National Mental Health
Development Unit

Mental Health and Housing: Resources for Commissioners and Providers

Housing and housing support in mental health and learning disabilities – its role in QIPP

Briefing

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SUMMARY

Adequate and appropriate housing is widely acknowledged to be a crucial underpinning of health and well-being. Inappropriate housing can significantly reduce the ability of people who have ill health or a disability to lead independent lives.

In mental health the trend has been for commissioners in health to see housing as outside the traditional care pathway and something provided by others and thus commissioned by others.

Quality, innovation, productivity and prevention (QIPP) is intended to enable the NHS to drive up quality while improving productivity. Mental health has one of the most successful track records in redesign for improving quality and productivity across services, particularly in adult mental health.

Housing is generally recognised to be central part of an effective recovery pathway. It provides the basis for individuals to recover, receive support and help and in many cases return to work or education. For all of us, housing is a critical part of our well-being; both physical and mental.

This report provides summary tables detailing the number of people between 18 and 64 years of age who are likely to be living with a mental health problem.

- The largest number is for those predicted to have a common mental disorder.
- In Leeds the current number of 86.3k is predicted to rise to 101.6k by 2030.
- At the other end of the range the numbers in North East Lincolnshire are predicted to fall from 15.2k to 14.5k.
- This is the only area in which the population in the 18 to 64 age range is predicted to fall over this period and with it the number of people living with a common mental disorder.
- Larger conurbations, such as Kirklees, Sheffield & Bradford are in the range of 40k to 50k, whilst the majority of districts are in a range 22k to 28k.

Whilst the numbers of those with other mental health problems: borderline personality disorder, anti-social personality disorder or a psychotic disorder are measured in hundreds rather than in thousands their numbers are still substantial.

- The mid- range is around five to six hundred in each area.
- In the larger conurbations that number is double and in Leeds numbers in the range of 2,000 to 2,500 in each category.

In addition to the summary comparative tables included in this document the accompanying “Compendium” provides detailed statistical information by local authority and Local Implementation Team (LIT) area.

As provision shifts from institutional to housing based forms it is those with anti-social personality disorders and those with psychotic disorder who are likely to present the greatest challenges in finding and sustaining appropriate provision of accommodation, care and support.

Of the related issues that arise the most prevalent is that of alcohol dependence and although the number predicted to be dependent on drugs is a little over half that for those dependent on alcohol they still represent substantial numbers at 4.5% of men and 2.3% of women in the age group within the whole population of each LIT.

When examining the numbers of those identified as living with a learning disability we recognise that those living with moderate or severe learning disability, and therefore likely to be in receipt of services, comprise a little less than a quarter of the total.

We note that the numbers of those with moderate to severe learning disability living with parents declines steeply from 45 years of age onwards, indicating in many cases a traumatic move to other accommodation in middle age or late in life. The nature of the informal support received means that independent living skills may be less well developed, which adds a further level of challenge in identifying appropriate accommodation options.

Severity of learning disability is not the only predictor of difficulty in identifying appropriate accommodation, care and support solutions. Some people with low to moderate levels of learning disability but with other needs arising from mental health issues, or from alcohol or substance abuse may, in fact, be more problematic.

Although relatively small in number those within this group who are predicted to display challenging behaviour represent a group of cases where appropriate placements may be difficult to identify and costly to procure.

All Local Implementation Teams have been engaged in facilitating a shift away from reliance upon registered care, whether offering personal care or nursing care. Although the current rate at which people with a learning disability are likely to be accommodated in a registered care home is much reduced there is a legacy of past practice to be managed. Some people with a learning disability who would not now be assessed as suitable for Registered Care may have spent the major part of their lives in such a setting and change must be handled sensitively, with the consequence that change takes time!

Research published in 2009 by the Department for Communities and Local Government sought to demonstrate the financial benefits of the Supporting People programme. Their review of the costs of community based support included not just the costs borne within Supporting People budgets but by all forms of public expenditure. The study contrasted the costs of existing housing based packages with a range of alternative scenarios which might apply should the existing support package not be available. Within the report there are data based estimates of the probability of various alternative outcomes and real-cost models of the financial consequences of alternative scenarios.

The report concludes that housing based solutions through which support is provided to a range of vulnerable adult groups represent a major saving in public expenditure when compared with the likely outcomes were those options to be no longer available.

By applying this data in the reverse direction we may assert that for each household unit (which broadly equates to one person together with the cost implications of the impact of their situation on other members of the household) currently receiving a package involving hospital care the cost saving to the public purse of substituting a housing based package would be £55,557 per annum. For those moving from a package involving residential care the total saving in public expenditure would be £4,249 per annum. However the impact for Adult Social Care budgets would be more marked: the residential package of £25,743 would reduce to £6,788, being the cost of the social care package; a saving of £18,955 per annum.

Whilst regional and local circumstances may vary costs the ratio between the costs is likely to be fairly constant. For the purposes of illustration we may assume, on the basis of the data contained in this study, that the full year saving to the social care budget of supporting individuals through a housing based support package will be almost nineteen thousand pounds less in a year than supporting them through a residential package.

Clearly savings in periods spent as a hospital in-patient are even more substantial: four weeks spent in a housing based setting, as opposed to being spent as a hospital in-patient, will save the public purse in the region of £4,270.

The benefits of community based solutions are more than financial. An earlier study[1] identified four specific uncosted benefits for people with mental health problems of being supported in the community:

- Improved quality of life for the individual including great independence, improved health, greater choice of options on where and how to live and lessened dependence on relative and carers;
- Prevention of further mental health problems and fewer suicides;
- Reduced burden of care for carers (leading to improved quality of life); and
- Easier access to appropriate services.

For people with Learning Disabilities the study estimates the total cost to public purse of community based packages, including the Supporting People element, at £39,010 per household per annum. This is contrasted with the costs of a package involving residential care which is estimated at £79,133 per annum

The total estimated savings for public expenditure are in the region of forty thousand pounds a year. For Adult Social Care the costs are reduced from £74,589 to £18,841 per annum; a saving of £55,748 per annum. The same caveats in relation to local and regional variations in costs against these nationally calculated averages but the ratio between the costs is likely to be broadly similar.

The non-financial benefits of community based packages with the range of support possible through the involvement of Supporting People funding were identified in earlier research[2], and are substantial:

- Allowing many people with learning disabilities to live relatively independently, lessening the burden of care on their family and friends and allowing them greater choice over where to live and more control over their lives;
- Consistent support that responds to people's needs offering stability in their lives, allowing them to plan ahead and reducing psychological distress;
- Improved health and mobility;
- Reduced fear of crime in people with learning disabilities living alone;
- Reduced social exclusion through frustration of access to services and social groups, which both benefits the individual by reducing isolation and increases the social capital of the community;
- Reduced reliance on informal carers. In turn this can have significant benefits for their physical and mental health, can increase their access to employment and can offer greater stability in their lives; and
- Ensuring that people with learning disabilities are catered for in appropriate environments and have the best outcomes possible in terms of health, psychological development and quality of life.

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1 Benefits Realisation of the Supporting People Programme, CLG, 2004
2 ibid

SECTION ONE

1 INTRODUCTION

The environment for commissioning and providing services in mental health and learning disability is changing as new models for commissioning across the NHS, set out in the coalition Government's Health & Social Care Bill are developed. This includes plans to move the responsibility for commissioning services from Primary Care Trusts (PCTs) to GP led commissioning consortia. The White Paper that preceded the *Bill, Equity and Excellence - Liberating the NHS* both stated that "healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients."[3]

The economic climate and the impact of public sector savings is likely to result in reduced budget allocations and the need to further prioritise investment. The requirement to commission the most clinically and cost effective services will be further intensified over the coming three to five years. New developments and existing service models will be scrutinised even more closely. As a consequence the public sector will have to clearly demonstrate that it is making the most effective use of public money to deliver quality care.

Adequate and appropriate housing is widely acknowledged to be a crucial underpinning of health and well-being. Inappropriate housing can significantly reduce the ability of people who have ill health or a disability to lead independent lives. They can often struggle to access preventive housing and related care and support services, which would allow them to participate in the community. This can often happen, for example, following discharge from hospital.[4]

While the impact of poor housing on health, well-being and quality of life is demonstrable – and the contribution of housing to all these areas is self evident – it has all too often been peripheral to the framing of policy at the interface between health and social care.[5]

This had led to a disconnect in the commissioning of housing and housing related support and health based services. In mental health the trend has been for commissioners in health to see housing as outside the traditional care pathway and something provided by others and thus commissioned by others. What remains central to effective mental health and learning disability commissioning, is that it must be a shared activity which is driven by an integrated approach involving all partners,[6] housing must be part of those partnerships.

The transition to GP led commissioning, coupled with the importance of improved outcomes and cost effectiveness, has led many to begin reconsidering the scope of commissioning not just of health services, but those services that are commissioned and delivered by other agencies, sometimes in partnership with 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 way.

3 Equity & excellence: Liberating the NHS Department of Health July 2010
4 Connecting Housing to the Health & Social Care Agenda, Appleton, N. & Molyneux, P. DH Care Networks Sept 2007
5 ibid
6 The Commissioning Friend for Mental Health Services, Appleton, S. NMHDU/CSL Dec 2009

CONTEXT FOR THIS STUDY

Quality, innovation, productivity and prevention (QIPP) is the framework that the NHS, in partnership with local authority colleagues, is using to create the changes needed to commission and deliver health services in this period of financial constraint. Although local authorities are working with those in the NHS on QIPP, they do not retain a lead and there is no defined equivalent framework for the delivery of quality and financial benefits in local authorities, although they are of course seeking to achieve similar outcomes through their own processes.

QIPP is intended to enable the NHS to drive up quality while improving productivity. Mental health has one of the most successful track records in redesign for improving quality and productivity across services, particularly in adult mental health; however there are areas where significant variation still exists across the country.

Nationally led mental health QIPP work is focused on three work streams that feed into the broader QIPP programme. Given that learning disability services are, in the main, commissioned and provided by local authorities, such a QIPP programme it seems unlikely that such a programme will be established. Plans for productivity gains and financial savings in learning disability serves will most likely be led by local authority adult social care departments.

The majority of these work streams have tended to concentrate on opportunities within health care settings, both in hospital and community settings. National work on Out of Area placements and acute care pathways in mental health has recognised the importance of housing. Those leading that work recognise that the links between mental health, learning disability and other services have yet to be fully explored. Housing, mental health and learning disability are areas that could have the potential to improve productivity and thus reduce costs, but also contribute to improved outcomes for services users.

Contact Consulting were commissioned by the Deputy Regional Director for Health and Social Care in Yorkshire & Humber in partnership with the National Mental Health Development Unit in late September 2010 to conduct a study on the contribution that housing and housing support can make to the QIPP agenda in mental health and learning disabilities.

The study has focused on a brief review of the current information (quantitative and qualitative) regarding the cost-effectiveness, value for money and service quality for service users and the impact of:

- Delayed discharges from hospital
- Housing related out of area placements (OOA)
- Registered care placements

All three of these areas have covered options for people with mental health problems and those with a learning disability. The focus of review of these three areas has been to identify the key issues for commissioners and providers in relation to housing and housing related support. Alongside this, it has been to attempt to establish a role housing can play, not only in improving productivity, but in maintaining independence for service users, maximising their recovery outcomes and reducing their need for in-patient, residential and nursing home care and out of area placements.

2 WHY HOUSING IS IMPORTANT

Housing is generally recognised to be central part of an effective recovery pathway. It provides the basis for individuals to recover, receive support and help and in many cases return to work or education. For all of us, housing is a critical part of our well-being; both physical and mental.

However, accessing housing and being able to move through a pathway of care, to appropriate accommodation still requires service users to negotiate a range of obstacles. This was highlighted in the conclusions of *The Impact of Choice Based Lettings on the Access of Vulnerable Adults to Social Housing*. The report concluded that, "there is a need for support to be available to help people navigate the system and to provide advice and support"[7] 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."[8]

In many cases, access to housing is a significant contributor to delayed discharge from hospital and to admission avoidance. A lack of housing can also lead to increased readmission rates, over use of residential care and in some cases the use of out of areas placements (OOA).

