commissioning), service or intervention / treatment
Out-of-area services	Treatment delivered in a care setting outside the person's home locality – either because of lack of resources or because they have special needs that can only be met elsewhere
Payment by Results	An annual transaction between a commissioner and a contractor that means the provider must be able to demonstrate that they have delivered the agreed level of activity and outcomes
Personalisation	Enabling people to make decisions about their own care and support and organising services and systems around their needs
QIPP	To achieve the necessary cost reductions, the NHS has adopted an approach called Quality Innovation, Productivity and Prevention or QIPP.
Recovery	At the heart of 'recovery' is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms.
Severe mental illness	Serious, high-risk or complex forms of mental distress (often as applied to schizophrenia and bipolar disorder)
Tariff	The overall cost or price of a programme or service or unit of activity.
Transformation	Large scale, negotiated change to behaviour and culture across an organisation/community
Telecare	Provides equipment and services to support people to live safely in the community often with a link to a central 24 hour centre that can provide support and advice as well as outreach support and access to emergency services.

National Mental Health
Development Unit

The National Mental Health Development Unit (NMHDU) is the agency charged with supporting the implementation of mental health policy in England by the Department of Health in collaboration with the NHS, Local Authorities and other major stakeholders.

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