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MENTAL HEALTH & HOUSING
Housing on the Pathway to Recovery

CONTENTS

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Purpose of This Report

In this report we outline the evidence to support the inclusion of housing in the recovery pathway and the types of intervention that can contribute to improvements in quality and costs savings in mental health. Housing and housing related support services have a key role to play at each stage of someone's recovery.

This report 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 when budgets are tight 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

This report also includes a number of case examples where housing, and housing related services, have been instrumental in tackling the challenge of improving cost effectiveness while also delivering higher quality services. The four case examples from different parts of England illustrate the possible contribution of housing services and housing professionals to effective pathway redesign.

This report argues for a whole system approach to ensure that every intervention that can contribute to someone's recovery are 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.

Executive Summary

Recovery focused services are a central component to making mental health services fit for the twenty-first century. At the heart of the recovery approach 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] It enables the person to gain confidence in their abilities and achieve their potential rather than fostering dependence on services.[2]

Housing is generally recognised to be a central part of an effective recovery pathway as well as a key element in preventing ill health and reducing the need for inpatient care. It provides the basis for individuals to recover, receive support and help and in many cases return to work or education.[3] 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. In addition, housing based services are often perceived to bring a number of advantages:

i. 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;

ii. 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 by service users; [4]

iii. Housing providers can lever in funding from other sources and unit prices are significantly lower than healthcare providers;[5]

iv. Clinical risk in the confines of statutory services is very different from community based risk. The supported housing sector has more experience in managing and mitigating community based risk, though work needs to be done to join the two risk systems.

Budgetary constraints provide 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 and manage more of their own care. In mental health this means reducing:

- The number of acute admissions
- The number of people living in institutional care
- Delayed discharge / transfer of care
- The numbers receiving treatment out of area

[1] Shepherd G. Supporting Recovery in Mental Health Services: Quality and Outcomes, http://www.imroc.org/wp-content/uploads/8Supporting-recovery-quality-and-outcomes-briefing-final-for-website-3-March.pdf

[2] Kalidini S, Killaspy H and Edwards T Community psychosis services: the role of the community mental health rehabilitation teams. Faculty Reort FR/RS/07 November 2013 Royal College of Psychiatrists. https://www.rcpsych.ac.uk/pdf/FR%20RS%2007_for%20web_rev.pdf

[3] Social Exclusion Unit, Mental Health and Social Exclusion, http://www.nfao.org/Useful_Websites/MH_Social_Exclusion_report_summary.pdf

[4] Berrington J (2013) Providing an Alternative Pathway: National Housing Federation. http://www.housing.org.uk/resource-library/browse/providing-an-alternative-pathway/

[5] McDaid, D & Park, A (2016) Mental Health and Housing: potential economic benefits of improved transitions along the acute care pathway to support recovery for people with mental health needs (HACT: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 close to home or in the home and offer a route to training or employment.

Ideally co-operation between commissioners and providers across the system will ensure that there is a more integrated system-wide approach that looks at need over the medium term, that provides early intervention, enables speedy admission where necessary but delivers as much care in the home as possible – and prevents placing people out of area which has been shown to be detrimental to peoples' longer term recovery and to increase suicide risk.[6]

In order to achieve this, a number of steps have been identified:

1. A whole system approach to the commissioning and provision of 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, from initial assessment onwards

2. Service users, commissioners and providers working together can arrive at good outcome[7] measures and incentivise innovation in the way services are developed. This needs to recognise the importance of settled accommodation with the right support in achieving recovery outcomes and reducing demand for in-patient services [8]

3. Providers will want to cooperate and develop new forms of integrated care across organisational and sector boundaries. They should develop long-term plans for reducing beds, developing new models for crisis management, reducing length of stay and delayed discharges, developing step down services and reducing use of out of area treatments. They should be allowed to use their flexibilities to purchase property, make best use of the NHS estate, and pull together supply chains for delivery[9]

4. As more care is planned to be delivered out of inpatient or institutional settings there will need to be a proper understanding that the care being delivered is no less sophisticated, risky or skilled because it is being delivered in a community setting. However, different skills and a different treatment of risk is required to work effectively in someone's home and alongside a range of community professionals.

The economic benefits to the NHS in developing new collaborations with housing providers that integrates housing in the aute care pathway are considerable. A 5% reduction in acute inpatient bed days potentially frees up £82.5 million, but this can only be realised if there is sufficient investment in alternative community based provision, such as supported housing.

[6] National confidential inquiry into suicides, http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf

[7] Joint Commissioning Panel for Mental Health (2012) Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs : JCP-MH https://www.rcpsych.ac.uk/pdf/rehab%20guide.pdf

[8] Improving acute in-patient psychiatric care for adults in England – interim report of the Commission to Review the Provision of acute psychiatric care for adults, 2015, http://www.caapc.info/

[9] Farmer P and Dyer J (2016) Five Year Forward View for Mental Health. NHS England : London. www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Conservatively if all delayed discharges could be eliminated, with appropriate care provided in other forms of supported accommodation, net resources of more than £54 million might be freed up. A 10% reduction in readmissions within 30 days of discharge from inpatient care might also save £10.35 million per annum.

The use and overall cost of out of area placements has been steadily rising, particularly as pressures on inpatient beds mounts. The economic benefits of reducing out of area placements will vary between trusts. If a trust which made 372 out of area placements in 2014/2015 were able to substitute all of these with local alternative accommodation this could make available £3.5 million that could be used for other purposes. These are direct savings that can contribte to Cost Improvement Programmes (CIPs) and can be reinvested in improving both recovery and housing outcomes.

The Mental Health Strategy for England, No Health without Mental Health, and its focussing document, Closing the Gap, have had the effect of driving a sustainable relationship with housing in some areas. The current pressures 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 Mental Health Taskforce, charged with interpreting the Five Year Forward View for Mental Health has a real opportunity to drive a more integrated and preventative approach that would deliver parity of esteem for mental health. The FYFV for Mental Health argues for easier access to supported housing for vulnerable people with mental health problems including step-down from secure care and calls for agencies to explore the case for using NHS land to make more supported housing available for this group.

The Crisp Commission calls for greater use of secure and settled accommodation to reduce unplanned admission and says that housing should no longer be seen as outside the traditional care pathway – or commissioned and provided by 'others' – to improve access to types of housing that provide for short-term crisis use, reduce delayed discharges and offer long term accommodation. It goes on to argue that a more innovative use of NHS Estate could release more value by developing supported accommodation to support speedy discharge and / or step down to recovery.

The challenge will be to develop and promote a compelling narrative with commissioners and healthcare providers in a way that encourages the new models of care that are emerging from the Vanguards – such as accountable care organisations and multi-specialist community 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. This will involve moving beyond both institutional and professional boundaries.

[10] McDaid, D & Park, A (2016) Mental Health and Housing: potential economic benefits of improved transitions along the acute care pathway to support recovery for people with mental health needs (HACT:London)

[11] Department of Health, No Health without Mental Health, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdfwww.gov.uk

[12] Department of Health, Closing the Gap, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

[13] http://www.england.nhs.uk/mentalhealth/taskforce/

[14] Farmer P and Dyer J (2016) Five Year Forward View for Mental Health. NHS England : London. www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[14] Crisp N (2016) Old Problems : New Solutions. Improving Acute Psychiatric Care for Adults in England. Royal college of Psychiatrists : London http://media.wix.com/ugd/0e662e_6f7ebeffbf5e45dbbefacd0f0dcffb71.pdf

SECTION ONE: SETTING THE SCENE

Changing Policy and Operating Context

The environment for commissioning and providing services in mental health is changing. The continued tightening of budgets 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.

The strategy pursued by Government and NHS England is set out in a number of documents including The economic case for improving efficiency and quality in mental health[16] 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

These priorities established under the Coalition Government in 2011 continue to shape the delivery of mental health services. More recently, the Five Year Forward View for Mental Health outlines how, with an additional £1bn of investment, the NHS should deliver improved mental health care in England. It focuses on:

- A seven day NHS for people in crisis
- Integrated approach to mental health and physical health
- Promoting good mental health and preventing poor mental health
- Focus on the foundations – commissioning for prevention and quality care
- Need for innovation and research to drive change
- Workforce development and a focus on leadership[17]

The quality and productivity challenge means reducing the number of acute admissions, reducing the number of people living in institutional care, reducing delayed discharge, 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.

[16] Department of Health, The economic case for improving efficiency and quality in mental health, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf

[17] Farmer P and Dyer J (2016) Five Year Forward View for Mental Health. NHS England : London. www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

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.[18] 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.[19] The report from the Mental Health Taskforce identified the real opportunity to drive a more integrated and preventative approach that would deliver parity of esteem for mental health[20]. And with the creation of placed-based Sustainability and Transformation Plans (STPs)[21], new frameworks are being set for further integration of local health and social care systems.

The new models of care that are emerging from the Vanguards – such as accountable care organisations and multi-specialist community providers – are intended to innovate and plan for the long term, to recognise the strengths of different professional groups and to create more integrated pathways to recovery. Commissioners and providers are looking at the new ways of addressing the issue of bed numbers both in terms of moving more care into the home[22] but also more transitional community based models such as those provided by housing associations. The emphasis on improved efficiency and 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. Housing services have important tangible and intangible assets to bring to such partnerships.

Adequate and appropriate housing is now 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.[23]

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.[24] 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.

As well as contributing to the built environment, housing associations provide a range of care and support services and healthy living initiatives that have a direct impact on the health needs of people with mental health problems. Given housing associations provide accommodation to some of the most vulnerable people in our society, these sorts of programmes can also make a big impact on health inequality.

