National Mental Health
Development Unit

Mental Health and Housing: Resources for Commissioners and Providers

Mental Health and Housing
Improving outcomes, integrating lives

Briefing

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"Traditionally someone's housing has been something we've looked at when they are ready to be discharged. We need to be looking at their housing options from the outset"
– NHS Mental Heath Foundation Trust

INTRODUCTION

In October 2010 the National Mental Health Development Unit commissioned a series of papers to define the new relationships needed between NHS organisations and providers of housing and housing-related support, to ensure that housing is cemented in the new NHS. This was founded on the belief that improved recovery outcomes can be delivered through housing and housing related services being seen as an essential part of the care pathway. If housing and housing-related support services are given their proper consideration throughout a patient's pathway to recovery then a more therapeutic pathway could be delivered, at lower cost and delivering improved outcomes for the patient. The particular issues for this piece of work to consider were:

- What is the contribution that housing services can play in delivering improved outcomes at lower cost?
- What are the opportunities created by the forthcoming re-organisation to commissioning that is set out in the Health and Social Care Bill ?
- Is it possible to articulate the processes and behaviours that will best encourage and enable provider innovation?
- How can we best move from there being a number of good practice examples to this being embedded in mainstream practice?

Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability[1]. Nearly 11% of England's annual secondary care health budget is spent on mental health[2]. Detailed estimates in 2003 put the costs of mental health problems in England at £77 billion, including costs of lost productivity and the wider impacts on wellbeing[3]. More recent estimates suggest that the costs may now be closer to £105 billion, of which around £30 billion is work related[4]. Sickness absence due to mental health conditions costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity[5]. The Coalition Government's new mental health strategy[6] sets out six objectives to improve the mental health and well-being of the population and to improve outcomes for people with mental health conditions. It supports the government's aim of achieving parity of esteem between physical and mental health and emphasises the interconnections between mental health, housing, employment, and the criminal justice system.

Housing and housing related support can improve health and reduce demand for health and social care services and enable the full benefits of other services to be realised[7]. However, a distinction needs to be made between those situations where improvements in health provide a case for increased Government investment in housing and those situations where there is

1 Who (2008) The Global Burden of Disease: 2004 update, available at: www.who.int/healthinfo/ global_burden_disease
2 Department of Health (2009) Departmental Report 2009: The Health and Personal Social Services Programmes, available at: www.official-documents.gov.uk/document/cm75/7593/7593.pdf
3 Sainsbury Centre for Mental health (2003) The Economic and Social Costs of Mental Illness. Policy paper 3, available at: www.centreformentalhealth.org.uk/pdfs/costs_of_mental_illness_ policy_paper_3.pdf
4 Centre for Mental health (2010) The Economic and Social Costs of Mental Health Problems in 2009/10, available at: www.centreformentalhealth.org.uk/pdfs/Economic_and_social_ costs_2010.pdf
5 Sainsbury Centre for Mental health (2007) Mental health at work. developing the business case, available at: http://www.scmh.org.uk/publications/publications_list.aspx?sortId=e
6 DH (2011) No Health Without Mental Health : a cross-government mental health outcomes strategy for people of all ages. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf
7 Bolton J (2009) The Use of Resources in Adult Social Care : A Guide for Local Authorities. DH : London.

a case for health commissioners to invest health resources in housing and housing related services. If housing organisations are to attract increased investment from health they will need to develop a case for how they can improve outcomes and reduce costs in health and social care to attract health funding to achieve it.

In mental health this has meant a focus on four areas:-

i) risk reduction;
ii) reducing demand for institutional care;
iii) earlier discharge;
iv) ending of out-of-borough placements.

There are a number of good examples of how housing services have contributed to improved outcomes at lower cost by preventing acute admission and promoting early discharge.

Housing is recognised to be the central part of an effective recovery pathway. In addition, there are some compelling arguments for increased investment in housing and the reconfiguration of care pathways to include a stronger housing element. Although the economic evidence base is limited, a strong argument 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. Much of this has been demonstrated in recent years through innovation and demonstration projects. However, it has not transferred into mainstream practice. How to change this is the key purpose of this report.