Equally, 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.[9]

Despite the lack of national figures that describe the extent of the problem, anecdotally the evidence suggests that many regions have issues relating to the use of OOA placements, residential care and delayed discharge from hospital due to a lack of appropriate housing or housing related support.

This can be an issue of supply, such as a dearth of supported housing and other independent living options being available locally. In other circumstances it can be due to the lack of appropriate and timely advice and support to services users who are in hospital and housing not being regarded as a key component of care planning. Often this is due to poor co-ordination between housing and health partners.

This can often lead to OOA and residential care placements being used when in fact, they are not the most appropriate solution. 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, and potential future use of health based services.

National SITREPS[10] data for inpatient mental health beds shows that around 9% of delayed bed days are due to a lack of suitable housing. Furthermore 23% are due to awaiting places in registered care homes offering personal care.[11] Housing is clearly an issue in the first instance, and supported housing can provide a more cost effective solution for the latter through the use of step down provision.

Recent reports indicate that moves to promote independent living for people with learning disability appear to have dwindled. A smaller proportion of working-age adults (61%, down from 64.5%) was living in "settled accommodation", such as adult placements, supported housing or living permanently with family, as opposed to care homes, nursing homes or NHS settings.[12]

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7 The Impact of Choice Based Lettings on the Access of Vulnerable Adults to Social Housing, Appleton, N. & Molyneux, P. DH Housing LIN February 2009
8 ibid
9 Support Related Housing - bringing together housing, health and social care. Care Services Efficiency Delivery www.csed.dh.gov.uk/supportRelatedHousing/
10 SITREPS (Situation reports) data is collected by NHS Trusts on delayed discharges. It records information about who is responsible for the delay and the reason for the delay, such as a lack of suitable housing.
11 ibid
12 Community Care report by Mithran Samudal 12 August 2010

It has been broadly accepted that where these kinds of issues exist it may be possible to address them within the framework of QIPP, drawing together individuals, organisations in partnership to seek solutions that can improve quality and productivity by developing housing and housing based support solutions as part of improved care pathways. Although QIPP is an NHS process, similar approaches in local authorities to delivering efficiency and value for money are intended to enable commissioners to drive up quality while improving productivity. Given that commissioning responsibilities for non-health related learning disability services rest with local authorities, the need to ensure a coordinated approach to the aims of QIPP has become more critical. Both can be used as levers across health and social care to deliver improvements in service and productivity to the benefit of the whole system.

3 POLICY AND ITS' IMPACT

Housing and mental health and learning disability are closely related and in policy terms have been afforded a good deal of consideration over the last decade. It is widely recognised that those who experience mental health problems or who have learning disability find that their situation can lead to the breakdown of a tenancy, loss of a job and hence the ability to pay a mortgage or rent which may lead to the loss of a family home. Being homeless, on the streets or insecurely housed can be particularly detrimental to a person's mental health or compound other issues associated with a person's learning disabilities.

It is fair to say that safe, secure and affordable housing is critical in enabling people to work and take part in community life.[13] There are a number of policy drivers that impact on mental health and learning disability, and some that cut across both areas of care commissioning and delivery. This section provides a concise summary of the key drivers and their impact.

THE HEALTH AND SOCIAL CARE BILL

The Health and Social Care Bill followed the White Paper, *Equity and Excellence - Liberating the NHS*[14] which set out the Coalition Government's plan for the NHS in England. Alongside the structural reform proposed, which includes the abolition of PCTs and SHAs, the Bill sets out a range of changes to the way in which services are commissioned and paid for.

A continuing emphasis on commissioning for mental health and well-being reflects the need to improve delivery of mental health services for those with a defined disorder and to improve the mental health and well-being and prevent mental ill health across the population as a whole, including those with a diagnosed illness.

GP consortia will take on responsibility for planning and commissioning mental health services, consortia commissioners will be expected to build and maintain partnerships with various other organisations and bodies, these include:

- Local Authorities
- Schools, Academies, Colleges, Universities, other education/training bodies
- HealthWatch
- Patient participation groups and service user groups
- Third sector organisations and community groups

PAYMENT BY RESULTS

Payment by Results (PbR) was introduced in the NHS in 2003/04 to improve the fairness and transparency of payments and to stimulate provider activity and efficiency. PbR means that providers are paid for the number and type of patients treated, in accordance with national rules and a national tariff.

Work continues towards creating a national tariff for mental health services for working age adults and older people and mental health tariffs are expected to be introduced by 2013.[15]

13 New Horizons Department of Health December 2009
14 Equity and Excellence, Liberating the NHS Department of Health 2010
15 http://www.hsj.co.uk/5002882.article

EXPANDING CHOICE OF PROVIDERS

The market environment in the NHS and social care will expand to admit a far wider range and diversity of providers. This has been driven by the introduction of PbR in mental health, the development of care packages against the new 'care clusters' and further developments in personal budgets. Other drivers include further freedoms for NHS Foundation Trusts in the Health and Social Care Bill.

NHS trusts will find themselves in competition with independent and voluntary sector providers. This presents both opportunities and challenges for commissioners to seek ways of improving quality and productivity. They will have a far greater choice in the care provider market place, but may also need to support the smaller, specialist voluntary sector agencies whose services are often more acceptable and accessible, and no less effective, than those offered by larger agencies.

QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION

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

Mental health has one of the most successful track records in redesign for improving quality and productivity across services, particularly in adult mental health and learning disability services; however there are areas where significant variation still exists across the country. As described earlier, there are three work streams at national level. They are examining physical and mental health co-morbidity, out of area treatments and the acute care pathway.

At the time of writing there is no defined QIPP programme for learning disability services. Given that the majority of those services are commissioned and delivered via local authorities, it seems reasonable to assume that they will take the lead, should any QIPP related initiative be launched. Local health and social care systems may put in place a similar process to ensure improvements in quality and productivity, using similar frameworks.

The majority of these work streams have tended to concentrate on opportunities within health care settings, both in hospital and community settings. However, the connection between mental health and other services has yet to be fully explored. Housing, mental health and learning disability are areas that could have the potential to improve productivity and thus reduce costs, but also contribute to improved outcomes for services users.

The quality and productivity challenge for the NHS and the need to improve value for money in local authorities requires a double shift in investment. This shift involves:

- A reduction in overall spend through increased productivity
- Moving upstream a proportion of the investment currently funding acute, specialist and other secondary care services (covering all tiers of prevention) in order to reduce demand on these downstream services in the longer term.

This will require the implementation of wider clinically owned and championed mental health and learning disability care pathways, largely in secondary services and acute care. It will also require a fundamental change in approach to commissioning and providing services, seeing

housing as a core component of the pathway, which can aid recovery and improve well-being. Such a shift can also assist in reducing admissions and average lengths of stay as well as the numbers of people needing to access out of area placements or forensic mental health services.

It will also be necessary to free up resources both to deliver efficiencies in the short term and to re-invest upstream in interventions that achieve improved outcomes for people in housing. Re-investments can then be made to deliver further medium and long-term reductions on the demand-side, as well as enhancing diversion or 'step-up' and 'step-down' options around crisis services and secondary care to reduce the need for lengthy, high-cost placements (in or out of the local area) and admissions to secure services.

SUPPORTING PEOPLE

The Supporting People programme (SP) is the main source of funding for housing related support. It can be used to fund a range of community based support services, including:

- floating support and tenancy sustainment
- rent deposit schemes
- hostels
- accommodation based supported housing
- housing advice and advocacy

It is delivered in partnership between Housing, Social Services, Health and Probation. Previously ring fenced, this protection was removed in April 2009 and SP now forms part of the Local Government Formula Grant.

SP funded services form a significant part of the range of housing and housing related support services in any given locality. They are often central to localities being able to offer independent living for people with mental health problems and learning disability.

SP budgets are expected come under increasing pressure over the next few years, with warnings of large reductions in some authorities. The NHS, although seen as a key partner in the programme, has not had a consistent engagement with SP in all areas of the country and joint commissioning of housing support has been under developed.[16]

Given the emerging NHS landscape, health commissioners and providers will need increasingly engaged in work to reconfigure services that minimises the impact of SP funding reductions. QIPP may be a framework within which commissioners and providers can stimulate innovation, re-design care pathways and support housing and social care colleagues to meet future funding challenges, whilst realising benefits to their own services in terms of productivity gains.

16 Edwards, M (2008) Commissioning housing support for health and wellbeing, CSIP, London

PERSONALISATION

Personalisation is about giving people more choice and control over their lives. It goes beyond giving personal budgets for people to buy in their own care and support, or providing funding to purchase specific health care services.

Embedding personalisation requires a move away from traditional models of health and social care and the embedding of a set of values that promotes the empowerment of individuals to take control and make their own choices about how they want to live their lives and what help they need to do so. Councils in England are expected to have 30% of service users on personal budgets by March 2011, under targets agreed by the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Department of Health.

The NHS has put in place a pilot programme for the development of Personal Health Budgets, drawing on the experience of colleagues in social care who have worked with individual budgets and direct payments for some time. A personal health budget is an amount of money that is spent on meeting the health care and wellbeing needs of people, generally those with a long term illness or disability.[17]

At the heart of a personal health budget is an individual care plan developed in partnership between a health care professional and service user. The plan sets out the individual's health care and wellbeing needs, the health outcomes the amount of money in the budget and how this will be spent. At present the care plan must be signed off by the local PCT.

VALUING PEOPLE NOW: A NEW THREE-YEAR STRATEGY

Services for adults with learning disability have undergone a transformation over the last eight years. The publication in 2001 of Valuing People was an important step in bringing about improvement in the delivery and commissioning of services. Valuing People set out how the Government would enable children and adults with learning disabilities and their families to live full and independent lives as part of their local communities.

The recognition that further work is needed required came with the publication of Valuing People Now: A New Three Year Strategy. This document re-iterates and re-enforces the focus set out in the original Valuing People strategy (2001). In particular, the strategy points to making significant improvements in giving adults with learning disability much more choice and control over their lives through person centred planning, advocacy and personalisation.

As a consequence of the Michael Report, better health for adults with learning disability has become a key priority. Existing programmes such as Supporting People may be used to increase the housing options available to adults with learning disability.

The three key priorities for Valuing People Now are improvements in health, housing and employment. The Coalition Government has committed to implementing the Valuing People Now strategy with these priorities.

17 www.personalhealthbudgets.dh.gov.uk/About/faqs/#item2

NO HEALTH WITHOUT MENTAL HEALTH

Good mental health and wellbeing is fundamental to all our lives, whether we are adults or children. The new mental health strategy, *No Health without Mental Health* sets out a two-track, life course approach that aims to:

- improve outcomes for people with mental ill health, and
- build individual and community resilience and wellbeing in order to prevent ill health.

It is closely linked with the Healthy Lives, Healthy People strategy for public health in England and expects input from all relevant government departments towards meeting these aims.

The strategy is structured around a number of high-level mental health outcomes that are consistent with those set out in the NHS, social care and public health frameworks. These cover areas such as: better mental health care; better physical health for those with mental health problems; and better mental wellbeing in the population.

An all-age, population-based mental health and well-being focus will be required across the NHS and Local Authority in order to create success. Such an approach should seek to include housing as a core component that can contribute to recovery and well-being.

The strategy is supported by a range of other documents including The economic case for improving efficiency and quality in mental health 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

THE LEGACY OF PUBLIC SERVICE AGREEMENTS

The Coalition Government has now ended the previous system of Public Service Agreements but their legacy in relation to the place of housing in health and social care remains.

The socially excluded adults Public Service Agreement (PSA 16) aimed to ensure that the most socially excluded adults are offered the chance to get back on a path to a more successful life, by increasing the proportion of at-risk individuals in:

- Settled accommodation; and
- Employment, education or training (only employment for mental health).

PSA16 focused on the four most excluded groups in society, including people in contact with secondary mental health services and people with moderate to severe learning difficulties. A total of eight indicators underpinned the PSA and were used to measure progress for each at-risk group towards increasing the proportions in settled accommodation and in employment, education or training.[18]

Although the targets have now ceased, the indications are that mental health, and to some degree learning disability within the context of accommodation being part of a care pathway, will continue to feature in policy and strategic direction.