These include, for example:

- Supporting people to live independently in their own homes
- Specialist accommodation and support to help people with mental health needs to stabilise their lives at points of crisis
- Step-down accommodation from hospital or a care setting to support recovery
- Working with homeless individuals with complex and multiple needs
- Supporting people to access local services, including support to access training and employment
- Direct health advice and support through community health workers and healthy living initiatives

As public investment has reduced, housing associations have needed to be more creative in funding the building of new homes and continue to invest in their stewardship roles in communities. The pressure on rents signalled in the 2015 Budget has led many to look again at models of neighbourhood management and a more segmented approach to their tenant and resident population. They have also begun looking at more peer support models and more specialist models of provision designed to support people before a point of crisis, providing easier access to crisis care in the community and step-down accommodation that supports recovery and, hopefully, preventing future crises.[25]

[18] http://media.wix.com/ugd/0e662e_6f7ebeffbf5e45dbbefacd0f0dcffb71.pdf

[19] Commission on the future of health and social care England http://www.kingsfund.org.uk/projects/commission-future-health-and-social-care-england

[20] http://www.england.nhs.uk/mentalhealth/taskforce/

[21] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

[22] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

[23] NHF, Connecting Housing and Health http://www.housing.org.uk/resource-library/browse/connecting-housing-and-health/

[24] ibid

[25] http://www.crisisclareconcordat.org.uk/

Housing as a Factor in Mental Health

Housing and mental health are closely related; in policy terms they 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 loss of a job, which can result in the loss of a family home through breakdown in tenancy or through losing the ability to pay a mortgage. 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.[26] Having settled housing and accommodation is known to have a positive impact on our mental health.[27] 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. [28]

The impact on mental health of poor housing is well evidenced.[29] 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. 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.[30] Housing problems are frequently cited as a reason for a person being admitted or re-admitted to inpatient medical care.[31]

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.

In summary, housing is generally recognised to have a central role both in preventing mental ill-health and in preventing unscheduled admission to acute care as well as in delivering effective recovery in the community. 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 found that, there is a need to help people navigate the system and to provide advice and support 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.

[26] Closing the Gap: Priorities for essential change in mental health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

[27] HM Government, State of the nation re: poverty, worklessness and welfare dependency in the UK. http://www.bristol.ac.uk/poverty/downloads/keyofficialdocuments/CONDEM%20-poverty-report.pdf

[28] Social Exclusion Unit, Mental Health and Social Exclusion, http://www.nfao.org/Useful_Websites/MH_Social_Exclusion_report_summary.pdf

[29] Johnson R, Griffiths C and Nottingham T. At home? Mental Health issues arising in social housing. http://www.rjaconsultancy.org.uk/At%20Home%20Full%20Report%20v7.vi.pdf

[30] Social Exclusion Unit, Mental Health and Social Exclusion, http://www.nfao.org/Useful_Websites/MH_Social_Exclusion_report_summary.pdf

[31] Johnson R, Griffiths C, Nottingham T. At Home? Mental Health Issues Arising in Social Housing.

[32] Appleton, N. & Molyneux, P. The Impact of Choice Based Lettings on the Access of Vulnerable Adults to Social Housing, http://www.housinglin.org.uk/Topics/browse/Housing/Commissioning/?&msg=0&parent=3693&child=5113

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.[33] The interim report of the Commission to review the provision of acute inpatient psychiatric care, led by Lord Crisp, reported that 16% of patients on acute wards were well enough to be discharged but could no be discharged for other reasons. The main reason given was the lack of suitable housing which was identified in 49% of cases - almost four times as many as the next significant factor (problems with transfer to rehabilitation unit at 14%). [34]

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.

Solutions 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, published by the Royal College of Psychiatrists, to help reduce the use of out of area services.[35]

Health and Wellbeing boards could act as a bridge between health investment on the one hand and housing capital and revenue investment on the other. If not, there is a risk that 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 maximising return on land that is held to deliver sustainable revenue streams.

Conclusion

A strong argument for housing and housing services to be considered when pathways are being redesigned particularly when looking at out of area treatments, the use of residential care, and tackling delayed discharge. However, much of this has thus far only been demonstrated through pilot projects and has not yet transferred into mainstream practice.[36] Current financial pressures on commissioners and providers present a 'burning platform' to make this part of the mainstream. And as the final report of the Crisp Commission recognises, housing should no longer be seen as outside of the traditional care pathway – or commissioned or provided by others.[37] This is what we will look at in the next section.

[33] Support Related Housing - bringing together housing, health and social care. Care Services Efficiency Delivery http://webarchive.nationalarchives.gov.uk/20091105150144/http:/www.dhcarenetworks.org.uk/_library/Resources/CSED/CSEDProduct/srhdiscussion.pdf

[34] http://media.wix.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf

[35] In sight and in mind: A toolkit to reduce the use of out of area mental health services, http://www.rcpsych.ac.uk/pdf/insightandinmind.pdf

[36] Appleton N and Appleton S, Housing and housing support in mental health and learning disabilities - its role in QIPP. http://base-uk.org/sites/base-uk.org/files/[user-raw]/11-06/qipp_housing_and_housing_support_report.pdf

[37] http://media.wix.com/ugd/0e662e_6f7ebeffbf5e45dbbefacd0f0dcffb71.pdf

SECTION TWO: MAKING THE CASE

Housing, Quality Improvement and Cost Improvement

The current financial pressures in the NHS means that it is now more than ever in need of new approaches to service delivery. The UK population is ageing, placing new demands on health and care services, and the overall cost of technology will likely increase. Ensuring the NHS can continue to provide, will require everyone working around mental health to ensure that examples of good practice are consistently adopted and that the need for radical service redesign is accepted.[38] 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. *Closing the Gap*,[39] emphasised 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 Payment by Results (PbR) Clusters and to pathway redesign using the acute care pathway as an example.

Housing's Contribution to the PbR Clusters

The development of care clusters and the introduction of Mental Health Payments[40] offer an opportunity to provide financial incentives that further drive innovation and enable a more 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. Housing based services bring a number of advantages:

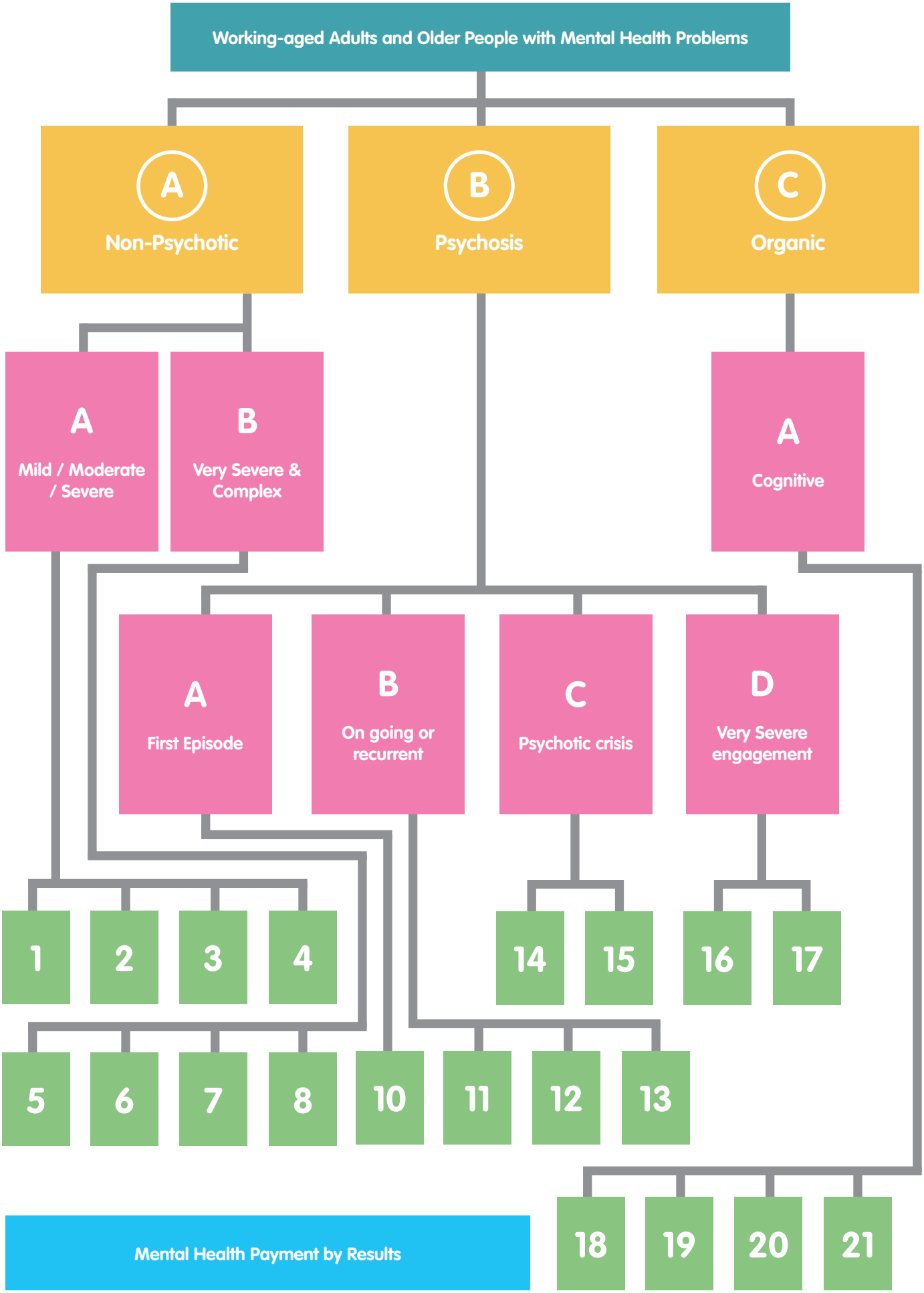
Perception	Service users see a move out of statutory care as progress and their recovery is enhanced by moving away from the service where they were most unwell.
Principles	Healthcare providers have made great strides in introducing the recovery model and moving away from diagnose and treat. However, housing services are often seen by service users to be more genuinely community focussed and 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. Housing sector has skills required to manage community based risk and has good frameworks to assess and manage that risk.