THE CASE FOR CHANGE

2011 promises to be a challenging year for people with mental health conditions and those who provide services to them. The Coalition Government is proceeding with its reform agenda, reductions in public funding will begin to work their way through the system and the shift to a smaller state and the "Big Society" will create renewed pressure to respond differently to provision of services at the interface between health, social care and housing. In this section of the paper we summarise the context in which the delivery of improved outcomes for health and social care will be set.

CHANGING NEEDS

For most people, the reality of a recession will be a complex inter-relationship between falling property prices, rising costs and the burden of personal debt. Those on low incomes who, under normal circumstances would expect to 'get by', may be at risk as their circumstances change. As people are forced to economise and reduce their outgoings, many find they have little choice but to spend less on the fundamentals of food and heating and debt may become an issue as they struggle to cope.

This is particularly true for those with mental health conditions. People already with mental health conditions are particularly vulnerable to becoming trapped in a cycle of debt or poverty. Others may experience mental illness as they find themselves under increased pressure and stress. This may come as a result of loss of employment or reductions in benefit. So, we can expect to see increased demand for services at a time when there is likely to be fewer resources.

The Joint Strategic Needs Assessment (JSNA) is a key vehicle for ensuring that changing needs are captured within local plans. It will also be a key part of any decision making by the health and well-being Boards and for, potentially, accelerating the pace of integration, delivering better outcomes and promoting joint working. The NHS will need to be engaged with local authority planning of specialist housing investment. However, there will need to be considerable creativity to ensure that best use is made of existing buildings and that new ways of maximizing return on the land that is held to deliver sustainable revenue streams.

FINANCIAL CHALLENGE

The Coalition Government has undertaken to maintain NHS funding at £114bn in 2014-2015. However, it is important to place this undertaking in context. Real increases in funding of up to 2% per year for the NHS, much lower than those experienced in recent years, might cover the implications of demographic change but not the increased costs of new technologies and pharmaceuticals[8]. To meet this challenge, the NHS has been charged with finding £20bn of efficiency savings. At the same time there is an anticipated 28% reduction in the levels of funding to Adult Social Care.

To achieve this the NHS has adopted an approach to implementing quality innovation, productivity and prevention or QIPP. A recent briefing showed how there are wide variations in bed usage in mental health. If QIPP is to be embedded in mental health then radical service redesign will be required[9]. Only by capitalising on examples of good practice, such as those provided by housing related support providers, can the NHS hope to achieve the necessary savings whilst continuing to deliver improvements in service quality. In mental health, No Health Without Mental Health[10] emphasises the importance of prevention, patient

8 Appleby J et al (2009) *How Cold Will It Be? Prospects for NHS Funding 2011 – 2017* Kings' Fund : London
9 Cotton R (2011) Efficiency in Mental Health Services : Supporting Improvements in the Mental Health Acute Care Pathway. NHS Confederation / NMHDU / Audit Commission.
10 DH (2011) No Health Without Mental Health : a cross-government mental health outcomes strategy for people of all ages. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

empowerment and quality. Moving forward housing services will have a key role to play in delivering QIPP.

In the past there has been a tendency for financial pressures to lead to cost-shunting – whether intended or unintended. Hopefully, the scale of the anticipated cost reductions will allow new forms of cooperation. Given the condition of public finances any enhancement in quality of service will need to be delivered with fewer resources. The challenge facing the NHS requires a transformation in the way healthcare services are delivered and, particularly the need for health to work with adult social care to prevent demand for institutional services. Certainly, the downturn provides an impetus within the system to ensure that there is consistent implementation of existing best practice, the early adoption of innovation, the consistent implementation of known productivity improvements and a more mutual relationship with the consumer to help them to make good choices about their own health.

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

> *"The financial pressure that is being felt by all parties – especially the users – creates a willingness to create new solutions and new approaches"*
> – Mental Health Commissioner

SYSTEM CHANGE

"Equity and Excellence : Liberating the NHS" sets out a major reform programme for the NHS. The abolition of SHAs and PCTs and the creation of a Commissioning Board for England, Public Health England, Health and Well-being Boards (HWB) and GP-led Commissioning Consortia (GPCC) signal a major change in the architecture of the NHS. The current performance regime will be replaced by separate frameworks for the NHS, public health and social care. The new framework will include i) the effectiveness of the treatment and care provided to patients – measured by both clinical outcomes and patient reported outcomes. Ii) the safety of the treatment and care provided to patients, and iii) the broader experience patients have of the treatment and care they receive. Progress on outcomes will be supported by quality standards that set out the each part of the patient pathway and indicators for each step.