OUTCOMES FRAMEWORK FOR THE NHS, SOCIAL CARE AND PUBLIC HEALTH

The Coalition Government is implementing new outcomes frameworks for the NHS, Social Care and Public Health. Both the NHS and Social Care Outcomes Frameworks have been published and the Public Health outcomes are in draft form at the time of writing.

The importance of settled accommodation has been recognised in the frameworks for Social Care and Public Health, taking forward the legacy from the previous government's approach to PSAs. The Social Care Outcomes Framework includes:

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

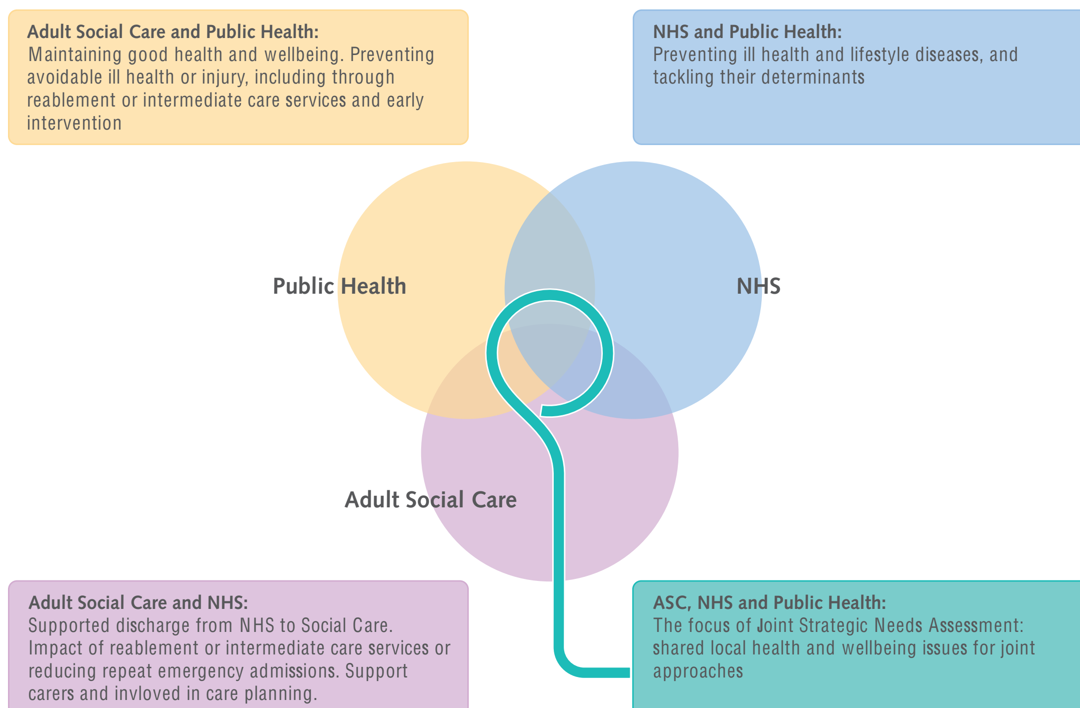
- The proportion of adults in contact with secondary mental health services living independently, with or without support.
- Proportion of adults with learning disabilities living in their own home or with their family.

Although this is subject to consultation, the proposed Public Health outcomes are:

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

- Housing overcrowding
- Proportion of people with mental illness and disability in settled accommodation
- Statutory homeless households

18 www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/psa/guidance_psa_indicators_032808.pdf



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

JOINT STRATEGIC NEEDS ASSESSMENT

Since 1 April 2008, local authorities and PCTs have been under a statutory duty to produce a Joint Strategic Needs Assessment (JSNA).[19] The process of conducting a JSNA will establish the current and future health and wellbeing needs of a population, leading to improved outcomes and reductions in health inequalities. This is a partnership duty which involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services.

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

The Department of Health and Communities and Local Government have been working together to identify where the JSNA is working well in incorporating the housing and support needs of vulnerable adults. One such example is Wiltshire, whose JSNA emphasises the 'wider determinants of health' such as affordable housing.[20] A series of case studies has been published by the LGID as part of their Communities of Practice – www.communities.idea.gov.uk.

As part of the NHS reforms, the JSNA will be a key responsibility and joint commissioning vehicle for the new Health and Wellbeing Boards.

STATE OF THE NATION REPORT: POVERTY, WORKLESSNESS AND WELFARE DEPENDENCY IN THE UK

19 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097
20 JSNA – Progress so Far, Hughes, L. IDeA April 2009 http://www.idea.gov.uk/idk/aio/9606722

The ‘State of the nation report: poverty, worklessness and welfare dependency in the UK’ was published in June 2010, just a few weeks after the formation of the new Government. The report highlights the importance being placed on addressing poverty and inequality in Britain.

Key statistics from the report include:

- Almost one in ten people live in persistent poverty, and there are 800,000 more working age adults in poverty than in 1998/99
- Health inequalities are higher now than they were in the 1970s
- 5.3 million people suffer from multiple disadvantages in the UK
- People living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods.

Access to appropriate housing remains one of the multiple disadvantages for people in the UK. Poor mental health, poor housing, worklessness and income poverty, are all indicators of multiple disadvantage.[21]

21 HM Government (2010) State of the nation report: poverty, worklessness and welfare dependency in the UK. Cabinet Office June 2010

4 A BRIEF ANALYSIS OF THE DATA RELATING TO POPULATION, PREVALENCE, COST EFFECTIVENESS AND QUALITY

Examination of the compendium of statistics prepared as a companion to this report demonstrates the substantial challenge presented to social care and health agencies in providing appropriate services for those living with mental health issues or learning disabilities in the Yorkshire and Humber region. Using validated prevalence figures the tables project the probable numbers of people living with particular conditions at five year intervals from 2010 to 2030 for each of the Local Implementation Team areas in the region.

In each set of tables the first sets out the number of people between 18 and 64 years of age who are likely to be living with a mental health problem.

- The largest number is for those predicted to have a common mental disorder.
- In Leeds the current number of 86.3k is predicted to rise to 101.6k by 2030.
- At the other end of the range the numbers in North East Lincolnshire are predicted to fall from 15.2k to 14.5k.
- This is the only area in which the population in the 18 to 64 age range is predicted to fall over this period and with it the number of people living with a common mental disorder.
- Larger conurbations, such as Kirklees, Sheffield & Bradford are in the range of 40k to 50k, whilst the majority of districts are in a range 22k to 28k.

Within the compendium the predicted prevalence numbers are presented in summary and disaggregated by gender.

Whilst the numbers of those with other mental health problems: borderline personality disorder, anti-social personality disorder or a psychotic disorder are measured in hundreds rather than in thousands their numbers are still substantial.

- The mid- range is around five to six hundred in each area,
- In the larger conurbations that number is double and in Leeds numbers in the range of 2,000 to 2,500 in each category.

Table One sets out the number of those aged between eighteen and sixty-four predicted to have an anti-social personality disorder.

TABLE ONE

PEOPLE AGED 18-64 PREDICTED TO HAVE AN ANTISOCIAL PERSONALITY DISORDER BY LOCAL IMPLEMENTATION (LIT) AREA[22]

	2010	2015	2020	2025	2030
Barnsley	491	501	508	515	520
Bradford	1,107	1,167	1,219	1,272	1,325
Calderdale	434	443	457	467	478
Doncaster	621	618	615	610	606
East Yorkshire	720	732	751	771	785
Hull	632	666	688	708	730
Kirklees	888	906	925	945	967
Leeds	1,886	2,024	2,126	2,215	2,315
North East Lincolnshire	331	328	327	325	324
North Lincolnshire	345	350	356	362	365
North Yorkshire	1,252	1,257	1,278	1,295	1,303
York	461	486	505	523	540
Rotherham	542	544	550	552	555
Sheffield	1,280	1,349	1,398	1,444	1,492
Wakefield	710	718	727	736	743

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

As provision shifts from institutional to housing based forms it is those with anti-social personality disorders and those with psychotic disorder who are likely to present the greatest challenges in finding and sustaining appropriate provision of accommodation, care and support. Table Two sets out the numbers of those between eighteen and sixty-four years of age predicted to have a psychotic disorder.

22 This table is based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2030.

TABLE TWO

PEOPLE AGED 18-64 PREDICTED TO HAVE A PSYCHOTIC DISORDER BY LOCAL IMPLEMENTATION (LIT) AREA[23]

	2010	2015	2020	2025	2030
Barnsley	565	576	583	589	591
Bradford	1,253	1,310	1,359	1,406	1,454
Calderdale	502	510	522	531	539
Doncaster	705	698	692	683	675
East Yorkshire	819	823	840	856	862
Hull	698	727	744	759	778
Kirklees	1,018	1,033	1,051	1,069	1,087
Leeds	2,145	2,265	2,353	2,431	2,523
North East Lincolnshire	379	374	370	366	360
North Lincolnshire	393	396	401	405	405
North Yorkshire	1,429	1,426	1,442	1,452	1,447
York	529	550	567	582	598
Rotherham	622	622	625	625	623
Sheffield	1,431	1,489	1,531	1,571	1,615
Wakefield	813	817	824	830	832

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

Of the related issues that arise the most prevalent is that of alcohol dependence and Table Three sets out the number of those between eighteen and sixty-four years of age predicted to be dependent on alcohol.

23 This table is based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2030.

TABLE THREE

PEOPLE AGED 18-64 PREDICTED TO HAVE ALCOHOLIC DEPENDENCE BY LOCAL IMPLEMENTATION (LIT) AREA[24]

	2010	2015	2020	2025	2030
Barnsley	8,428	8,603	8,714	8,835	8,896
Bradford	18,921	19,911	20,760	21,611	22,462
Calderdale	7,469	7,614	7,827	7,998	8,157
Doncaster	10,623	10,554	10,495	10,402	10,321
East Yorkshire	12,324	12,488	12,798	13,105	13,311
Hull	10,727	11,272	11,622	11,931	12,286
Kirklees	15,230	15,517	15,832	16,156	16,506
Leeds	32,292	34,495	36,123	37,559	39,178
North East Lincolnshire	5,674	5,621	5,595	5,549	5,509
North Lincolnshire	5,911	5,982	6,079	6,164	6,201
North Yorkshire	21,457	21,508	21,834	22,082	22,164
York	7,916	8,309	8,620	8,895	9,183
Rotherham	9,299	9,324	9,409	9,430	9,463
Sheffield	21,809	22,912	23,693	24,424	25,204
Wakefield	12,178	12,294	12,436	12,573	12,667

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

Although the number predicted to be dependent on drugs is a little over half that for those dependent on alcohol they still represent substantial numbers at 4.5% of men and 2.3% of women in the age group within the whole population of each LIT.

24 The report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009, provides prevalence rates for both alcohol and drug dependence. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have drug or alcohol dependence, projected to 2030.

TABLE FOUR

PEOPLE AGED 18-64 PREDICTED TO BE DEPENDENT ON DRUGS BY LOCAL IMPLEMENTATION (LIT) AREA[25]

	2010	2015	2020	2025	2030
Barnsley	4,781	4,878	4,942	5,007	5,039
Bradford	10,709	11,256	11,725	12,193	12,661
Calderdale	4,239	4,318	4,436	4,528	4,614
Doncaster	6,015	5,972	5,935	5,878	5,828
East Yorkshire	6,979	7,068	7,231	7,398	7,504
Hull	6,052	6,351	6,538	6,705	6,899
Kirklees	8,634	8,790	8,964	9,143	9,332
Leeds	18,286	19,494	20,384	21,171	22,064
North East Lincolnshire	3,216	3,185	3,166	3,139	3,111
North Lincolnshire	3,348	3,386	3,438	3,483	3,501
North Yorkshire	12,156	12,176	12,352	12,482	12,513
York	4,488	4,703	4,892	5,024	5,182
Rotherham	5,272	5,284	5,329	5,337	5,351
Sheffield	12,323	12,924	13,352	13,752	14,181
Wakefield	6,902	6,963	7,040	7,112	7,159

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

Tables Five and Six compare the numbers between eighteen and sixty four years of age with mental health problems who are helped to live independently and those in residential care purchased or provided by the CSSR.[26]

25 The report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009, provides prevalence rates for both alcohol and drug dependence. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have drug or alcohol dependence, projected to 2030.