[38] Cotton R, Efficiency in Mental Health Services: Supporting Improvements in the Mental Health Acute Care Pathway, http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Efficiency_in_mental_health_services_Briefing_214.pdf

[39] Op. cit. Note 17

[40] https://www.gov.uk/guidance/new-payment-approaches-for-mental-health-services

The Care Cluster



The economics of housing within the acute care pathway

There are clear economic benefits that may be realised through the inclusion of housing services as part of the mental health acute care recovery pathway. Analysis from the London School of Economics[42] identifies some potential opportunities for freeing up resources from inpatient care which might then be used to invest in alternative community and residential support services provided by housing organisations. Such services could be provided at a lower cost, contribute towards better support for recovery as well as avoid future repeat admissions. Housing organisations can also play an important role in reducing the need for out-of-area placements, which not only tend to be expensive, but can be very detrimental to the quality of life of service users and their families.

For cashable savings to be realised, local service commissioners and providers must be able to move resources away from traditional inpatient care towards community based alternatives. In practice, bed occupancy rates will need to fall sufficiently to justify the closure of a ward or unit without having a detrimental impact on service availability. Even if inpatient provision remains open at the current scale, with increasing pressures on beds and the use of out of area treatments to manage both discharge and overflows from wards, cost improvements can still be made through alternative investment.

For adult mental health services, of interest is the data on activity across 17 of the 21 mental health currency clusters (see Figure 1 above). Clusters 18-21 which focus on cognitive impairment and dementia have been excluded; nonetheless similar potential economic arguments might also be made for these client groups where alternatives to inpatient care can be identified.[43]

Acute care pathways for individuals who require urgent mental health care will vary a little between different local areas but in broad terms the process consists of a number of linked stages. Following referral from a GP or other health care provider related to mental health an assessment will be made of an individual's needs by a specialist mental health team[44]. Individuals assessed as having more serious mental health needs may be referred to the ongoing care of a specialist team such as an early intervention team for psychosis, a community based crisis resolution / home treatment care team, or a more general community mental health team. Only a relatively small number of cases will be admitted to a psychiatric inpatient unit. In 2014/2015 they accounted for 5.8% of all individuals in contact with specialist mental health and learning disability services[45]. The vast majority of cases are supported in the community.

[42] McDaid, D & Park, A (2016) Mental Health and Housing: potential economic benefits of improved transitions along the acute care pathway to support recovery for people with mental health needs (HACT:London)

[43] HACT/NHF report reference

[44] Names will vary from area to area, for example, Assessment, Single Point of Access teams, Access and Assessment teams or Crisis and Home Treatment Teams.

[45] Health and Social Care Information Centre 2015. Mental Health Bulletin. Annual Statistics 2014-15, Leeds, Health and Social Care Information Centre,.

Table 1. Selected potential for improved outcomes at each stage of the care pathway

Care Pathway Stage	Potential Opportunities
Initial (and subsequent) referral for assessment	Opportunities to develop services to reduce risk of deterioration in initial mental health state, and in ongoing mental health following recovery from acute poor mental health event.
Admissions to psychiatric inpatient unit	Making use of appropriate alternatives to hospital admission. Greater avoidance of admission to out-of-area placements.
Treatment by specialist home treatment teams	Greater collaboration with housing services in provision of home treatment
Discharge from inpatient care	Opportunities for improved discharge planning, including greater involvement of specialist housing support services. Increase availability of step-down / crisis beds delivered by housing sector. Reduce delays in discharge due to lack of appropriate accommodation and support
Post discharge from inpatient or home treatment teams	Provision of appropriate support services in community to aid in recovery and reduce risk of relapse and readmission.

As Table 1 indicates, there are potentially several different opportunities at all stages of the care pathway where the housing sector could make an impact. This might be to help prevent deterioration of mental health, provide alternatives to inpatient care, provide support to reduce delayed discharge, and provide ongoing support for recovery.

One potential way of impacting on resource use would be to reduce the use of acute inpatient beds. This could be achieved by a reduction in the number of new and repeat admissions and also by a reduction in length of stay when admitted. As Table 1 indicates this in part might be achieved through an assessment process that considers more community based alternative services to admission, including services such as supported housing, floating support and crisis home care provided by the housing sector.

Recent data across Great Britain points to continued reductions in available beds, coupled with very high occupancy rates with improved levels of efficiency in mental health services.[46] There has been a 17% reduction in adult acute mental health beds in the three years to April 2015, while admission rates to inpatient units have remained steady. The average length of stay in adult acute mental health wards was 32 days in the year 2014/15.

[46] NHS Benchmarking Network 2015. Largest ever review of mental health services reports on findings - increases in efficiency evident in highly utilised services. . London: NHS Benchmarking Network.

94% of available bed days are typically occupied, higher than the 85% safe standard rate. A survey conducted by the Commission on Acute Adult Psychiatric Care of 119 inpatient wards reported that 91% were operating above the recommended level, with a rate of 138% reported in some wards.[47] This lack of beds has been highlighted as the key reason for the increase in the use of out of area placements seen in recent years.

Another challenge has been the reduction in the availability of crisis resolution and home treatment (CHRT) teams, many of whom have been subsumed into generic community mental health teams rather than remaining as separate specialist teams.[48] Recent analysis from the Care Quality Commission also noted that only 14% of individuals who experience a crisis felt that they received appropriate support; they have also noted a reduction in access to out of hours care from these teams[48]. In 2014/15 the number of contacts CRHT teams had with patients fell by 6 per cent.[49]

More than 50% of all Early Intervention for Psychosis Teams in England have reported a decline in resources and staff[50]. This is at a time when national waiting time standards for psychosis services are being introduced and will increase the demands being placed on these teams.

Earlier analysis of the potential economic benefits of acute care pathway reform in 2010 estimated scope for a 12% - 15% reduction in bed days over a three year period; in fact there has been a 17% reduction in the number of beds available, while occupancy rates for remaining beds have increased. There has also been a 10% increase in sections under the Mental Health Act in 2014/15 which suggests that the balance may be increasing towards more severe cases being in inpatient care.

Given the current pressures in the system, with high levels of bed occupancy, a continuing reduction in the availability of inpatient beds and pressures on community services, there may be limits in the scope for immediate reductions in the provision of acute inpatient care beds. However, reducing the need for overflow into expensive spot purchase out of are provision, and reducing length of stay and readmissions, further efficiencies can be found through new partnerships with local housing providers.

Potential economic benefits of reduced admissions to inpatient wards

LSE analysis of the potential for savings related to inpatient activity looks at the 17 clusters highlighted in pink in Table 2 along with reported inpatient activity rates for each cluster in 2014/2015. Clusters highlighted in red which focus on symptoms of cognitive impairment and/or dementia are excluded from the analysis. Inpatient activity for patients who were not assessed or assigned to a cluster have, however, been included.

In total these groups had more than 4.5 million days in admitted patient care. These included 3.1 million in clusters 10-17 that were experiencing psychotic symptoms. This is a very conservative estimate of bed use as in total there were 8.5 million bed days. This upper number includes all cognitive impairment and dementia related beds, as well as bed days not allocated to any of the 21 cluster groups for both mental health and learning disabilities. A breakdown of the additional 2.7 million inpatient bed days was not available and so have not been included in the economic analysis.

[47] Improving acute in-patient psychiatric care for adults in England – interim report of the Commission to Review the Provision of acute psychiatric care for adults, 2015, http://www.caapc.info/

[48] Care Quality Commmission 2015. Right here, right now – help, care and support during a mental health crisis, London, Care Quality Commmission,

[49] Health and Social Care Information Centre 2015. Mental Health Bulletin. Annual Statistics 2014-15, Leeds, Health and Social Care Information Centre,.

[50]Rethink Mental Illness 2014. Lost generation: why young people with psychosis are being left behind and what needs to change., London, Rethink Mental Illness, .