Public Health will transfer to Local Authorities. Local Authorities will set up new Health & Well being Boards that will join up the commissioning of local NHS services, social care and health improvement. These HWBs will promote integration and partnership working between the NHS, social care, public health, housing support and other local services and strategies; leading the Joint Strategic Needs Assessment and support joint commissioning arrangements as well as building partnerships for service change.

In the past there has been a tendency to insert mental health services into a pattern of commissioning, procurement and delivery that has been designed with the needs of those

with physical health problems primarily in mind. This means that mental health often ends up being "retro-fitted". Under GP fund-holding in the 1990s the commonest service purchased by practices was in-practice counselling. Counselling was seen as an essential service and many practices also purchased access to talking therapies. This has left a pattern of service that is very variable. Practice Based Commissioning (PBC), the current GP led commissioning programme, is led by many of the champions of fund-holding. However, most of their focus has been on acute services for physical rather than mental health.

Given the current position relating to the implementation of evidence-based interventions, the link with long term conditions, and dissatisfaction with current services make commissioning of services for people with common mental health conditions a likely area for GP led commissioning – including community mental health teams. However, there is a sense that the commissioning of services for people with a serious or enduring mental illness is likely to sit along side the commissioning of acute services for people with physical illnesses.

The commissioning of early onset services, crisis intervention teams, assertive outreach teams and forensic services and community mental health teams are usually jointly commissioned with local authorities. We will have to see if commissioning these services appeals to GP led Commissioning Consortia. This will partly be a factor of the geographical areas that consortia cover. The Secretary of State has not specified a size. However, there seems to be an assumption emerging that they will need to serve a population of about 300,000 people. As such this is likely to be larger that the area covered by specialist mental health services. However, this must remain as speculation for the moment.

MOVING FROM NATIONAL TO LOCAL TO PERSONAL – THE BIG SOCIETY

Much of the integration between health and housing has come about as a result of central policy directives, central funding mechanisms or top-down targets[11]. The Department of Health has said that the current reforms are "designed to turn government on its head, taking power away from Whitehall and putting it into the hands of people and communities…. people themselves will have the power to improve our country and services, through the mechanisms of local democratic accountability, competition, choice and social action"[12]. In order to achieve this a bigger role is envisaged for voluntary groups, social enterprises and co-operatives. We are already seeing the ways in which voluntary sector services, including providers of housing care and support, can create new approaches to integration at a local level and contribute to the desire to devolve power and resources, promote local action and develop new community delivery organisations.

Mental health services are increasingly focused on supporting each person's potential for recovery. Recovery is seen within this model as a personal journey that is likely to involve a secure base, supportive relationships, social inclusion and access to training or employment. This fits well with the increasing emphasis in policy on personalisation. Personalisation is about giving people more choice and control over their lives and to take control of how they want to live and the help they need to do so. Housing is generally recognized to be a central part of an effective recovery pathway. Users will often prefer a service provided by a social housing provider and the support they get to navigate the system and to plan the pathway in the way that has most meaning for them[13].

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11 Humphries R and Curry N (2011) Integrating Health and Social Care Where Next ? King's Fund : London (forthcoming)
12 DH (2010) Structural Reform Plan. London : DH
13 Appleton N and Molyneux P (2009) The Impact of Choice Based Lettings on the Access of Vulnerable Adults to Social Housing. Housing LIN : London

> *"We are all going to have to do more for ourselves and for each other. If we feel we are in an honest dialogue we can be part of any cost reduction"*
> – Mental Health Service User

CONCLUSION

The environment in which people with mental health conditions are living is challenging and is likely to become more so - if the recovery model implies the ability to access housing, training and employment and the opportunity to reduce social inclusion then, arguably, all of these things are going to be harder to achieve. The pressure on resources across public services creates a renewed opportunity for cooperation and new models of care and support. Housing and housing-related support providers are well-placed to support commissioners and NHS mental health providers to deliver better outcomes at lower cost. In the next section we will look in more detail at how this might work.