26 The numbers quoted are the totals of those supported in residential or nursing care in the course of the year.

TABLE FIVE

PEOPLE AGED 18-64 WITH MENTAL HEALTH PROBLEMS BY LOCAL IMPLEMENTATION (LIT) AREA[27]

	2010	2015	2020	2025	2030
Barnsley	722	735	744	754	758
Bradford	1,220	1,277	1,328	1,377	1,426
Calderdale	732	745	762	777	789
Doncaster	686	680	674	668	659
East Yorkshire	No return	No return	No return	No return	No return
Hull	226	236	242	247	254
Kirklees	1,067	1,085	1,106	1,125	1,147
Leeds	1,622	1,721	1,792	1,856	1,930
North East Lincolnshire	377	373	370	366	360
North Lincolnshire	420	425	430	434	435
North Yorkshire	2,931	2,930	2,967	2,993	2,990
York	415	433	447	460	473
Rotherham	899	900	904	905	906
Sheffield	1,619	1,691	1,743	1,792	1,844
Wakefield	711	715	722	727	731

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

27 The information on people aged 18-64 with mental health problems helped to live independently is taken from Social Care Indicators from the National Indicator Set 2008-09 final, reference NI136. National Indicator NI136 gives information on the number of adults that are assisted directly through social services assessed/care planned, funded support to live independently, plus those supported through organisations that receive social services grant funded services. The information is broken down by primary client type (adults with a learning disability, a physical disability, a mental health problem, a substance misuse problem and vulnerable people) and by age group (adults aged 18 - 64 and older people aged 65 and over).

TABLE SIX

PEOPLE AGED 18-64 WITH MENTAL HEALTH PROBLEMS IN RESIDENTIAL AND NURSING CARE DURING THE YEAR, PURCHASED OR PROVIDED BY THE LOCAL IMPLEMENTATION (LIT) AREA[28]

	2010	2015	2020	2025	2030
Barnsley	75	77	78	79	79
Bradford	127	133	138	143	148
Calderdale	30	31	31	32	33
Doncaster	20	20	20	19	19
East Yorkshire	116	116	119	121	123
Hull	117	122	125	128	132
Kirklees	45	46	47	48	49
Leeds	173	184	191	198	206
North East Lincolnshire	45	45	44	44	43
North Lincolnshire	101	102	103	104	104
North Yorkshire	40	40	41	41	41
York	46	48	49	51	52
Rotherham	35	35	35	35	35
Sheffield	81	85	87	90	92
Wakefield	40	40	41	41	41

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

Turning to the numbers of those identified as living with a learning disability we recognise that those living with moderate or severe learning disability and therefore likely to be in receipt of services comprise a little less than a quarter of the total.

Table Seven sets out the total number predicted to have a learning disability.

28 People aged 18-64 with mental health problems in residential and nursing care during the year, purchased or provided by the CSSR is taken the National Adult Social Care Intelligence Service (NASCIS), Referrals, Assessments and Packages of Care data, final 2008/09, page P1 "Number of clients receiving services during the period, provided or commissioned by the CSSR, by primary client type, service type, and age group". Page P1 gives the estimated number of clients receiving services during the period by client type (adults with a learning disability, a physical disability, a mental health problem, a substance misuse problem and vulnerable people), by services provided (community based services in own home, nursing care and residential care) and by age group (adults aged 18 - 64 and older people aged 65 and over).

TABLE SEVEN

PEOPLE AGED 18-64 PREDICTED TO HAVE A LEARNING DISABILITY BY LOCAL IMPLEMENTATION (LIT) AREA[29]

	2010	2015	2020	2025	2030
Barnsley	3,419	3,487	3,530	3,580	3,609
Bradford	7,690	8,058	8,380	8,700	9,034
Calderdale	3,036	3,095	3,163	3,234	3,291
Doncaster	4,284	4,251	4,216	4,182	4,145
East Yorkshire	4,945	4,993	5,105	5,214	5,288
Hull	4,330	4,533	4,646	4,753	4,891
Kirklees	6,194	6,308	6,432	6,556	6,697
Leeds	13,262	14,083	14,653	15,181	15,818
North East Lincolnshire	2,301	2,279	2,259	2,239	2,213
North Lincolnshire	2,378	2,406	2,438	2,466	2,476
North Yorkshire	8,616	8,631	8,740	8,828	8,846
York	3,254	3,398	3,506	3,611	3,720
Rotherham	3,773	3,782	3,799	3,809	3,825
Sheffield	8,860	9,268	9,543	9,816	10,128
Wakefield	4,933	4,965	5,012	5,057	5,097

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

Table Eight sets out the numbers of those between eighteen and sixty-four years of age predicted to be living in each area who have a learning disability.

29 These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004. The authors take the prevalence base rates and adjust these rates to take account of ethnicity (i.e. the increased prevalence of learning disabilities in South Asian communities) and of mortality (i.e. both increased survival rates of young people with severe and complex disabilities and reduced mortality among older adults with learning disabilities). Therefore, figures are based on an estimate of prevalence across the national population; locally this will produce an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community. Prediction rates have been applied to ONS population projections of the 18-64 population in the years 2011 and 2021 and linear trends projected to give estimated numbers predicted to have a mild, moderate or severe learning disability, to 2030. (For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

TABLE EIGHT

PEOPLE AGED 18-64 PREDICTED TO HAVE A MODERATE OR SEVERE LEARNING DISABILITY BY LOCAL IMPLEMENTATION (LIT) AREA[t]

	2010	2015	2020	2025	2030
Barnsley	768	785	801	824	842
Bradford	1,715	1,810	1,906	2,013	2,119
Calderdale	682	698	719	746	770
Doncaster	960	955	956	962	967
East Yorkshire	1,110	1,125	1,159	1,198	1,232
Hull	965	1,015	1,053	1,096	1,145
Kirklees	1,388	1,420	1,461	1,513	1,567
Leeds	2,953	3,153	3,326	3,509	3,709
North East Lincolnshire	517	512	511	515	516
North Lincolnshire	534	541	553	567	577
North Yorkshire	1,933	1,944	1,982	2,027	2,058
York	727	763	797	834	871
Rotherham	846	851	862	878	894
Sheffield	1,981	2,082	2,168	2,267	2,372
Wakefield	1,108	1,118	1,137	1,165	1,190

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

Within the Compendium we set out the figures for those with a learning disability living with parents. We note that the numbers of those with moderate to severe learning disability living with parents declines steeply from 45 years of age onwards, indicating in many cases a traumatic move to other accommodation in middle age or late in life. The nature of the informal support received means that independent living skills may be less well developed, which adds a further level of challenge in identifying appropriate accommodation options.

Severity of learning disability is not the only predictor of difficulty in identifying appropriate accommodation, care and support solutions. Some people with low to moderate levels of learning disability but with other needs arising from mental health issues, or from alcohol or substance abuse may, in fact, be more problematic.

Table Nine sets out the numbers of people between eighteen and sixty-four years of age who have a learning disability and are predicted to display challenging behaviour. Although relatively small in number they represent a group of cases where appropriate placements may be difficult to identify and costly to procure.

30 Notes on basis of calculation are as for Table 7. Prediction rates have been applied to ONS population projections of the 18-64 population in the years 2011 and 2021 and linear trends projected to give estimated numbers predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, to 2030.

TABLE NINE

PEOPLE AGED 18-64 WITH A LEARNING DISABILITY, PREDICTED TO DISPLAY CHALLENGING BEHAVIOUR BY LOCAL IMPLEMENTATION (LIT) AREA[31]

	2010	2015	2020	2025	2030
Barnsley	34	34	35	35	36
Bradford	75	79	82	85	88
Calderdale	30	31	31	32	32
Doncaster	42	42	42	41	41
East Yorkshire	92	93	95	97	98
Hull	42	44	45	46	48
Kirklees	114	116	118	121	123
Leeds	129	137	142	147	153
North East Lincolnshire	23	22	22	22	22
North Lincolnshire	44	45	45	46	46
North Yorkshire	161	161	163	164	164
York	60	62	64	66	68
Rotherham	70	70	70	70	71
Sheffield	162	169	174	179	184
Wakefield	92	92	93	94	94

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

Although we have reproduced them in the Compendium we believe that the available figures on the numbers of people having a learning disability who are in receipt of social care through a Direct Payment and/or an Individual Budget may under represent the current situation in what is a rapidly developing area of work.

In Table Ten we set out the predicted numbers of those between eighteen and sixty-four with a learning disability who are helped to live independently.

31 This table is based on the report by Emerson, E., Challenging Behaviour: Analysis and Intervention in People with Severe Intellectual Disabilities, 2001, Cambridge University Press. Emerson's prevalence rate for adults with a learning disability who present a serious challenge at any one time is 24 per 100,000 total population in England. It includes people with mild as well as severe learning disability. A few of these people will present such a challenge more or less all the time and will become well-known to local services (as well as, in some cases, other agencies like the police and housing departments); but many people will move into and out of this group depending both on changes in their characteristics and on how well services meet their needs over time.
The prevalence rate has been applied to ONS population projections of the 18 to 64 population to give estimated numbers with a learning disability predicted to display challenging behaviour to 2030.

TABLE TEN

PEOPLE AGED 18-64 WITH A LEARNING DISABILITY HELPED TO LIVE INDEPENDENTLY BY LOCAL IMPLEMENTATION (LIT) AREA[32]

	2010	2015	2020	2025	2030
Barnsley	332	338	343	347	349
Bradford	1,298	1,358	1,412	1,464	1,517
Calderdale	436	444	454	463	470
Doncaster	456	452	448	444	438
East Yorkshire	554	558	570	582	589
Hull	330	345	354	361	371
Kirklees	796	809	825	840	856
Leeds	1,934	2,051	2,136	2,212	2,300
North East Lincolnshire	225	222	220	218	215
North Lincolnshire	310	313	317	320	321
North Yorkshire	1,883	1,882	1,906	1,922	1,921
York	576	601	621	639	657
Rotherham	424	424	426	426	427
Sheffield	1,035	1,081	1,114	1,145	1,179
Wakefield	664	667	674	679	682

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

All Local Implementation Teams have been engaged in facilitating a shift away from reliance upon registered care, whether offering personal care or nursing care. Although the current rate at which people with a learning disability are likely to be accommodated in a registered care home is much reduced there is a legacy of past practice to be managed. Some people with a learning disability who would not now be assessed as suitable for Registered Care may have spent the major part of their lives in such a setting and change must be handled sensitively, with the consequence that change takes time! Table Eleven sets out the numbers of those in residential and nursing care during the year, purchased or provided by the CSSR.

32 People aged 18-64 with a learning disability helped to live independently is taken from Social Care Indicators from the National Indicator Set 2008-09 final, reference NI136. National Indicator NI136 gives information on the number of adults that are assisted directly through social services assessed/care planned, funded support to live independently, plus those supported through organisations that receive social services grant funded services. The information is broken down by primary client type (adults with a learning disability, a physical disability, a mental health problem, a substance misuse problem and vulnerable people) and by age group (adults aged 18 - 64 and older people aged 65 and over).

TABLE ELEVEN

PEOPLE AGED 18-64 WITH A LEARNING DISABILITY IN RESIDENTIAL AND NURSING CARE DURING THE YEAR, PURCHASED OR PROVIDED BY LOCAL IMPLEMENTATION (LIT) AREA[33]

	2010	2015	2020	2025	2030
Barnsley	65	67	67	68	69
Bradford	289	302	314	326	337
Calderdale	146	149	152	155	157
Doncaster	300	297	295	292	288
East Yorkshire	322	324	331	338	342
Hull	198	207	213	217	223
Kirklees	282	287	292	297	303
Leeds	173	184	191	198	206
North East Lincolnshire	130	129	128	126	124
North Lincolnshire	95	96	98	99	99
North Yorkshire	295	295	299	302	301
York	107	111	115	118	122
Rotherham	190	190	191	191	191
Sheffield	330	344	355	365	375
Wakefield	151	151	153	154	155

(For source and basis of calculation see the footnote, re-formatted by Contact Consulting)

All Local Implementation Teams have been engaged in facilitating a shift away from reliance upon registered care, whether offering personal care or nursing care. Although the current rate at which people with a learning disability are likely to be accommodated in a registered care home is much reduced there is a legacy of past practice to be managed. Some people with a learning disability who would not now be assessed as suitable for Registered Care may have spent the major part of their lives in such a setting and change must be handled sensitively, with the consequence that change takes time! Table Eleven sets out the numbers of those in residential and nursing care during the year, purchased or provided by the CSSR.