Table 2: Mental health care clusters and bed days 2014/2015

Mental Health Currency (Cluster) Description	Cluster days in admitted patient care 2014/2015
Cluster 00: Variance (Unable to assign mental health care cluster code)	29,364
Cluster 01: Common mental health problems (low severity)	16,384
Cluster 02: Common mental health problems (low severity with greater need)	24,146
Cluster 03: Non-psychotic (moderate severity)	109,095
Cluster 04: Non-psychotic (severe)	215,370
Cluster 05: Non-psychotic (very severe)	227,811
Cluster 06: Non-psychotic disorders of over-valued ideas	53,248
Cluster 07: Enduring non-psychotic disorders (high disability)	186,171
Cluster 08: Non-psychotic chaotic and challenging disorders	270,779
Cluster 10: First episode psychosis	241,346
Cluster 11: Ongoing recurrent psychosis (low symptoms)	317,154
Cluster 12: Ongoing or recurrent psychosis (high disability)	598,736
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	852,648
Cluster 14: Psychotic crisis	476,371
Cluster 15: Severe psychotic depression	94,610
Cluster 16: Dual diagnosis	170,835
Cluster 17: Psychosis and affective disorder (difficult to engage)	364,835
Cluster 18: Cognitive impairment (low need)	60,874
Cluster 19: Cognitive impairment or dementia (moderate need)	186,717
Cluster 20: Cognitive impairment or dementia (high need)	380,935
Cluster 21: Cognitive impairment or dementia (high physical or engagement)	195,062
Cluster 99: Patients not assessed or clustered	316,719
Total: 0-17	4,248,903
Total: 0-17 plus Cluster 99	4,565,622
Total: 18-21	823,588
Total: All Clusters	5,389,210

The official NHS Reference Costs for each of these mental health clusters for 2014/ 2015 has been used to calculate the potential savings related to any potential reductions in bed days. The overall mean inpatient bed day cost for 0-17 plus Cluster 99 is £361 with costs per bed day per cluster ranging from £324 for Cluster 0 to £396 for Cluster 14 for individuals experiencing a psychotic crisis (Table 3). In comparison the average cost of a non-inpatient cluster day is approximately £13.

Table 3: NHS Reference Costs - Mental Health Cluster Currencies 2014-2015

Currency Description	Unit cost per occupied bed day
Cluster 00: Variance (unable to assign mental health care cluster code)	**324.20**
Cluster 01: Common mental health problems (low severity)	**346.87**
Cluster 02: Common mental health problems (low severity with greater need)	**329.05**
Cluster 03: Non-psychotic (moderate severity)	**345.37**
Cluster 04: Non-psychotic (severe)	**345.82**
Cluster 05: Non-psychotic (very severe)	**342.54**
Cluster 06: Non-psychotic disorders of over-valued ideas	**342.70**
Cluster 07: Enduring non-psychotic disorders (high disability)	**347.85**
Cluster 08: Non-psychotic chaotic and challenging disorders	**369.13**
Cluster 10: First episode psychosis	**361.55**
Cluster 11: Ongoing recurrent psychosis (low symptoms)	**348.94**
Cluster 12: Ongoing or recurrent psychosis (high disability)	**369.27**
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	**357.64**
Cluster 14: Psychotic crisis	**396.39**
Cluster 15: Severe psychotic depression	**369.63**
Cluster 16: Dual diagnosis	**366.93**
Cluster 17: Psychosis and affective disorder (difficult to engage)	**360.05**
Cluster 18: Cognitive impairment (low need)	**372.72**
Cluster 19: Cognitive impairment or dementia (moderate need)	**388.42**
Cluster 20: Cognitive impairment or dementia (high need)	**389.80**
Cluster 21: Cognitive impairment or dementia (high physical or engagement)	**383.16**
Cluster 99: Patients not assessed or clustered	**354.14**

Conservative scenarios looking at potential savings if bed days can be reduced by as much as 5% show a significant impact. Each 1% reduction in bed day use, a decrease of 42,489 bed days or 116 bed years across all clusters from 0-17 would potentially reduce costs by £15.4 million. 116 bed years equates to 6 fully occupied wards with between 15 and 20 beds; adding in cluster 99 would potentially reduce costs by £16.5 million per annum, with 125 bed years saved, equivalent to more than 6 twenty bed wards. This is also equivalent to 1,427 fewer admissions to acute care.

If a 5% reduction in bed days were achieved, then 625 bed years would be avoided, equivalent to a reduction of 31 wards. This would free up budgetary resources of £82.5 million. This a gross rather than net cost saving, as the additional costs of providing community support or alternative stepped down care or supported accommodation need to be taken into account. The analysis is conservative as it does not include all mental health related bed days, only those that have been allocated to a mental health currency cluster for payment.

Table 4 summarises financial resources that may be freed up for a 1% reduction in bed days for clusters 0-17 and 19. Given that more than 50% of the costs of inpatient bed days are for individuals with psychotic symptoms – to achieve resource savings mental health trusts must place a strong focus on determining and providing alternative support, with appropriate risk management, for people with psychosis.

Evidence suggests that crises houses can lead to better longer term outcomes and lower costs to health and social care services compared to traditional inpatient services. Per bed day costs in one crisis house in Tower Hamlets in 2012/13 were £220 – more than £100 less per day than the costs of acute inpatient care (see case study for more description of the crisis house). However in formal evaluations the differences in costs (taking other factors into account such as the wider use of health and social care services), have not been statistically significant, reflecting the small scale of these evaluations and diversity in what is actually considered to be a crisis house[51].

Table 4: Potential budgetary impact (resources saved) of a 1% reduction in bed days by mental health cluster activity rates 2014-15.

	1% bed day reduction	Potential Budgetary Impact	% of total saving
Cluster 00: Variance (unable to assign mental health care cluster code)	294	95,197	0.01
Cluster 01: Common mental health problems (low severity)	164	56,831	0.00
Cluster 02: Common mental health problems (low severity with greater need)	241	79,452	0.00
Cluster 03: Non-psychotic (moderate severity)	1,091	376,784	0.02
Cluster 04: Non-psychotic (severe)	2,154	744,787	0.05
Cluster 05: Non-psychotic (very severe)	2,278	780,337	0.05
Cluster 06: Non-psychotic disorders of over-valued ideas	532	182,481	0.01
Cluster 07: Enduring non-psychotic disorders (high disability)	1,862	647,594	0.04
Cluster 08: Non-psychotic chaotic and challenging disorders	2,708	999,523	0.06
Cluster 10: First episode psychosis	2,413	872,593	0.05
Cluster 11: Ongoing recurrent psychosis (low symptoms)	3,172	1,106,672	0.07
Cluster 12: Ongoing or recurrent psychosis (high disability)	5,987	2,210,934	0.13
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	8,526	3,049,392	0.18
Cluster 14: Psychotic crisis	4,764	1,888,291	0.11
Cluster 15: Severe psychotic depression	946	349,710	0.02
Cluster 16: Dual diagnosis	1,708	626,844	0.04
Cluster 17: Psychosis and affective disorder (difficult to engage)	3,648	1,313,587	0.08
Cluster 99: Patients not assessed or clustered	3,167	1,121,635	0.07
0-17	42,489	15,381,009	
0-17+99	45,656	16,502,644	

[51] Knapp, M., Andrew, A., McDaid, D., Iemmi, V., McCrone, P., Park, A.-L., . . . Shepherd, G. 2014. Investing in recovery. Making the business case for effective interventions for people with schizophrenia and psychosis., London, Rethink.

Economic impact of reducing delays in discharge

One area where there are clear opportunities for housing organisations to reduce mental health care costs and improve outcomes concerns delayed discharges or transfers of care. The costs of acute inpatient care can be reduced by supporting early discharge through better community services and effective liaison with supported accommodation.

The recent NHS benchmarking analysis in Great Britain suggested that delayed transfer of care for adult mental health inpatient services represented 4.7% of all bed days in 2014/15. This continues to be a pressing issue; looking at all mental health and learning disability services in England in October 2015 delays in transfer of care accounted for 3% of all bed day[52].

One major factor in delayed discharges is lack of stable accommodation. Offering housing options, advice and support within acute inpatient wards has the potential to significantly reduce these undue delays, particularly as only 42% of individuals who had inpatient stays in 2014/2015 stated that they had stable accommodation.

Presented below are different scenarios looking at the potential reduction in bed day costs that may be achieved, including a scenario focusing on individuals without stable accommodation only, as well as the total elimination of delayed discharges, an objective that has been previously been demonstrated to be feasible to achieve in pilot studies.

Again restricting the analysis solely to bed days that have been linked to the mental health cluster codes for 2014/2015 if delayed discharges account for 3% of all inpatient bed days then eliminating all delayed discharges for the 0-17 and 99 cluster codes would free up 136,969 bed days while if delayed discharges account for 4.7% of all bed days then potentially 214,584 days of inpatient care could be avoided. These scenarios would generate cost reductions of £66 million or £75.5 million respectively, but the costs of alternative accommodation have to be included.

The costs of providing alternative supported housing for this time period would vary between £15 million and £28 million. This assumes that costs would be £930 or £760 per week (£132 and £109 per day), making use of unit cost estimates for local authority and private/voluntary sector residential care homes for people with mental health needs taken from the 2015 Unit Costs of Health and Social Care[53].

Tables 5 and 6 summarise the potential inpatient costs avoided, additional supported housing costs incurred and net savings under different scenarios. There is a minimum saving of £21 million if additional discharge planning efforts are targeted solely at a 3% reduction in bed day use by service users without stable accommodation who are then transferred to high cost supported accommodation. There will be net savings of £54 million if a 4.7% reduction in bed days is achieved for all service users and the lower cost estimate for supported accommodation is used.

While this analysis does not take account of the additional costs associated with employing housing related staff as part of the mental health system to aid in discharge planning, it is also conservative as not all of the delayed transfers of care will require supported accommodation, but rather accommodation through the general rental market.

[52] Health and Social Care Information Centre 2015. Mental Health Bulletin. Annual Statistics 2014-15, Leeds, Health and Social Care Information Centre,.

[53] Curtis, L. & Burns, A. 2015. Unit Costs of Health and Social Care 2015, Canterbury, Personal Social Services Research Unit, University of Kent.