HOW HOUSING AND HOUSING-RELATED SUPPORT CAN HELP

In mental health the challenge is to keep the person concerned at the heart of a seamless system of treatment, care and support. This might include i) support for them to manage their own health, ii) an easily navigable pathway, iii) their own experience and the achievement of outcomes that are meaningful to them and iv) some ability to design their own packages of care and support. Above all any integration must deliver improved outcomes for the individual and not simply deliver organisational, professional or budgetary boundaries. In this section we will look at what needs to happen and raise some questions for further discussion.

SYSTEM CHANGE

Some have argued that the Government's proposals propose a new settlement between the NHS and local government. The new Health and Well-being Boards could be vehicles for more integrated commissioning. They will also have a responsibility to promote joined-up commissioning of services across health, social care and health improvement[14]. This is further enforced by the expectation set out on the face of the Bill that consortia will work with patients and the public to secure more patient-centred and integrated delivery of care.

GPCC will not have the budgets to replicate the commissioning structures of PCTs. It is to be hoped that they will move to outcomes-based commissioning and will seek to purchase services from groups of providers who have come together to provide an integrated approach to the delivery of the desired outcomes. The Mental health pathway is acknowledged to be an area where patients are actively involved in the development and delivery of services. They have been at the forefront of multi-disciplinary working and in integrating care between secondary and community services. The development of care clusters and the introduction of tariffs provides the opportunity to provide financial incentives that further drive innovation and the seamless delivery of care.

A key tool for commissioning of housing and mental health could be HoNOS PbR. This combines Health of the Nation Outcome Scores with payment by results. Against each of the care clusters we can establish a package of care for a range of patient types, with established sets of need (HoNOS). We can show the contribution that housing and housing-related support services can make to each cluster and then build the provision of the housing need into the specification of services for the target group, together with a cost (PbR).

NHS Foundation Trusts have considerable freedoms when it comes to owning property and sub-contracting to third parties. Up until now their appetite for doing either has been decidedly variable. Certainly many are looking to expand their property portfolios (especially in London) and to own assets that can be used to deliver a revenue stream. They are also looking to develop their own control of the care pathway by forming new relationships with primary care, with community organisations and voluntary sector providers. It is also being widely speculated that they will soon get the power to commission services themselves. This will establish them as key players in creating choice for patients and reducing the cost of an episode of care.

Housing providers and housing related support services have a key role to play in creating new forms of service. There are already examples across the country where housing organisations have formed a supply chain with an FT to deliver a pathway in the community. There are also examples of commissioners contracting with a housing association who sub-contract to an acute mental health provider. Whatever the model of commissioning they can make a significant contribution to a "supply chain" that fully meets the needs of the individual

14 DH / CLG (2010) Liberating the NHS: Local Democratic Legitimacy in Health – a Consultation on Proposals. London : DH.

and delivers better outcome at lower cost – particularly with their experience of assessing community based risk rather than clinical risk.

This also has the advantage that many service users see a move out of statutory care as progress and no matter how good an NHS trust is at delivering services in the community they often hold associations for people of when they were at their most unwell. There is also a perception among users that, although many Trusts have moved on from diagnose and treat, that recovery is the primary function of a third sector provider. In addition housing providers and providers of housing-related support can lever in resources from a range of sources and, sometimes, there unit costs are lower.

FINANCIAL CHALLENGES

There will need to be ways of ensuring that current joint commissioning arrangements can continue. If only to ensure that the current reductions in demand for institutional care that flow from investment in primary care continue. Certainly, consortia and local authorities will want to align their resources to ensure that there is no cost-shunting and that they are both making the best use of their joint resources. As Elinor Ostrom demonstrated in Common Pooled Resources, all parties have everything to gain from cooperating and everything to lose from competing[15]. Certainly, if NHS organisations do not work in partnership with local authorities to examine ways of improving the use of resources in the round, then it will be increasingly difficult to give priority to new models of care that rely less on hospitals and more on caring for people at home and in community settings[16].