33 People aged 18-64 with a learning disability in residential and nursing care during the year, purchased or provided by the CSSR is taken from the National Adult Social Care Intelligence Service (NASCIS), Referrals, Assessments and Packages of Care data, final 2008/09, page P1 “Number of clients receiving services during the period, provided or commissioned by the CSSR, by primary client type, service type, and age group”. Page P1 gives the estimated number of clients receiving services during the period by client type (adults with a learning disability, a physical disability, a mental health problem, a substance misuse problem and vulnerable people), by services provided (community based services in own home, nursing care and residential care) and by age group (adults aged 18 - 64 and older people aged 65 and over).
The Referrals, Assessments and Packages of Care Project (RAP) was developed to provide a coherent set of national statistics on adult community care, purchased or provided by Councils with Social Services Responsibilities (CSSRs).

5 COST EFFECTIVENESS AND QUALITY – THE COST AND NON-FINANCIAL BENEFITS OR HOUSING BASED SOLUTIONS

Research published in 2009 by the Department for Communities and Local Government sought to demonstrate the financial benefits of the Supporting People programme. Their review of the costs of community based support included not just the costs borne within Supporting People budgets but by all forms of public expenditure. The study contrasted the costs of existing housing based packages with a range of alternative scenarios which might apply should the existing support package not be available. Within the report there are data based estimates of the probability of various alternative outcomes and real-cost models of the financial consequences of alternative scenarios.

The report concludes that housing based solutions through which support is provided to a range of vulnerable adult groups represent a major saving in public expenditure when compared with the likely outcomes were those options to be no longer available.

Within the report the impact on people with Mental Health issues and on those with Learning Disabilities are separately described and quantified.

We make the assumption that the reported savings achieved by people being currently supported in the community can be used as the basis for modelling the outcomes that would be achieved if those currently in residential settings were to be placed in the community with appropriate support.

COST COMPARISONS WITH MENTAL HEALTH PROBLEMS

For people with mental health problems the report estimates that the annual cost per household unit for people being supported in the community is £23,458. Table Twelve provides the detail and cites the sources for this estimate.

TABLE TWELVE — **PACKAGE WITH SUPPORTING PEOPLE SERVICES (THE EXISTING PACKAGE): COST PER HOUSEHOLD UNIT PER ANNUM**

COMPONENT	COST PER ANNUM	SOURCE
SP Package	£6,823	SPLS data [see 6.4.4.]
Housing Costs	£5,548	SP Leads estimate of £96 per week
Social Services Care	£6,788	Estimates based on published data [see table 6.4.2.]
Benefits & Related Services	£4,298	SP Lead estimate of £60 per week + £643 unit cost of Jobcentre Plus administration [see 6.4.1.]
TOTAL	**£23,458**	

(Source: research into the financial benefits of the Supporting People Programme, 2009, DCLG, Table 6.3.4(i))

These costs are contrasted with those that arise when the package of care, support and accommodation involves residential care which are estimated at £27,707 per annum. The detail is in Table Thirteen. The study estimates that 8% of those currently supported in the community would otherwise require a package that would include residential care. This is not relevant to our calculations but we report it as it is significant in understanding the conclusions of the report from which we are quoting.

TABLE THIRTEEN — PACKAGE INVOLVING RESIDENTIAL CARE

COMPONENT	COST PER ANNUM	SOURCE
Residential Package	£25,743	PSSRU 2008[34] (P45) cost of £465 per week (£485 less £20 living expenses)
Benefits & Related Services	£1,964	PSSRU 2008[35] (P45) estimate of £20.45 per week living costs while in residential care+ £643 unit cost of Jobcentre Plus administration [see 6.4.1.
TOTAL	**£27,707**	

(Source: research into the financial benefits of the Supporting People Programme, 2009, DCLG, Table 6.3.4(iii))

For those who would otherwise receive a package involving hospital care the estimate of cost is substantially higher at £79,015 per annum. The study estimates that 33% of households currently supported in the community would otherwise require a package that would include hospital care. Again, it is the bottom line cost, rather than the prevalence, that concerns us in looking at the savings to be achieved by supporting those currently in hospital in a housing based setting.

34 Units costs of Health and Social Care 2008, Curtis and Netton, PSSRU, University of Kent, 2008
35 ibid

TABLE FOURTEEN	PACKAGE INVOLVING HOSPITAL CARE	
COMPONENT	COST PER ANNUM	SOURCE
Residential Package	£71,104	PSSRU 2008[36] (P51): Daily inpatient costs of £183 per inpatient (excluding living costs)
Benefits & Related Services	£7,910	PSSRU[37] (P51): Daily allowance of £18.20 per day allowance for long-stay hospital patients + £643 unit cost of Jobcentre Plus administration [see 6.4.1]
TOTAL	£79,015	

(Source: research into the financial benefits of the Supporting People Programme, 2009, DCLG, Table 6.3.4(iv))

By applying this data in the reverse direction we may assert that for each household unit (which broadly equates to one person together with the cost implications of the impact of their situation on other members of the household) currently receiving a package involving hospital care the cost saving to the public purse of substituting a housing based package would be £55,557 per annum. For those moving from a package involving residential care the total saving in public expenditure would be £4,249 per annum. However the impact for Adult Social Care budgets would be more marked: the residential package of £25,743 would reduce to £6,788, being the cost of the social care package; a saving of £18,955 per annum.

Whilst regional and local circumstances may vary costs the ratio between the costs is likely to be fairly constant. For the purposes of illustration we may assume, on the basis of the data contained in this study, that the full year saving to the social care budget of supporting individuals through a housing based support package will be almost nineteen thousand pounds less in a year than supporting them through a residential package.

Clearly savings in periods spent as a hospital in-patient are even more substantial: four weeks spent in a housing based setting, as opposed to being spent as a hospital in-patient, will save the public purse in the region of £4,270.

The benefits of community based solutions are more than financial. An earlier study[38] identified four specific uncosted benefits for people with mental health problems of being supported in the community:

- Improved quality of life for the individual including great independence, improved health, greater choice of options on where and how to live and lessened dependence on relative and carers;
- Prevention of further mental health problems and fewer suicides;
- Reduced burden of care for carers (leading to improved quality of life); and
- Easier access to appropriate services.

36 ibid
37 ibid
38 Benefits Realisation of the Supporting People Programme, CLG, 2004

LEARNING DISABILITIES

For people with Learning Disabilities the study estimates the total cost to public purse of community based packages, including the Supporting People element, at £39,010 per household per annum. Table Fifteen sets out the detail:

TABLE FIFTEEN	PACKAGE WITH SP SERVICES (THE EXISTING PACKAGE), COST PER HOUSEHOLD, PER ANNUM	
COMPONENT	COST PER ANNUM	SOURCE
SP Package	£11,824	SPLS data [see 6.4.4.]
Housing Costs	£4,046	SP Leads estimate of £70 per week
Social Services Care	£18,841	Estimates based on published data [see table 6.4.2.]
Benefits & Related Services	£4,298	SP Lead estimate of £60 per week + £643 unit cost of Jobcentre Plus administration [see 6.4.1.]
TOTAL	£39,010	

(Source: research into the financial benefits of the Supporting People Programme, 2009, DCLG, Table 6.3.3(i))

This is contrasted with the costs of a package involving residential care which is estimated at £79,133 per annum, as Table Sixteen explains:

TABLE SIXTEEN	PACKAGE INVOLVING RESIDENTIAL CARE	
COMPONENT	COST PER ANNUM	SOURCE
Residential Package	£74,589	PSSRU 2008[39] Weekly costs of £1,131 (establishment) + £179 (day services) + £36 (community services
Benefits & Related Services	£4,544	PSSRU 2008[40] estimate of £67 per week living costs while in residential care+ £643 unit cost of Jobcentre Plus administration [see 6.4.1.]
TOTAL	£79,133	

(Source: research into the financial benefits of the Supporting People Programme, 2009, DCLG, Table 6.3.4(iii))

39 Units costs of Health and Social Care 2008, Curtis and Netton, PSSRU, University of Kent, 2008
40 ibid

The total estimated savings for public expenditure are in the region of forty thousand pounds a year. For Adult Social Care the costs are reduced from £74,589 to £18,841 per annum; a saving of £55,748 per annum. The same caveats in relation to local and regional variations in costs against these nationally calculated averages but the ratio between the costs is likely to be broadly similar.

The non-financial benefits of community based packages with the range of support possible through the involvement of Supporting People funding were identified in earlier research[41], and are substantial:

- Allowing many people with learning disabilities to live relatively independently, lessening the burden of care on their family and friends and allowing them greater choice over where to live and more control over their lives;
- Consistent support that responds to people's needs offering stability in their lives, allowing them to plan ahead and reducing psychological distress;
- Improved health and mobility;
- Reduced fear of crime in people with learning disabilities living alone;
- Reduced social exclusion through frustration of access to services and social groups, which both benefits the individual by reducing isolation and increases the social capital of the community;
- Reduced reliance on informal carers. In turn this can have significant benefits for their physical and mental health, can increase their access to employment and can offer greater stability in their lives; and
- Ensuring that people with learning disabilities are catered for in appropriate environments and have the best outcomes possible in terms of health, psychological development and quality of life.

41 Benefits Realisation of the Supporting People Programme, CLG, 2004

5 INITIAL CONCLUSIONS

From our review of the prevalence, population and economic data it is possible to draw some initial conclusions that help to place that information into the context of QIPP and other related productivity and efficiency processes.

- The size of the challenge in terms of prevalence continues to grow. In almost all age groups, the levels of incidence of mental health problems are increasing. Rates of learning disability prevalence are also rising and predicted to continue to do so. This continuing rise will place statutory health and social care services under considerable pressure to provide an adequate range of locally based services, both in the community and in hospitals and other institutional settings.

- The costs of providing those services within current models (e.g. acute in-patient care, residential care) will continue to rise.

- There are significant variations in the levels of spending on housing and housing based solutions across the Yorkshire & Humber region.

- There is no co-ordinated approach across the region to the development and delivery of housing and no degree of strategic consistency.

- Where collaboration has been developed there have been benefits for commissioners, practitioners and service users.

- There are associated variations in the levels of spending on a range of health and social care services across the region. Whilst this is to be expected, at least to some extent, by the differing sizes of the constituent local authorities,

- That the economic advantages of housing based solutions can be clearly seen, with significant savings being achievable.

- The argument regarding the impact of housing on QIPP and other efficiency processes in health and local authorities, has been based, at least in part on anecdotal evidence. Although the data reviewed for this project tells a coherent and compelling story, the lack of any detailed national data requires local commissioners to engage in longer term work at a regional and local level to monitor and evaluate interventions and developments that can provide a broader evidence base both regionally and nationally.

- That a fundamental change in the approach to commissioning and delivering care services for people with mental health problems and learning disabilities will be needed across the Yorkshire & Humber region if the benefits of housing and housing related support are to be delivered, both financially and from a quality of service perspective.

- Commissioning needs to take a whole-system approach that includes housing. The scale of the challenge is clear from the data outlined here. Therefore, an integrated approach to commissioning housing and housing based solutions will be needed to tackle that challenge.

- A greater degree of focus on housing is required, and it should have a central place in the commissioning processes of health and local authority commissioners. By doing this, those commissioners can design and develop a more appropriate set of services that will promote independence, re-ablement, address well-being and reduce the longer term reliance on statutory services by those with mental health problems and learning disabilities.

SECTION TWO

1 WHAT ARE THE ISSUES FOR COMMISSIONERS AND PROVIDERS

In the course of the study we spoke with a range of people across the Yorkshire and Humber region who are or were involved at different points in the mental health and learning disability fields. These included people in a range of local authority, health service and third sector organisations; those with lead responsibilities at a strategic level, commissioners and service providers. From those conversations we have gleaned a range of issues that are reflected in the following section. We have sought to illuminate the issues with quotations from the notes made during the interviews. To honour the protocols under which the interviews were conducted they have all been anonymised.