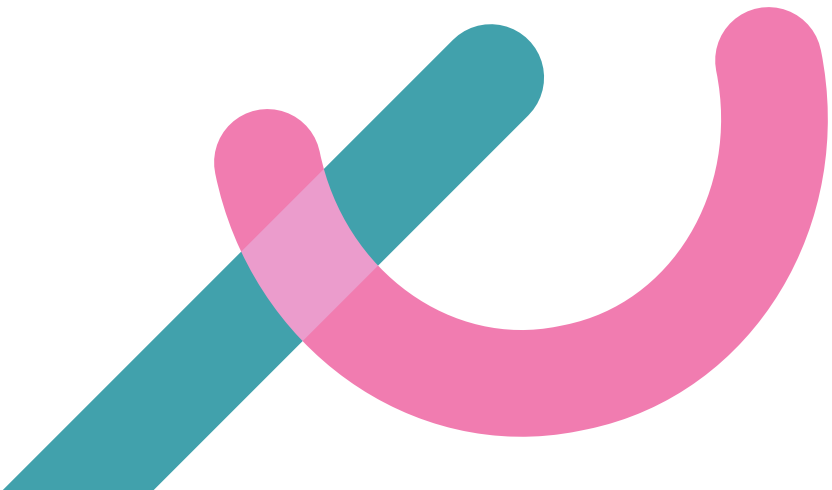


Table 5: Potential net savings through reduction of 3% bed days related to delayed transfers of care

Addressing Delayed Discharge (3% reduction in bed days)			
Targeted at all service users			
High and Low Supported Housing Costs	**Inpatient Costs Avoided**	**Supported Housing Costs**	**Net Costs Avoided**
£132 per day	49,507,933	18,079,863	31,428,070
£109 per day	49,507,933	14,929,584	34,578,350
Targeted only at service users without stable accommodation			
High and Low Supported Housing Costs	**Inpatient Costs Avoided**	**Supported Housing Costs**	**Net Costs Avoided**
£132 per day	33,665,395	12,294,307	21,371,088
£109 per day	33,665,395	10,152,117	23,513,278

Table 6: Potential net savings through reduction of 4.7% bed days related to delayed transfers of care

Addressing Delayed Discharge (4.7% reduction in bed days)			
Targeted at all service users			
High and Low Supported Housing Costs	**Inpatient Costs Avoided**	**Supported Housing Costs**	**Net Costs Avoided**
£132 per day	77,562,429	28,325,119	49,237,310
£109 per day	77,562,429	23,389,682	54,172,748
Targeted only at service users without stable accommodation			
High and Low Supported Housing Costs	**Inpatient Costs Avoided**	**Supported Housing Costs**	**Net Costs Avoided**
£132 per day	52,742,452	19,261,081	33,481,371
£109 per day	52,742,452	15,904,983	36,837,468

Reducing readmission rates

Another area where economic benefits potentially might be achieved is through a reduction in readmission rates. The latest NHS Benchmarking report found a 9% readmission rate within 30 days of discharge[54]. In 2014/15 there were over 119,000 discharges from inpatient mental health and learning disabilities care services. If we crudely assume that about 100,000 of these discharges are not related to dementia or learning disabilities, then about 9,000 mental health readmissions would be expected within 30 days. Applying a mean cost per bed day of £361 and assuming that a subsequent admission would have a 32 days length of stay (the average), with a cost per admission of approximately £11,500 then a 10% reduction in annual readmissions would potentially avoid inpatient costs of approximately
£10.35 million.

Net savings would be lower as resources would have to be invested in community mental health services to support individuals and reduce the risk of readmission. Key questions remain as to what are the most effective and cost effective ways to reduce readmissions rates and the role of different stakeholders, including housing organisations, in delivering effective interventions. This is currently being explored as part of guidelines being developed by the National Institute for Health and Care Excellence (NICE) on "Transition between inpatient mental health settings and community and care home settings"[55].

Reducing out of area placements

In the absence of beds in a locality mental health service users may be admitted to inpatient facilities outside their local area. These service users can be a mixture of short and long stay individuals. As bed numbers have fallen in England the issue of out of area placements has risen to prominence in discussions on the mental health system. One recent analysis found that 37 NHS mental health providers had funded 4,447 out of area placements in 2014/15 – almost 25% higher than in the previous year[56]. The cost of out-of-area placements in just 30 of these 37 providers rose from £51.4m to £65.2m. 88% of these placements were due to full occupancy of beds in the local area. Other analysis in 2012/13 suggested that between 4% and 5% of all emergency admissions were out of area.

Estimating the average cost of an out of area placement is complex. Placements can be of very different length. In 2010 the average annual cost of an out-of-area placement was estimated to be £34,000, compared with around £21,000 for an equivalent local placement, about 65% higher in cost[57]. Obtaining more recent figures can be difficult, as contractual arrangements with private providers may be deemed to be too commercially sensitive to disclose[58]. As the primary reason for out of area placement now appears to have become a lack of suitable local accommodation rather than because of the complexity of cases, the mean costs of cases can be expected to be lower.

One trust responding to a recent FOI request reported that in 2013/2014 it made 372 placements all of which were due to local bed pressures. The total cost of these placements to the trust was £4.884 million or £13,129 per placement. In 2012/2013 it made 171 placements at a cost of £1.982 million or £11,590 per placement[59]. Recently it has been reported that Lancashire Care NHS Foundation Trust are currently paying about £500 per client per day for out of area placements[60], which is considerably more than the mean NHS reference cost of £361 for clusters 0-17, plus cluster 99. In addition to excess costs to the public purse, there are also substantive financial out of pocket costs and emotional costs for individuals and their families, given that there may be a need to travel very long distances on a regular basis in order to maintain contact.

Tables 7 and 8 summarise the LSE estimates of potential cost savings for different levels of reduction in out of area placements. In these tables the cost of £500 per day of out of area placement reported in Lancashire has been used to look at the potential economic benefits of avoiding some out of area placements through use of local inpatient facilities, as well as through the provision of alternative supported accommodation. At best there might be a 50% reduction in placements and have very conservatively assumed that the only out of area placements are the 4,447 placements reported by 30 trusts. There are more than 20 further NHS mental health trusts that may have to make use of out of area placements and such placements are not included in the analysis.

[54] NHS Benchmarking Network 2015. Largest ever review of mental health services reports on findings - increases in efficiency evident in highly utilised services. . London: NHS Benchmarking Network.

[55] National Institute for Health and Care Excellence 2014. Guideline scope: transition between inpatient mental health settings and community or care home settings, London, NICE.

[56] McNicoll, A. 2015. Mental health patients sent hundreds of miles for beds as out of area placements rise 23 per cent. Community Care.

[57] Brindle, D. 2010. Millions wasted on treating mentally ill away from their communities. Guardian, 14 April.

[58] Northamptonshire Healthcare NHS Trust 2015. Freedom of Information Act 2000 request: Out of Area Placements for Mental Health Patients, Northampton, Northamptonshire Healthcare NHS Trust

[59] Southern Health NHS Trust 2016. FOI898 – FOI request concerning out of area placements, Calmore, Southern Health NHS Trust,.

[60] Magill, P. 2016. Lancashire mental health bosses paying out almost £50,000 a night to care for patients outside county. Lancashire Telegraph, 7 January.

Table 7 assumes a very short length of stay on average of only 5 days; one Leeds trust reported that more than half of all its placements were 5 days or less[61]. Net savings if all out of area placements were of this duration would be modest at about £4 million. Table 8 looks at potential savings assuming that the mean length of stay is equivalent to that for acute inpatient care of 32 days. These tables suggest savings of up to £26 million that may be realised through reductions in out of area placements.

Because of the conservative assumptions adopted these cost savings will be an underestimate; there is potential for greater levels of savings. This is achievable; it is partly about management of existing accommodation, but also about improving links with local organisations including housing associations. In a Parliamentary debate in December 2015 the then care minister, Alastair Burt MP, cited the example of Sheffield which "has almost entirely eliminated adult acute out-of-area treatments, and has reduced average bed occupancy to 75% by redesigning the local system, That has included investing in intensive community treatment, and working in partnership with housing."

If we take the concrete example of the Southern Health Foundation Trust which made 372 out of area placements in 2014/2015; and assuming a length of stay of 26 days so as to approximate their mean cost of just over £13,000 per placement, providing local alternative accommodation for all of these placements would avoid costs of £3.5 million alone.

Table 7: Potential economic payoffs related to a reduction in out of area placements – short length of stay

Out of area placements						
		Potential reduction in out of area placements				
Number of placements	4447	10%	20%	30%	40%	50%
Out of area daily placement cost £	500	1,111,750	2,223,500	3,335,250	4,447,000	5,558,750
National reference costs mean bed day cost £	361	802,684	1,605,367	2,408,051	3,210,734	4,013,418
Private / voluntary sector supported accommodation day cost £	132	293,502	587,004	880,506	1,174,008	1,467,510
Mean length of stay	5					
Net saving if switched to in-area inpatient treatment		309,067	618,133	927,200	1,236,266	1,545,333
Net saving if switched to in-area private / voluntary sector supported accommodation		818,248	1,636,496	2,454,744	3,272,992	4,091,240

[61] Pritlove, J. 2012. Out of area treatments in mental health: the Leeds experience. Mental Health Today, 19-21.