As we have said, personalisation is about giving people much more choice and control over their lives. It goes well beyond giving personal budgets for people to buy in their own care and support, or providing funding to purchase specific health care services. This will require 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. It requires commissioners to completely reshape their approach to both the commissioning and delivery of care services.

Given the focus on QIPP, this will include an emphasis on reducing overall spend through increased productivity, and to shift investment into initiatives that will prevent the demand for acute and specialist hospital services. This will require the backing of clinicians in the development of new pathways and especially their willingness to see housing services as a suitable way of managing clinical risk with a view to reducing admissions, average lengths of stay, the numbers of people needing to access 'out of area' placements or forensic mental health services.

> "If we don't plan strategically then the only option will be out of area treatments. Any change in the pathway will need to be supported by a coherent estates strategy" – Mental Health Provider.

15 Ostrom E et al (2010) Social Capital : Conceptual Explorations. Indiana University Press.
16 Appleby J (2010) Improving NHS Productivity : More With the Same Not More of the Same. King's Fund : London.

MOVING FROM NATIONAL TO LOCAL

It is important not to assume that organisational reorganisation is the optimal way of achieving integrated care for patients[17]. Relationships and trust are key to the successful integration of services. Innovation is often said to be the result of personal chemistry between a particular group of individuals. However, trust can be built if a project is given the time for it to be built[18]. In areas where housing organisations are working with clinicians to reduce beds, out of area treatments and reduce the use of residential care it has happened through the development of a shared understanding of the wishes of service users, the models of service available, a willingness to look strategically at the desired outcome and to transfer budgets to providers with appropriate incentives for delivery.

This implies a key role for the health and well-being boards as the place at a local level where clinicians, politicians and social care can come together as leaders of local innovation and integration and develop links across to those responsible for investment in supported housing, training and employment and leisure. As GPs take on commissioning they will demand new relationships and a new set of skills. They will recognise that many of the outcomes that they, and patients, want to see will be easier to achieve if there are integrated arrangements across health and housing and housing related support. The development of policy along permissive rather than prescriptive lines allow for successful integration through local vision, local leadership and local commitment[19].

> *"Some local authorities and in mental health trusts still don't understand what housing support services can do. Whereas, in other areas they have reduced beds and ended the use of residential care"*
> – Mental Health Commissioner

CONCLUSION

Housing services have a key role to play in the delivery of the QIPP agenda. For each cluster there is a housing related intervention that can help deliver better outcomes at lower cost. Some areas have no out of area placements and make no use of residential care. However, this is not the case everywhere. PCTs and GP led Commissioning Consortia need to look strategically at how they deliver services in the community and specify contract outcomes in a way that can only be delivered in partnership.

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17 Lewis R et al (2010) Where Next for Integrated Care Organisations in the English NHS ? Nuffield Trust : London
18 Ramsay A, Fulop N (2008) The Evidence Base for Integrated Care. DH : London
19 Humphries R (2011) Integrating Health and Social Care What Next ? King's Fund : London

MOVING FORWARD

As we previously discussed, the downturn creates a renewed imperative to deliver improved outcomes and to ensure that increasingly scare resources are allocated in a way that makes most sense to users and patients. In this section we will look at how housing-based interventions could achieve this and then how commissioners and providers of service can create a system where the opportunities to create a community based pathway to recovery are maximized.

MANAGING DEMAND

There are primarily four areas where effort could be usefully focused :

- i) risk reduction;
- ii) reducing demand for institutional care;
- iii) earlier discharge;
- v) ending of out-of-borough placements.

RISK REDUCTION

Using predictive analyses to identify high risk patients who are risk of an acute admission is well established in primary care. It has been suggested that the data coming from IAPT starts to provide the evidence base for such predictive risk reduction in mental health. The NMHDU has suggested that many IAPT teams are already addressing the links between long term conditions and psychological distress. However the same level of awareness is not present amongst physical health commissioners and GP led commissioning groups. Local authorities and the third sector could help to develop capacity here.