We would acknowledge that this study is not necessarily reflective of practice across the region. The response to our requests for information and contact was much stronger from West Yorkshire and South Yorkshire than from other parts of the region.

Although many of the issues are common between those commissioning services for people with Mental Health problems and those commissioning on behalf of people with Learning Disabilities there are some fundamental differences. Whilst the focus of attention for those commissioning services for those with Mental Health problems may be primarily around avoiding or minimising time spent in hospital this will not always be the primary concern in relation to Learning Disabilities. For people with Learning Disabilities the route is unlikely to be into hospital, unless there are other needs, such as significant Mental Health problems. The two strands of service are at different points in the journey from institutional to community based care, with differing policy and legislative imperatives and service models. Whilst this influences thinking and priorities in considering where they are travelling from, there is much greater convergence in the issues and solutions that are relevant to where they are travelling to. There is widespread awareness that those working in the two strands of service have much to learn from one another about constructing and delivering community based solutions.

Commissioning activity needs to be grounded in a clear strategic framework that identifies the needs, opportunities and benefits of housing based solutions in relation to the needs of people with mental health problems and people with learning disabilities. Each strand needs to articulate a housing strategy and these in turn need to be reflected in the corporate housing strategy for each local authority. These strategies need the informed input of a wide range of stakeholders: commissioning and providing functions within health, housing and social care; voluntary sector and commercial providers of housing and housing related support services; and, of course, of service users themselves (and where appropriate their families and carers).

Practice is often shaped, and re-shaped, in response to external influences and this can lead to a “one size fits all” approach which does not accord with the experience of those working at the frontline of service delivery in the community. Even an approach so generally laudable as the “Recovery Model” can distort practice if it is applied in a way that assumes a full range of desirable outcomes can be achieved for all service users within the same standardised time period.

> *Not everyone is ready to move on after twenty-six weeks. Certainly not everyone will have achieved progress in all the areas we might hope for; but they have to be moved on. We can end up with people being passed from service to service – each one may be positive in its own terms but it provides no stability for the service user. There is too much short-term thinking, the real question is: "Will they still be in their tenancy in twelve months or two years?!"*
> – Provider organisation, West Yorkshire.

At the higher end of need, or where people have spent a lifetime in receipt of services, the appropriate community based services may be hard to find. If commissioners need to take a more sophisticated view of the needs for which they are commissioning, providers too may need to raise their game.

> *We see the same people coming round time and time again, especially those with complex and high levels of need. It requires a specialist approach to cope with these cases. We are seeking to encourage providers to develop appropriate responses to these more challenging needs.*
> – SP Lead, South Yorkshire

Similar concerns about "short-termism" are voiced in relation to discharge from in-patient care.

> *The pressures that drive the endeavour to achieve timely discharge are enormous and so long as the immediate move is successful there is often little thought given to measuring the long-term outcomes.*
> – Strategy Lead, West Yorkshire

The general shortage of social rented housing in the region impacts on the ability to provide appropriate housing for people with mental health problems. Poor quality accommodation in a poor location can adversely affect the mental health of the individual and previous good work be undone.

> *Just any housing is not good enough: it is the quality and appropriateness of the accommodation that is the key to positive and sustainable outcomes.*
> – Provider organisation, West Yorkshire.

Securing appropriate housing is seen to be increasingly problematic. There is a general acceptance that capital funding to registered Social Landlords from the Homes and Communities Agency will continue to be in short-supply for the foreseeable future. Some providers have, in any event, concluded that the timescales involved in application for grant, lengthy wait and then build or acquisition periods do not match the timescales required by people with Mental Health problems or Learning Disabilities.

> *We need a more radical look at how we acquire property. For short to medium term purposes we are better off doing deals with people who own reasonably modern property which they acquired under "buy to let" arrangements and are now often keen to find a means of maintaining their income stream.*
> – National provider organisation

The issue is recognised by commissioners too who accept the need for good quality housing opportunities but see too that the ability to provide quality, appropriate, well located and affordable housing is becoming increasingly difficult.

Location is crucial but must be determined by individual circumstances: some need the support of family and friends within a community they know; for others, locating them back in familiar surroundings increases the possibility that negative social and behavioural patterns will re-assert themselves. Quality too is important, my test is: "would I live in it?"
– Commissioner, West Yorkshire

Greater choice, for example in location has a positive impact on well-being.
– Strategy Lead

The deficits in housing are in the quality of the accommodation and the choice of location.
– MH Commissioner, Care Trust

To be effective the Housing Pathway needs to start on the ward, in some cases even before any potential admission, with the consideration of housing options, and the patient's response to them, forming part of the process of recovery.

It's about bringing housing options onto the ward, rather than expecting people who are "discharged onto the street" too find their own way to services and navigate their way through. The housing expert needs to be on the ward. When we do this the old pattern of people going from hospital to some form of intermediate accommodation and then moving on again can be avoided: many can jump straight into a tenancy with Floating Support.
– NHS based service developer

We need to put housing options into the discharge plan alongside the identification of support needs, with one clearly related to the other.
– Commissioner, South Yorkshire

Good mutual understanding between professionals and the engagement of housing experts in all levels of assessment and allocation are seen to add value. Where the Housing Options assessor has been working with patients on the ward they are able to bring that knowledge to planning meetings with the providers who can tailor their offer of accommodation and support more accurately.

In the Discharge Group providers engage in discussion with the Housing Options Assessor, drawing on her knowledge of the individuals involved.
– NHS based service developer

For those commissioning services for people with learning disabilities the challenges are not generally around making access to sound accommodation, care and support packages possible within the timescales of hospital discharge. In this area crises often arise out of a sudden collapse of existing care and support arrangements, most commonly for people with learning disabilities who have been accommodated and supported by parents who suddenly become unable to continue. Although requiring great sensitivity there is clearly a need to work with families on the housing, care and support options that may be available should the current family arrangements become unsustainable.

The main reason for transition is when caring parents can no longer cope. The lack of planning for this eventuality leads to emergency admission to residential care. Often the person who has been supported at home will have relatively under-developed skills for living independently and it becomes not so much a matter of re-ablement as simple "ablement"!
– MH & LD Lead, South Yorkshire

The benefits of a "joined up approach" were mentioned in many interviews and many individuals testified to the progress made in achieving improvements since such connections had been made. There was a general recognition that to be sustainable this process of collaboration needed something more than the goodwill of individuals.

> *We need a clearer view, overall and in detail, of what happens in the various parts of the system, we need "system architects" to help us design the interfaces and to avoid duplication.*
> – NHS based service developer

The benefits of avoiding hospital admission were seen to be much more than financial. Admission should be reserved for those who were so unwell that no other response would appropriately meet their needs.

> *Most people who are admitted are very unwell, otherwise they wouldn't get there but wellness plans and prevention plans can avoid matters getting to that point. For some even a night in a luxury hotel would be more effective than an in-patient episode.*
> – NHS based service developer

Although LITs in different parts of the region are at differing points in the process all seem to be working toward the reduction of dependence on residential placements.

> *Even for those with quite complex or high needs we have gone for placing people in accommodation with intensive floating support. We sometimes have difficulty in getting health colleagues fully engaged with this.*
> – SP Lead, West Yorkshire

Extending the capacity and sophistication of the community based packages will allow people with more complex needs.

> *We need more intensive Floating Support alongside, for example, Assertive Outreach teams that will allow more than one visit a day and enable higher risk and more complex needs to be sustained in the community.*
> – SP Lead, West Yorkshire

A reduction in the proportion of people with Mental Health problems placed in residential care settings must be founded upon a changing culture among frontline staff.

> *We very rarely get recommendations for residential care now, staff understand that this is not our direction of travel, it's not what we want for our service users. Given that they are naturally risk averse it takes time to convince people that you really mean it and will support them through the exploration and implementation of other alternatives. The culture needs to be genuinely corporate to create the right climate for change.*
> – LD Commissioner

It is not only those carrying our assessments whose attitudes and assumptions need to change. Unless providers, for example, rise to the challenge of "re-inventing" their offer options will continue to be limited.

> *It takes a long time to change hearts and minds. Some traditional service providers are especially resistant to change.*
> – LD Commissioner

Service users and their families will find it difficult to visualise alternatives to the service patterns they know or to exercise choice when they have no clear concept of the options they are being offered.

> *We have invested in a range of literature and DVDs to try to open up to service users and their families the possibilities that we can explore with them. Giving them some insight into the positive experiences of others when they have embraced new opportunities through a DVD or a personal visit is extremely helpful in empowering them embrace new opportunities.*
> – LD Commissioner

The change in culture needs to be reinforced it with a filtering system that diverts those recommendations for residential care where ever possible.

> *We review all recommendations for residential care in the Resource Group (we only get a couple of serious residential care recommendations a month) and generally offer them a budget below the residential care costs they are proposing and challenge them to find a better solution within that financial constraint. The outcome is generally a more appropriate and more affordable solution.*
> – MH Commissioner, Care Trust

There is a need for discernment in considering the implementation of change as it impacts individuals. For many who are in "out of area" placements returning them to the funding authority which was, at one time, their usual place of residence would not be appropriate. In many cases the placement has been determined by the location of family members or others providing support and social connection. In other cases the individual may have spent the greater part of their life in the residential establishment in which they live and retains no connection to the area, other than the legal connection established at their original placement. These are not excuses for not exploring alternative arrangements but they are a legacy, not all of which can be addressed in the immediate term.

> *We try to avoid new out of area placements where we can. We have the capacity to support people through intensive support teams that we might formerly have placed in specialised settings outside our area. For the legacy cases you have to accept that uprooting people who we placed out of area possibly decades ago is not really on.*
> – MH & LD Lead, South Yorkshire

In all parts of the service there are anxieties about the future availability of appropriate housing and for the various elements of housing based packages.

> *Levels of funding are not certain: what is sure is that they will go down whilst need will continue to increase. The Ring fence has gone from Supporting People funding now that it is incorporated into Area Grant. The proposed changes to Housing benefit and to Disabled Living Allowance could cut the feet from under us.*
> – SP Lead, West Yorkshire

The move to GP commissioning provides a source of anxiety among many with a social care background who fear that a medical/treatment model will dominate and the housing related support models that have been the cornerstone of service improvements will be undervalued because they are not properly recognised.

> *We need to spell out the agenda for Mental Health and Housing before we move to GP commissioning because there is a real danger that the medical/treatment model will be dominant.*
> – NHS based service developer

2 WHAT WORKS
GOOD PRACTICE EXAMPLES FROM YORKSHIRE AND HUMBER REGION

Central to the process of this review has been the identification of good practice across the Yorkshire & Humber region. There are a number of examples of work that have been conducted or that are underway that demonstrate the impact that housing can have in relation to QIPP both in terms of quality and productivity.

LEEDS ACCOMMODATION PATHWAY PROJECT

This project was a collaboration between the PCT, Leeds Partnership NHS Foundation Trust, Leeds City Council and local housing support providers via a voluntary and community sector body, Volition.

The purpose of the project was to undertake a whole system review of the accommodation assessment process within acute inpatient care pathways in order to make recommendations for service improvement.

Service user feedback the key themes were:

- Practical support (finances, repairs, heating, etc).
- Someone to help me find accommodation/ do things on my behalf.
- To be asked how I feel about my accommodation / what support I need.
- Advice / clear information about options available.
- Finding the right help can be difficult when not well / in an unfamiliar situation.

In addition to this the feedback from the service users involved in the project was that they found it useful to have someone available in the ward with housing experience.

The project re-stated the consequences of delayed discharge from acute care:

- People remaining in hospital when they don't need to be there can have an impact on their social functioning and well being.
- Increased length of time service users have to wait for the therapeutic intervention or a local bed.
- Financial cost: Acute care costs £300 per day. Cost of delays due to housing needs in December 2008 = £27,900 and in January 2009 = £31,800.