Table 8: Potential economic payoffs related to a reduction in out of area placements – average length of stay of acute inpatient units

Out of area placements						
		Potential reduction in out of area placements				
Number of placements	4447	10%	20%	30%	40%	50%
Out of area daily placement cost £	500	7,115,200	14,230,400	21,345,600	28,460,800	35,576,000
National reference costs mean bed day cost £	361	5,137,174	10,274,349	15,411,523	20,548,698	25,685,872
Private / voluntary sector supported accommodation day cost £	132	1,878,413	3,756,826	5,635,238	7,513,651	9,392,064
Mean length of stay	32					
Net saving if switched to in-area inpatient treatment		1,978,026	3,956,051	5,934,077	7,912,102	9,890,128
Net saving if switched to in-area private / voluntary sector supported accommodation		5,236,787	10,473,574	15,710,362	20,947,149	26,183,936

Housing in the Acute Care Pathway

In mental health the acute care pathway starts when an individual is first referred to the home treatment team (HTT). 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[62].

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.

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[63].
As part of the implementation of cost savings and quality improvements in mental health the Audit Commission developed a model for reviewing the acute care pathway and in particular bed utilisation[64].

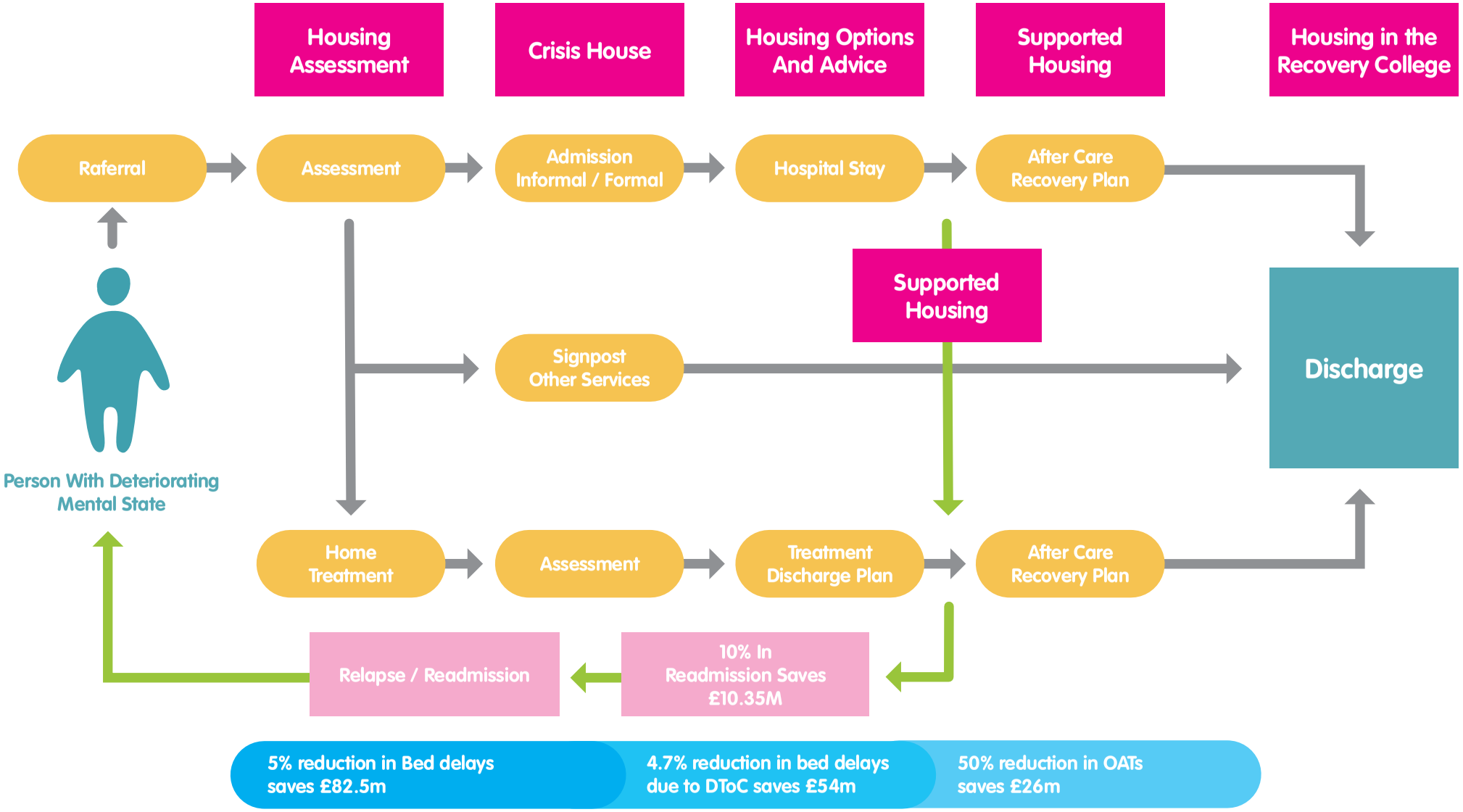
[62] Shepherd G, Making Recovery a Reality http://www.imroc.org/wp-content/uploads/Making_recovery_a_reality_policy_paper.pdf.

[63] Shepherd G, Implementing Recovery: A New Framework for Organisational Change. http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/centreformentalhealth/128566implementing_recovery_paper.pdf

[64] Getting Better All the Time – making benchmarking work, Audit Commission (2000)

Figure 2 – MENTAL HEALTH ACUTE CARE PATHWAY WITH HOUSING INTERVENTIONS

MENTAL HEALTH CARE PATHWAY WITH HOUSING INTERVENTIONS



In Figure 2 we have set out an example of the acute care pathway. Each input shows the possible contribution that housing and housing related support services can make to improve 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 redesigning services to promote independent living with some commissioners seeking 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 have a team managing the transition or build a good relationship with a provider of housing related support who was trusted to manage the shared risk. At each stage of the process there needs to be a positive contribution from a partnership with housing[65], which should no longer be seen as outside of the traditional pathway[66].

The following case examples show how this is happening in practice. These four examples show how these associations are providing

i. **Crisis intervention services**

ii. **Step down recovery services**

iii. **Community recovery services**

iv. **Community services for people with complex needs.**

[65]Community psychosis services: the role of community mental health rehabilitation teams https://www.rcpsych.ac.uk/pdf/FR%20RS%2007_for%20web_rev.pdf

[66]http://media.wix.com/ugd/0e662e_6f7ebeffbf5e45dbbefacd0f0dcffb71.pdf

CASE EXAMPLE

Look Ahead Housing and Care: Tower Hamlets Crisis House

Since 2010, Look Ahead has delivered a Crisis House to provide a community-based alternative to hospital admission. Rooted in the principles of recovery, the service seeks to empower, support and encourage each individual to focus on goals that will have an immediate and lasting impact on their circumstances and presentation of their complex needs.

Customers stay at the house for four weeks and the service focusses on i) ensuring customers feel safe and welcome by better understanding and managing their clinical presentation and risks as well as the home and social circumstances that immediately preceded the admission; ii) building hope and resilience by using a range of psychosocial interventions (delivered by Look Ahead and clinical staff from East London NHS Foundation Trust) to address the causes and impact of their crisis, and how they might begin to exercise informed choice and control; iii) working towards recovery staff work to ensure that support plans / actions are as self-directed as possible and support customers towards discharge, to improve their self management skills and develop the confidence and resilience to return home; and iv) providing aftercare and a period of support for all planned discharges. Where customers give consent the staff conduct a 'check in' with customers 12 weeks after discharge from the service to monitor outcomes.

The service is provided in collaboration with East London NHS Foundation Trust. The service has been designed to provide support to customers in crisis as an alternative to hospital admission where this is deemed to be clinically safe/appropriate. Consequently, whilst all referrals come via the Home Treatment Team the service works closely with a range of health and social care stakeholders including GPs, Ambulance service, A & E, Social Care, Housing and police. The service can also facilitate early discharge for people occupying acute in-patient beds who no longer require intensive clinical input in a hospital setting. This includes people on leave as part of their step down from hospital admission.

According to a recent evaluation based on data between 2010 and 2013 the cost per positive move-on reduced by 59.96%. the volume of positive outcomes increased by 81.5% and the total contract value reduced by 13%. Based on 2012/13 actual occupancy, the bed day rate was £220 which is 35.7% less than the £342 per in-patient day rate listed as the national average in units costs of Health and Social Care, PSSRU, 2013. During 2012/13 95% customers expressed high satisfaction with the service.

CASE EXAMPLE

One Housing Group and Camden and Islington NHS Trust Partnership: Tile House

Tile House opened in September 2012 and provides 15 high quality, self-contained supported housing units in the Kings Cross area of London. Each customer has their own flat with purpose designed safety features to effectively manage risk, and communal areas which can be used for workshops and group sessions. Tile House works with people with high levels of risk and complex needs who have previously been excluded from supported housing, including those with forensic backgrounds and those who are subject to Section 37/41 of the Mental Health Act.

Support is delivered by One Housing Group in partnership with Camden and Islington (C&I) NHS Trust which provides dedicated, on-site clinical input. The service provides double staff cover 24 hours a day, seven days a week, with both One Housing and C&I staff on-site to provide a seamless, wraparound service for customers. Recruitment is carried out jointly between the OHG team manager and the C&I service manager. Shared team meetings also take place to ensure a consistent team approach. The service is funded through adult social care contract income, with OHG subcontracting the clinical inputs from C&I.

The two year evaluation of the project showed that there had been eight admissions to hospital among the customer group at Tile House, compared with ten admissions among the same group in the two years prior to Tile House opening. While a relatively small reduction, the service has been successful in enabling those customers who have been admitted to hospital to return to the service on discharge.