The initial project recommended a redesigned pathway for access to housing related support to make it simpler and more efficient. One of the main aims of this project has been to reduce the number of delayed discharges from acute psychiatric wards due to waits for housing. The new pathway is based on earlier identification of housing needs by Leeds Partnership Foundation Trust staff, improved access to housing advice and support on the wards and the development of a single point of access for all the organisations who provide housing related support for people with mental health needs.[42]

In their update report in March, figures showed that there had been no delayed discharges related to housing for six months.[43] The average cost of an acute bed in Leeds is £315 per day – the impact of reduced delays on costs and productivity is clear, as are the benefits for service users. The impact of reducing delayed bed days can be seen more broadly on the

42 Accommodation Pathway Project Update Leeds Partnerships NHS FT, NHS Leeds, Leeds City Council, Volition March 2010
43 ibid

system overall. It is not just the bed saving itself (this only becomes a saving when beds are decommissioned), but more importantly it is about reducing the need to send people out of area for emergency admissions.

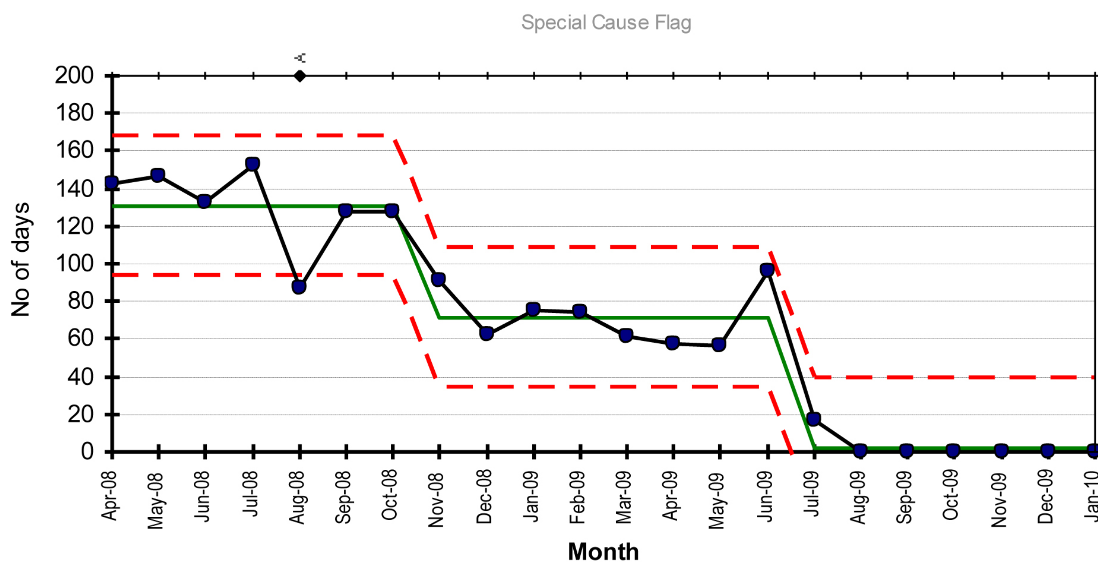
The evidence of the impact of the project so far includes:

- No placements in emergency accommodation in the six months to March 2010.
- Service users on acute wards have improved access to an increased range of housing options on discharge.
- Regular communication and review of capacity and demand across the whole system by housing services and mental health services has now established.
- No delayed discharges due to housing for the six months to March 2010

Table 17 provides the detail of the fall in delays in Leeds following the project implementation.

TABLE SEVENTEEN

NUMBER OF DELAYS DUE TO HOUSING (DELAY CODE 1)



KIRKLEES HOUSING STRATEGY AND DEVELOPMENT

A Home of my own - A guide to housing in Kirklees for people with learning disabilities

The pack contains information for people with learning disabilities and their carers about the different housing and support options available to them in Kirklees. Fact sheets give clear and comprehensive information on a range of options. The first sheet explains how services may be accessed and provides telephone and web contacts through which more information can be found or access initiated. There follow eight sheets dealing with specific options:

- Residential home
- Shared lives
- Supported living
- Renting a council house
- Renting from a housing association
- Renting from a private landlord
- Shared ownership or buying you own home

The Right Move

The Right Move is a DVD, produced by Kirklees Council, local Mencap in Kirklees and Kirklees Neighbourhood Housing to allow people with a learning disability and their carers to see what new options for accommodation and care look like, and to hear from those who have already made the move. This is a powerful tool in overcoming anxiety about embracing change and the use of local examples and local voices makes it the more convincing. This tool is equally applicable to presenting unfamiliar options to be people with Learning disabilities and people with mental health problems.

"A Place to Live"
Joint commissioning strategy for accommodation for adults who experience mental health problems in Kirklees; 2008-2009

A Place to Live reflects the joint strategic intentions of Kirklees Council and NHS Kirklees. After setting out the shared policy intentions of the two organisations the document gives an account of the outcome of consultation with those who use residential services and their providers before analysing current support solutions. Accommodation types and their relationship to levels of support are set out in diagrammatic form, annotated to indications of commissioning intentions aimed at increasing some service volumes. This is followed by more detailed information about current provision and future commissioning intentions, set out in tabular form. With a clear internal narrative from broad policy objective, through the articulation of user and provider views and analysis of current provision to future intentions this offers a simple, clear and accessible format.

Although there is no financial information in the strategy that identifies specific savings to health, however they are clearly the work done in Kirklees has been an important stimulus for system wide improvement and change that we can assume will lead improved efficiency and effectiveness.

These examples demonstrate the compelling arguments for the increased investment of housing and the reconfiguration of care pathways to include a stronger housing element. Although the early signs are that the economic evidence base is limited, a strong narrative exists for housing to feature strongly in QIPP, particularly when looking at out of area placements, the use of residential care and tackling delayed discharge.

Reducing "Out of Area" placements.

Work at both national and regional level has highlighted the excess cost to commissioners of out of area placements. Of the just over £3,000 million spent in 2009/2010 by health and social care commissioners on specialist mental health services approximately £692 million (23%) was spent on out of area services.[44] Annual costs for out of area placements vary significantly in the range £50,000 to £150,000 per annum. Given the diversity of circumstances and costs an averaged indicative saving per case would be misleading but the evidence is strong that commissioners will have greater control over costs with in-area, as opposed to out of area services and in the majority of cases will be able to achieve savings[45].

Example from Kirklees

Person A, a person with a learning disability – used to be placed in an out of area fully health funded specialist care home setting. A continuing care assessment was carried out and identified the funding should be 80% social 20% health the cost was £2,000 per week. Person A wanted to return to live in Kirklees near her family. A supported living service was commissioned in Kirklees at a cost of £689.06 per week, saving £1,310.94 split 80-20 between social and health.

Some informants had put considerable effort into reducing the use of out of area placements. What they told us was that this was a complex exercise that could not operate principally on the basis of comparative cost. Even authorities that had made substantial progress identified a small but significant remaining group for who alternative provision within their own local authority area might not be the most appropriate option:

1. Those who had been living in their current out of area location for a long-period of time, in some cases multiples of the time they lived "in area", where a move back to their own local authority would have a serious negative impact on their well-being.
2. Those who had been placed out of area because the alternative location was close to supportive family members and those links would not be maintained or replicated if they were placed back in their own local authority area.
3. Those for whom specialist provision was required and this was not available within the area.
4. Those whose safety, or the safety of the community, required that they be placed at a distance from their original location.

The advice offered by those who had put greatest effort into addressing the issues of out of area placement was that having reduced current use to those who met the criteria identified above effort was best applied to new cases. For a few the availability of supportive family members in another area of the country and not in their current location might still justify an out of area placement. The development and use of regional and sub-regional specialist provision would mitigate the third and fourth sets of conditions.

44 QIPP workstream analysis, quoted in "In Sight and in Mind – a toolkit to reduce the use of out of area mental health services" 2011
45 In relation to one service in a London Borough where local high level supported housing was substituted for out of area placements for people with complex mental health needs a saving was reported of £10,000 per year. "London Cyrenians Housing – Royal Borough of Kensington and Chelsea. *Forthcoming*

Expediting Hospital Discharge

The outcomes demonstrated in the Leeds Accommodation Pathway Project and service development work elsewhere within the region demonstrate that timely, safe and appropriate discharge from an in-patient episode is facilitated by a number of factors:

- The identification of a lead person to provide information and advice on housing options.
- Understanding between all professional stakeholders of the issues, options and portals involved in securing appropriate accommodation.
- Prior work to establish the pathways into alternative accommodation options.
- A sound strategic framework that sets out the shared values and operational principles of the organisations and professionals involved.
- The opportunity for issues of accommodation to be addressed at the earliest possible point in the episode of in-patient care. (Some would argue that the intervention should be made before the episode of in-patient care occurs. Certainly trying to pursue it within a few days of discharge limits the possibilities for successful outcome.)

We have sought to set out some key principles gleaned from the experience and good practice we identified in the "Tool kit" section, under the heading: Moving housing options "upstream".

The financial benefits of moving expeditiously to an appropriate housing setting when therapeutic activity that form part of the in-patient episode are complete are scaleable from the examples given in Section Five above: around £152 per day.[46]

46 Package involving hospital care = £79,015 per annum, package involving some one supported to live at home = £23,458; annual difference £55,557 ÷ 365 = £152.21p

SECTION THREE

1 WHAT DOES THE YORKSHIRE & HUMBER EXPERIENCE TELL US ABOUT NATIONAL AND LOCAL APPROACHES?

This report has already highlighted some of the approaches that organisations across the YHIP region are taking in respect of housing and its role in delivering more effective and efficient care for people with mental health problems and learning disabilities.

As we have identified, housing is recognised to be the central part of an effective recovery pathway. In addition, there are some clear arguments for the increased investment in housing and the reconfiguration of care pathways to include a stronger housing element. The experience in Leeds has demonstrated that the benefits of partnership working to develop clearer pathways can bring about economic and well as service benefits.

Nevertheless, the wider economic evidence base is limited, but a rationale does exist for housing to feature strongly in QIPP, particularly when looking at out of area placements, the use of residential care and tackling delayed discharge. A good deal of this has been demonstrated in recent years through innovation and demonstration projects. However, it has not transferred into mainstream practice.

One of the lessons for the NHS more broadly is that housing must be afforded a degree of importance and priority when considering changes and improvements to local services. A whole system approach that recognises the role housing can play is central to potential success in redesign, and should be a stronger factor in QIPP plans at both a national and local level.

The engagement of housing organisations has been shown to be of benefit across the Yorkshire and Humber region. Much of this has relied upon local relationships, built up over time and based on mutual trust and a willingness to support improvement. This suggests that at a national level, more could be done to work closely with housing organisations, including providers and representative bodies to consider how housing can be part of decision making, strategically as well as practically.

Discussions have already begun at national level to establish partnerships and we suggest that this work be focused on how housing can play a part in the delivery of care closer to home. This should be seen in the context of the measures described in the new mental health strategy that set out a focus on prevention and recovery.

Our work across Yorkshire and Humber has shown that although there are pockets of good practice they are hard to access, and tend to be focused in the metropolitan areas. The lesson of this nationally is that a one size fits all approach is unlikely to succeed and that developments and strategies need to reflect the diverse nature of the population and the localities that people live in.

From a more strategic perspective we suggest that the lessons learnt in the region are that there should be clear focus on a small number of key areas if housing is to play a full part in delivering QIPP and the associated benefits:

- **Leadership**
  - Make sure there is a clear sense of leadership around housing
  - Executive sign-up and endorsement is key
  - Good relationships built on trust
- **Information sharing**
  - Where good practice exists, share it more widely
  - Create networks for learning
  - Provide information
- **Using the right levers**
  - Mental health strategy
  - Health & Social Care Bill provisions – more dynamic market place
  - Freedoms for Foundation Trusts
  - Increased Engagement with housing organisations
- **Workforce**
  - There is a need for commissioning workforce that understands housing issues so that they can commission effective solutions
  - Capacity – are there enough people to make things happen
  - Are the right skills 'on the ground'? Social workers and health professionals need to understand housing and place it at the centre of care planning and review
- A clearer economic argument
  - Further work is needed to more clearly make the case for housing
  - Evidence remains largely anecdotal and needs to be more empirical

2 RECOMMENDATIONS

- Collaboration and integration of commissioning processes between housing, health and social care to deliver a more co-ordinated and sustained approach to housing and housing related support service development.
- Health, housing and social care need to form a robust triumvirate to ensure that the impact of changes delivered by QIPP do not 'shunt costs' across agencies
- To invest in solutions that ensure housing is part of a whole system approach to delivering a care pathway.
- The transition to GP led commissioning should be utilised as a lever for improved and sustained clinical engagement and leadership.
- To focus on the development of housing and housing support in localities where there are high levels of delayed discharge and inappropriate use of institutional care in order to deliver the twin goals of improved service and productivity.
- Engage housing commissioning colleagues fully and ensure synergy between local strategies for mental health, learning disability and housing.
- Use QIPP models to assist in the development of more specific data regarding costs in local areas that can drive improvement.
- Develop and implement a clear, coherent and agreed strategy for housing that has QIPP as a key component.
- Focus on the medium to long term and aim for sustainability. The drive for quick savings will most likely lead to short term changes to services that will impact negatively on quality and effectiveness. A more mature approach is needed that plans for the longer term and recognises that investment in housing now will have a positive impact on budgets and quality over a longer period.