In the two years prior to the service opening, nine of the customers involved in this study spent an average of 317 days as inpatients, with a total of 2,856 occupied bed days. In the two years since Tile House opened, this had fallen significantly to an average of 81 days in hospital for each admission, with 404 occupied bed days for the five customers who had admissions.

The avoidance of admission is also a key- there were 23 occasions when a customer might usually have been admitted to hospital. But the partnership approach between One Housing and the clinical team from the C&I NHS Trust meant that on-site support and input was appropriately utilised to manage and avoid crisis and mitigate the need for more expensive hospital admission.

The overall cost to the NHS in the year prior to customers moving to Tile House was £527k compared to £71k in the two years at Tile House. Compared with the customers' previous placement costs, Tile House has saved the system £443,964 per annum.

CASE EXAMPLE

Stonham, Home Group:
Enhanced Community Recovery Service

Background

Working with Devon Partnership NHS Foundation Trust, Stonham (part of the Home Group) support people with mental health issues as they leave intensive clinical supervision and work to avoid the use of costly out of area facilities. Stonham provide high level support and a level of personalised care rarely seen in discharge services. Patients are asked which area or town would best support their recovery and were then grouped depending on their response. In order to deliver on these requests, Stonham collaborate with other housing providers, both private and social, to locate a suitable property. Over time Stonham will be able to gather valuable information on the places people favour for their recovery, and then look to find more permanent properties there.

Personalised Outcomes

After Stonham have found a property in which they can supply 'pop-up' care to an individual or group, an Individual Patient Placement contract is negotiated with the trust. The contract is a form of spot purchasing that allows new providers to be included in the support of a person's recovery. Clinical outcomes are determined on the basis of patient history but crucially, personal outcomes that are tailored to each person's barriers to entry back into everyday life. Emerging needs are fed back into the contract after the first few weeks of Stonham working with an individual.

Integration

Stonham work within the trust care pathways, so have clearly defined roles in relation to other services and clinical staff.As the support is high level, Stonham staff can provide care coordination across the formalised care pathway and with different groups. This approach to integration produces immediate results for the individual. A network of recovery support can be built by Stonham staff without tricky negotiation of organisational boundaries. Clinical staff are provided by the Trust and provide the overarching structure clinical governance of the care pathway.

This highly personalised support scheme is a bottom up approach to integration, providing tailored outcomes that consider a whole person's needs. Devon Partnership Trust can discharge people quicker knowing that everything is being done by Stonham to ensure that the individual recovers and avoids unnecessary use of clinical services.

CASE EXAMPLE

Midland Heart:
Integrating Services for Complex Needs

Lancaster Street is a complex needs service focused on supporting single homeless men aged 25-45 who are experiencing serial exclusion from direct access accommodation in Birmingham. Barriers to inclusion might include substance misuse, mental health issues, physical health needs and vulnerability due to age or lifestyle.

In order to tackle such a wide range of needs, Midland Heart have had to engage with a variety of stakeholders from Local Authorities and the Prison Service to Home Treatment Services and GPs.

Midland Heart provides personalised and recovery orientated support that is responsive to the individual's needs. Behaviour that in other settings might lead to eviction is challenged and change is sought through consultation and realistic goal setting with the individual. By both supporting and challenging the individual, it is hoped that the difficult transition from long-term homelessness to stable accommodation is achieved – an invaluable contribution to tackling serial exclusion.

All support is provided in close conjunction with the referring agencies to offer a holistic joined-up approach that enables the individual to move on to an independent and fulfilled life. Information on how to access health care services is provided alongside emotional & psychological support so as not to merely burden the NHS. As a housing provider, Midland Heart can also provide easy access to drug and alcohol agencies, tackle behavioural issues, and provide advice on housing and move-on accommodation.

Interviews with customers and stakeholders suggest that without the support of this scheme many customers would remain homeless and continue to misuse substances. Their mental health needs would not be addressed and their engagement with services would be infrequent or would cease. The effect of this would most likely be further emergency or crisis based interventions from statutory services such as A&E, NHS mental health crisis care services and the police.

Assuming a month in an NHS ward costs around £10,140, Midland Heart's scheme may represent a saving. Customers are largely positive about their experience. The most common response received was that the service had helped them to recover and re-establish their confidence, their independence and to make realistic plans for the future.

As well as the immediate potential savings to the NHS, the community setting of the service contributes to several further economic effects, though they would need to be properly modelled to provide a compelling case:

- Economic savings associated with improved wellbeing, such as reduced welfare dependency, reduced use of health and social care services, less use of homelessness services, less crime and greater social cohesion.
- Economic savings resulting from reduced health risk behaviour and subsequent physical illness.
- Economic benefits associated with improved wellbeing due to improved educational outcomes, higher employment rates and greater economic productivity.

SECTION THREE: DELIVERING AN INTEGRATED PATHWAY

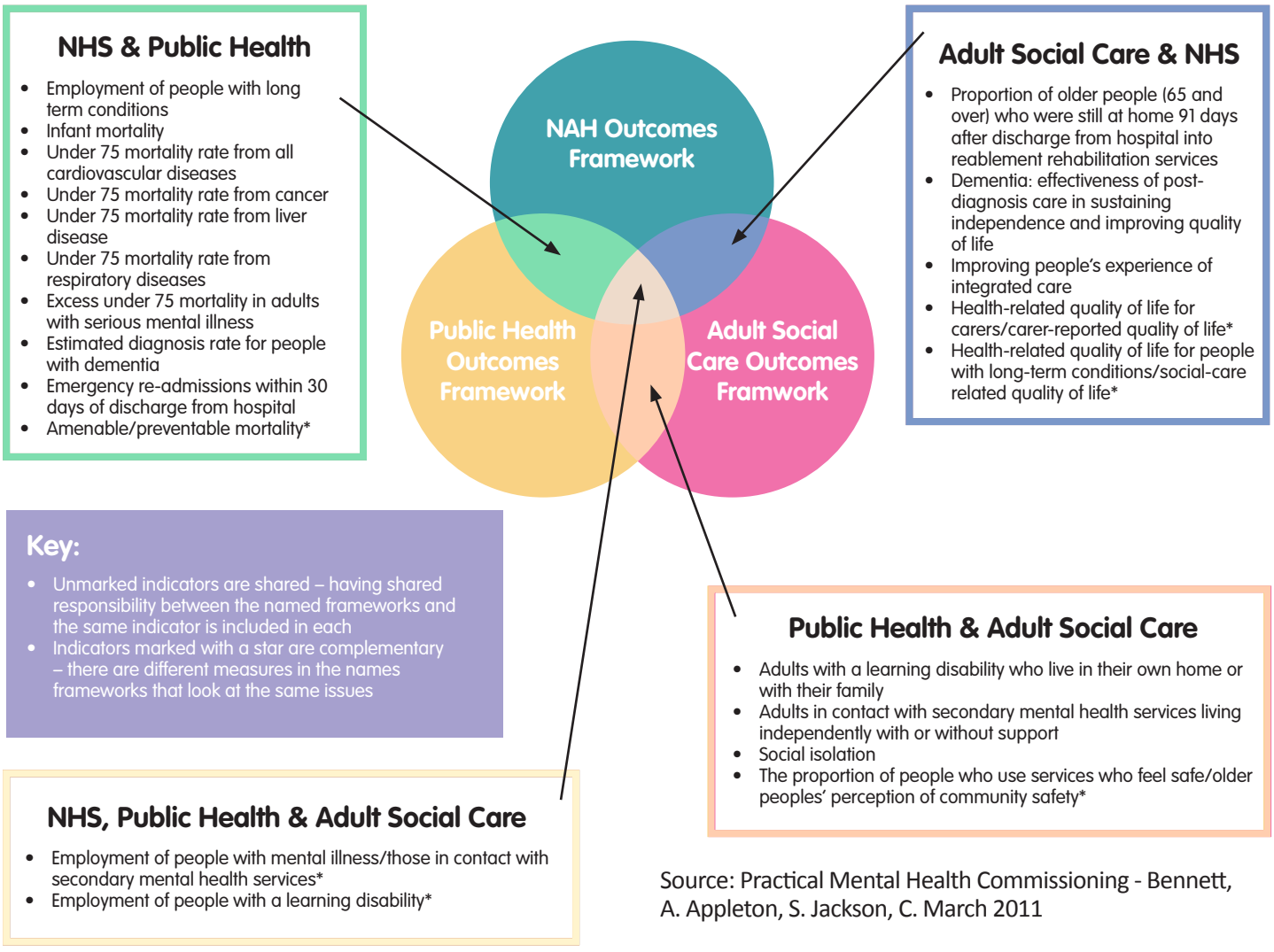
Setting Outcomes for the Whole System

An effective acute recovery pathway relies on a shared understandings of what a journey through services might look like, and what the ultimate goal of that journey is. The recovery approach provides guidelines, but specific outcomes need to be agreed on so that all parties are working collaboratively, with people's interest at heart.

Traditionally outcomes have sat in different places across the system, for example, housing outcomes sit 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. Outcomes frameworks for the NHS, Social Care, and Public Health were published in 2015-2016.[67] Supporting people's independence from the statutory support features heavily in all three frameworks, an outcome that housing can play a big part in helping to achieve. Figure 3 shows how the three outcome frameworks inter-connect.

Figure 3 – NHS, Public Health and Adult Social Care Outcomes Frameworks

CURRENT SHARED OR COMPLEMENTARTY* INDICATORS



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

[67]The NHS Outcomes Framework www.gov.uk/government/uploads/system/uploads/attachment_data/file/385749/NHS_Outcomes_Framework.pdf

The Five Year Forward View signals a move away from rigid demarcations between physical health care, mental health care and social care services towards new models of care and a partnership with patients over the long term.[68] Amongst a range of possible options, Multi-speciality Community Providers are intended to become the focal point for a far wider range of care services than currently provided by much of primary care. These practices could include psychiatrists, psychologists, social workers and link to other community professionals such as housing support staff to take responsibility for the care of a registered population and taking new approaches to health behaviours.

To deliver outcomes across all the desired domains there is a need to operate at scale[69] and a real understanding between providers to achieve the best and most cost-efficient outcomes. By adopting an outcomes based approach there is a greater opportunity to ensure that scarce resources are being allocated where they can have best effect.[70]

There are perceived to be a number of benefits of an outcome based approach to commissioning.[71] 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. 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.

When commissioners and providers work together to arrive at good quality measures, it is more beneficial 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. There are a wealth of organisation models open to NHS providers and their partners ranging from structural transactions to collaboration between organisations to deliver the required outcomes. However, that improvement is driven, not by organisational form, but through strong board leadership, cultural change over time, and with the engagement and contribution of staff and local communities.

Pulling Together a Supply Chain

There will be significant local variations in the way mental health commissioning is delivered. Arguably mental health commissioning has not been as well resourced and has not always managed to establish the same level of authority over the provider market as in other areas of commissioning. 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. Voluntary, community and independent sector providers have played a significant role in the development of Improving Access to Psychological Therapies (IAPT) and other community services. They are also very visible in the provision of specialist services and rehabilitation services.

[68]NHS Five Year Forward View http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/

[69]Smith, J., Curry, N., Mays, N., Dixon, J., Where next for commissioning in the English NHS? The Nuffield Trust and The Kings Fund, http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/where_next_for_commissioning_in_the_english_nhs_230310.pdf

[70]Devlin, N., Appleby, J. Getting the most out of PROMs: Putting health outcomes at the heart of NHS decision-making. The Kings Fund, https://www.kingsfund.org.uk/sites/files/kf/Getting-the-most-out-of-PROMs-Nancy-Devlin-John-Appleby-Kings-Fund-March-2010.pdf

[71]Kerslake, A. An approach to outcome based commissioning and contracting www.thinklocalactpersonal.org.uk

The Dalton Review[72] and the Five Year Forward View[73] recognise that partnerships and joint ventures can help to drive improvements in services. There is also an increasing recognition that mergers and acquisitions make significant demands on management time and that changes to organisational structures come with significant risks. Hence more focus being placed on partnerships, joint ventures and greater cooperation between organisations to deliver seamless care.

Delivering quality services across institutional boundaries and ensuring safe transfer of care requires investment in relationships and developing a shared understanding of risk and a common set of outcomes. For partnership working to be successful there are a common set of issues that need addressing:

- Measuring outcomes that matter most to service users.
- Be more transparent with internal and external stakeholders about the quality of services and plans for improvement.
- Scrutinising quality and safety and asking the right questions is vital to ensuring that there is a culture that challenges the normalisation of variance from required standards.
- Boards are informed about performance against key quality indicators, risks to delivery of quality and risks to reputation given equal weight to financial risks.
- Focus external reporting on the delivery of patient outcomes and ensure that the organisation has identified the high-level operational, corporate and strategic risks to the delivery of its objectives and desired outcomes.[74]

Conclusions

If commissioners decide to shape the market providers will want to cooperate and develop new forms of integrated care across organisational and sectoral boundaries. They could be encouraged to use their flexibilities to purchase property and pull together supply chains for delivery. So, pursuing the opportunities for integration offered in this report should be of benefit to both housing providers and health commissioners. Both parties are undergoing change and an evaluation of their purpose.

In health, Quality, Innovation, Productivity and Prevention (QIPP) and Cost Improvement Programme (CIP) are driving budget cuts and promoting innovation in order to tackle new health challenges. Mental health is now widely accepted as being as important as physical health. Delivering on the aspiration to achieve parity will require new thinking, which has also been forced by reorganisation. New commissioning bodies like Health and Wellbeing Boards are still discovering their purpose in assisting mental health in their areas.

Housing providers have seen the removal of direct public investment as a means of funding the construction of new properties. At the same time, many of the communities they operate in are seeing the withdrawal of statutory services, including in mental health. In reaction to this, many providers are looking for ways to partner with remaining services to invest and support communities.

The pathway approach to recovery could be a crucial point at which the two parties meet. A common language can be established which reinforces peoples progression on a journey that includes all the bodies they might encounter. Thinking in this way should ensure that all services are working collaboratively with the person's interests at the heart of their operations. Where the components of a pathway approach have been implemented, significant cost savings have been produced alongside improved outcomes.

[72] Examining new options and opportunities for providers of NHS care https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

[73] ibid

[74] Molyneux P and van Doorn A (2015) Managing quality across organisational boundaries. www.housingandhealth.org

With the acute inpatient bed sector operating at capacity, with occupancy rates currently exceeding safe levels of 85% of beds in many inpatient wards, there is a critical need to reduce pressures and ensure that inpatient beds are used by those who most need them. Conservatively every 1% reduction in acute inpatient bed days potentially frees up £16.5 million, but this can only be realised if there is sufficient investment in alternative mental health service provision including different forms of residential and community support, such as supported housing.

Conservatively if all delayed discharges could be eliminated, with appropriate care provided in other forms of supported accommodation, net resources of more than £54 million might be freed up for alternative use within the mental health system. These resource savings would be greater if individuals are able to move to even more independent living arrangements and working with housing providers would enable this to happen.

A 10% reduction in readmissions within 30 days of discharge from inpatient care might also mean that about 900 admissions could be avoided; at an approximate cost of £11,500 per admission £10.35 million per annum in resources could be used for other purposes. These efficiencies would in part need to be offset by greater investment in community mental health services to support individuals and reduce the risk of readmission, again this support could be provided through collaboration with housing.

The use and overall cost of out of area placements has been steadily rising, particularly as pressures on inpatient beds mounts. The cost of out-of-area placements in just 30 providers rose from £51.4m to £65.2m with 88% of these placements were due to full occupancy of beds in the local area. Other analysis in 2012/13 suggested that between 4% and 5% of all emergency admissions were out of area. Out of area placements tend to be more expensive to the public purse, but also in terms of out of pocket costs and emotional costs for both people with mental health needs and their families, given that there may be a need to travel very long distances, sometimes several hundred miles, on a regular basis in order to maintain contact.

The economic benefits of reducing out of area placements will vary. For instance if a trust which made 372 out of area placements in 2014/2015 were able to substitute all of these with local alternative accommodation this could make available £3.5 million that could be used for other purposes. These are direct savings that could be reinvested in improving both recovery and housing outcomes.[75]

As more care is planned to be delivered out of in-patient or institutional settings there will need to be a proper understanding that the care being delivered is no less sophisticated, risky or skilled because it is being delivered in a community setting. However, different skills and a different understanding of risk is required together with new approaches to relationship building to work in someone's home and alongside a range of other community professionals. The leadership required will also be different as the skills required to lead multi-agency partnerships are different from those traditionally required to run a
single organisation. [76]

Recent reports from both the NHS Mental Health Taskforce[77] and the Commission to Review the provision of acute inpatient psychiatric care[78], both point towards the need for a stronger focus on housing and encourage greater collaboration with housing providers. They are clear that housing should no longer be viewed as outside of the traditional care pathway, or commissioned and provided by 'others'. There are opportunities for considerable and immediate innovation in this space, sharing expertise between partners and combining the assets of both the NHS estate and the investment capacity of housing associations. The time for greater integration between housing and mental health has come and the current pressures in the acute care pathways demand an immediate response.

[75]McDaid, D & Park, A (2016) Mental Health and Housing: potential economic benefits of improved transitions along the acute care pathway to support recovery for people with mental health needs (HACT:London)

[76]Future organisational models for the NHS - Perspectives for the Dalton review http://www.kingsfund.org.uk/publications/future-organisational-models-nhs

[77]Farmer P and Dyer J (2016) Five Year Forward View for Mental Health. NHS England : London. www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[78]http://media.wix.com/ugd/0e662e_6f7ebeffbf5e45dbbefacd0f0dcffb71.pdf

GLOSSARY:

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.
Cost Improvement Programme	Schemes to increase efficiency / or reduce expenditure both recurrently (year on year) and non-recurrently (one-off) savings. CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in a permanent cost saving but also improve patient care, satisfaction and safety.
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 Voluntary, community and independent 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 Voluntary, community and independent and supports people to identify suitable local accommodation.

Outcomes	The effect or result of commissioning process (i.e. 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.

housing & health

Housing and Health is a collaboration between HACT and Common Cause Consulting, working to forge links between providers of social housing and health care services. We help housing and health providers to identify current and future opportunities in the healthcare market; develop business cases for transformation and NHS investment; reach the right people in the NHS and housing; create new partnerships between Housing Associations and NHS Providers and improve evidence and demonstrate value. housing and health offers a set of services such as consultancy; innovation and business development programmes; strategy development; masterclasses, workshops and training; good practice briefings and resources published on www.housingandhealth.org as well as research.

NATIONAL HOUSING FEDERATION

The National Housing Federation is the voice of affordable housing in England. We believe that everyone should have the home they need at a price they can afford. That is why we represent the work of housing associations and campaign for better housing.

Our members provide two and a half million homes for more than five million people. And each year they invest in a diverse range of neighbourhood projects that help create strong, vibrant communities.

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