3 HOW MIGHT THE FINDINGS AND RECOMMENDATIONS BE USED? A TOOLKIT FOR LOCAL HEALTH AND SOCIAL CARE COMMISSIONERS

This section contains some tools that reflect or prompt good practice. For some they will reflect what they already do and we hope they will see that as endorsement of their practice. Others may find prompts to expand or modify their current practice in considering the role of housing, housing strategy and commissioning in relation to mental health and learning disability.

TEMPLATE FOR A STRATEGY DOCUMENT

This template is offered as a combination of checklist and signpost to sources, it is not intended to be definitive and some may wish to change the order or to place some sections in appendices or within supporting documents.

	SECTION	COMMENTARY AND SOURCES
1	Purpose, audience and intended high level outcomes	Obviously specific to the individual strategy and to be drafted by the individual or group commissioning it.
2	Narrative of the process through which the need for the strategy has emerged.	Again this is likely to be drafted by the individual or group commissioning the strategy. It may be that the strategy responds to a change in policy, to the outcome of inspection or review, or some other circumstance and it is helpful to the reader to have this made clear.
3	Context in legislation, policy and guidance.	You may use and update the summary included in this report, or draft your own.
4	Context in corporate, departmental or other specific local policy or strategy.	It is helpful to set down in summary the corporate, high-level objectives, together with the more specific policies that are relevant to the strategy and to demonstrate the linkage between them.
5	Outcomes of local soundings taken to provide inputs to the strategy.	The outcome of interviews with stakeholders and formal or informal consultation with service users, carers and others.
6	Current and projected populations and epidemiology.	The Authority may have its own statistical data, alternative the data sets and sources set out in the Compendium which accompanies this report may be helpful.

7	Current demand and service volumes	This data will be available internally. You may consider a range of measures including Hospital Episode Statistics (HES) data, information on average length of stay, PROMS data when available, and from 2013, mental health PbR tarriff and currencies. Local authority Resource Allocation Systems (RAS) as well as RAG ratings for use of residential and nursing home care. CQC data may also be of help.
8	The current pattern of service	This provides the narrative to the data on service volumes set out in the previous section and may include judgements about the adequacy of current arrangements in the light of material contained in sections 3,4,5 and 6.
9	Future patterns and aspirations for service	This is a narrative section describing the outcomes the strategy intends to achieve in terms of service patterns for the future and the ways in which this will respond to the concerns identified in the preceding section.
10	Costs and funding	This section should set out the cost of current provision, the projected costs of continuing with the current pattern unchanged and the costs associated with a re-shaped service pattern. The savings or cost-containment achieved should be clearly quantified.
11	Impact on partner organisations.	This section should spell out the consequences for partner organisation, both commissioners and providers, of the proposed changes.
12	Outcomes of local soundings taken to evaluate the proposed changes.	Some will prefer, or be required by statute, to consult formally after the strategy has been published. Others will undertake consultation before finalising the document.
13	Implementation	Whilst a full implementation plan may form and appendix, or possibly follow as a subsequent piece of work, the Strategy should make clear who will carry forward the strategy, in outline what actions will be needed and what timeframe is proposed.

14	Summary or overview	This should be a brief statement summarises the consequences of the new strategy and of the evidence that supports it. The summary should particularly emphasise the benefits of proposed changes both in financial terms and in achieving better quality outcomes. Some may prefer to put this at the beginning of the document. In most cases this may also be produced as a stand-alone summary document for wider circulation than the full strategy documentation.

BALANCING THE RANGE OF PROVISION

It is a truism to say that a "one size fits all" approach cannot work in a situation where needs, constraints and personal circumstances are infinitely varied. So the dilemma for those planning and commissioning services is always "how much of what types of provision do we need and shall we need in the future?" Finding a route through the options and the variables can be very challenging and what happens is intended to offer a route to establishing solutions that will be appropriate in the context of local needs and circumstances.

What do we know about the categories of accommodation currently available?

- How many beds providing in-patient care and directed to which particular needs?
  - Acute adult in-patient
  - Rehabilitation services
  - Acute forensic beds
  - Low secure and step-down services
- How many places in therapeutic communities available to meet local needs?
  - How many units of "step down" or transitional accommodation?
  - How many units of specialist supported accommodation?
  - How many units of general housing occupied by people receiving a support service and in what tenures?

What do we know about the spatial distribution of this accommodation?

- Is the accommodation in areas that people want to live?
- Are there particular concerns about the location of individual units of accommodation?
- Are all areas of the patch adequately served?
- Have we avoided creating dependency ghettos?

What do we know about the quality of what is provided?

- Where accommodation is from a statutory provider (such as in-patient units) what is its standard? Are there plans to up-grade or re-provide?
- In housing based provision what standards are in place to ensure the quality of the accommodation?
- Are there any particular areas of concern?

Are the profiles of identified need and of provision congruent?

- Do current bed numbers, particularly in acute adult in-patient services provide sufficient capacity for the range of mental health needs faced by the local population? Does the profile of use indicate that housing, or lack of it, has been or continues to be a precipitant factor for admission, or a factor in delaying discharge. For those with learning disability, is there a sufficient range and number of appropriate placements.
- Have we clarified our thinking about the role of step-down and specialist accommodation? Do we have too much or too little of it?
- Do we have access to sufficient general housing to maximise our use of this form of accommodation?
- Do we have the right patterns of support available in sufficient volume to sustain these housing based solutions?

How can we ensure congruence?

- Have we quantified the need for accommodation?
- Do we have a strategy to increasing or reducing particular categories of provision?
- Do we understand what support providers may require to manage these changes?
- What mechanisms do we have in place to keep these matters under review?

IDENTIFYING THE STAKEHOLDERS

Emerging solutions to meeting the accommodation needs of people with a learning disability or with mental health issues, and meeting them in ways that link appropriately to responses to therapeutic, support and care needs, requires the engagement of individuals and organisation divided by many organisational and disciplinary boundaries. The list that follows is not comprehensive, and job titles and roles may vary locally but it may prompt the inclusion of a wider circle of people who may contribute to creative solutions and their delivery in a connected fashion.

STAKEHOLDER	LOCATION
Supporting People Lead	Local Authority
Housing Strategy Lead	Local Authority
Housing Advice Lead	Local Authority
Head of Provider Services for Supported Housing	Local Authority
Lead or Joint Commissioner LD Services	Local Authority
Lead or Joint Commissioner MH Services	NHS/Local Authority
Director of Adult Social Care	Local Authority
Regional Director of Public Health	Local Authority
Supported Housing specialist	Registered Provider (RSL)
Housing Related Support providers	Registered Provider / Charitable Organisation
Service User Advocates bodies	Advocacy organisations / specialist charitable
Service Users forums / advocacy organisations	Purpose created consultative bodies / user

MOVING HOUSING OPTIONS AND INTERVENTIONS "UPSTREAM"

Experience demonstrates that the best outcomes in placing people in appropriate and sustainable accommodation arise when the exploration of options and exercise of access to them happens well ahead of crucial points of transfer. In the past people with mental health issues have sometimes been discharged from in-patient care with no long-term accommodation arrangements in place, or these have been explored only at the point of discharge. People with learning disabilities who have lived in the parental home and face re-location when that arrangement breaks down, often in traumatic circumstances such as the death or illness of a parent-carer, may have had no previous conversation about alternative options for accommodation. Innovative service developments have shown that introducing the options at an earlier stage brings a range of benefits to commissioners, providers and service users. What follows is simply a set of questions for an interdisciplinary group to explore together the current pattern of service, the resources available to them, and the opportunities for moving "upstream".

- When are housing options currently explored with service users?
- Who is responsible for identifying the options and exploring them with service users and carers?
- Do we need to create a network of those involved in supporting people with mental health issues or with learning disabilities and those engaged in commissioning, providing and allocating housing and in providing housing related support?
- If a network already exists does it engage all the key players?
- Are the objectives of the network clearly stated and understood?
- Have we identified the most appropriate person or agency to provide advice on housing options?
- Are those involved in planning discharge from in-patient care aware of the options and constraints and are they able to engage the best advisors to work with patients in a timely way?
- Do we have a single point of entry and a clear pathway through which people with mental health issues or with learning disabilities may access appropriate housing, and housing related support services?
- How do we integrate the provision of housing advice into care plans so that there is an opportunity for appropriate accommodation and housing related support can play a part in avoiding episodes of in-patient care, residential or emergency placements?
- What information and training needs are there for the various professionals and agencies involved so that all understand the range of available housing options and the routes to accessing them?

IDENTIFYING THREATS TO GOOD PRACTICE

Those seeking to develop or sustain good practice in the provision of housing based solutions to the accommodation needs of those with mental health issues or learning disabilities face a number of challenges. Changes in funding patterns and levels, and proposed changes in legislation and eligibility rules may make the continuation of some good and innovative practice unsustainable.

Whilst we are confident that these are unintended consequences they offer a serious threat to the capacity of commissioners and providers to deliver the outcomes that guidance and broader policy intentions indicate are desirable.

We have thought it important to identify these so that those directly engaged in commissioning and delivering services may engage with professional colleagues and elected members to mitigate the negative impact of changes.

	CONCERN	POSSIBLE CONSEQUENCE
1	Removal of ring-fence on Supporting People funding	Under current financial pressures funding for housing related support services, crucial to delivering housing based solutions for people with mental health issues and people with learning disabilities, may fall below the levels required to maintain services.
2	Withdrawal of Disabled Living Allowance	There is a presumption that people receiving benefit will return to the waged economy. Many people with long-term mental health issues or a learning disability find themselves disadvantaged in the labour market and may find it difficult to meet the expectations of the new benefit models.
3	Reduction in levels of Housing Benefit.	The danger that people with mental health issues will be compelled to accept lower quality accommodation, or accommodation in less favoured areas, will have a direct and negative impact on their well-being and increase the probability of further episodes of ill-health requiring in-patient care or other intensive interventions.
4	Raising of the threshold of entitlement for single persons to individual accommodation from 26 to 36 years of age.	Many people with a history of mental health issues, or with a learning disability, who have been settled in independent accommodation will be forced to move back to a shared accommodation setting.

5	Proposed changes to Attendance Allowance	For many people the financial viability of their package of care and support has rested on their ability to deploy their Attendance Allowance alongside other benefits. There is general anxiety that the proposed changes to Attendance Allowance and Disabled Living Allowance will squeeze the resources available, especially for less favoured groups.
6	Move to GP led commissioning of health services.	It is likely that there will be less consistency in the commissioning of community based services required to adequately support people with mental health issues or learning disabilities living in independent accommodation.

This report provides a basis for sharing the available evidence about the impact housing can have in relation to QIPP, both locally and nationally. It may act as a stimulus for action on housing and QIPP by commissioners, both in PCTs, local authorities and emerging consortia, as well as for providers of mental health and learning disability services.

It should provide a locally relevant evidence base that can be drawn upon to inform future strategy and development. This may be used to promote the impact housing can have on service user outcomes as well as productivity.

It helps health commissioners and providers to view more clearly the role that housing can play in enabling a more effective care pathway, and how investment in housing and housing related support and solutions can be of benefit to the health system in terms of productivity.

This regional project will also link to national work that is examining commissioning of housing and housing related support in mental health being conducted by the National Mental Health Development Unit.

National Mental Health
Development Unit

Written by Steve and Nigel Appleton of Contact Consulting.
A specialist consultancy and research practice working at the intersection of health, housing and social care.

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

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