REDUCING DEMAND FOR INSTITUTIONAL CARE

The acute care pathway describes the journey that the client makes from initial referral to discharge from acute services. Housing Associations have been involved in reducing demand for institutional care through the provision of psychological therapies - through the Improving Access to Psychological Therapies Programme (IAPT) or by offering early intervention and crisis diversion services – especially with those who are new to the mental health system. These services have tended to be provided in partnership with mental health providers either as part of their block contract or through a commission from the Primary Care Trust. Modelling by the National audit Office suggests that up to £50m could be saved annually by improving the use of crisis intervention services.

EARLIER DISCHARGE

Inevitably, some patients will need a period in hospital. The integration of housing options with discharge planning is critical if delayed discharges are to be avoided. Some clinicians are nervous about community based care given the risks involved. There are a number of good examples of where housing and housing related support organisations have provided step down accommodation. Whilst these services will often be directly commissioned by PCTs from housing associations they will also be offered in partnership with mental health trusts. Certainly, where they are there is evidence that clinicians concerns about risks are easier to manage.

ENDING OUT OF BOROUGH PLACEMENTS

Unless PCTs or GP Led Commissioners take a strategic approach to discharge then all too often the choice will be to place people out of area. There is a need for health and social care commissioners to understand that there are other models available and to plan the supply chain appropriately. Where they commission for the right outcomes they will be able to encourage mental health providers to do this themselves. There are significant savings to be made from repatriating people to housing based services in the local area .

It will be important to ensure that the pathway to recovery that delivers the outcomes that users are looking for and offers a degree of choice. Broadly speaking it needs to be safe, offer a positive experience, be delivered in the home or close to home and offer a route to training and employment. Against each of the clusters it is possible to identify a range of community based interventions that reflect service users aspirations. These then need to be procured in way that specifies the required outcomes in a way that specifies the desired outcomes and that can only be delivered in partnership.

INTEGRATING THE PATHWAY

Outcomes will need to be developed at a local level that reflect the lived experience of service users and the contribution of the whole system to delivering them. Using some of the thinking and methodology that influenced the Total Place pilots there is an opportunity to work with users, carers, clinicians, practitioners and the wider public to engage in a debate and discussion about priorities and where best to achieve the necessary productivity gains. This provides the opportunity of doing things differently through i) prevention, ii) early intervention, iii) re-profiling care pathways to improve routes to recovery and iv) personalisation.

Commissioners will need to take a strategic approach to the procurement of services and the availability of housing over the medium term if out of area treatment is to be avoided. Under the system set out the Health White Paper, Health and Well-Being Boards could take responsibility for ensuring that the JSNA is reflecting need in the right way, that this is translated into plans and then aligning together health, social care and housing investment.

Inventive joint working is needed between the public and private sectors to support capital input to reprovision and refurbishment. Housing organisations will be well placed to offer health care organisations new ways of using their existing estate to i) deliver the facilities that local residents require; ii) delivers change through a social enterprise driven long term investment model; iii) creates a public asset that strengthens the balance sheet and contributes to deficit reduction; and iv) delivers a model that uses the public estate in both a more commercial and creative way. Some FTs will be open to providing capital and to developing accommodation themselves. Most will want to retain ownership of the asset – although some may be open to other forms of joint venture given that they pay capital charges on any assets that they do hold.

> *"GPs will want to influence the design and then commission the whole of the care pathway"*
> – GP Commissioning Pathfinder Chair

Much of the focus at present has been on the changes to the commissioning landscape through the creation of GP Led Commissioning Consortia, Health and Well Being Boards and Public Health England. Certainly, as we have said in this report, they are to be encouraged to move more towards outcome based commissioning and to transferring responsibility for budgets to providers. However, there is also going to be a change to the provider landscape as providers seek to develop supply chains to deliver these outcomes.

One approach to this has been the development of integrated care pilots (ICPs). ICPs are intended to encourage primary care and other clinicians to take responsibility for designing, delivering and, ultimately, for managing the budget for integrated clinical services. They may take many forms including:

i) networks of provider organisations operating under a single integrated budget ,

ii) organisational mergers ('real' integration) to bring together different care sectors (e.g. acute trust ownership of GP services)

iii) integrated commissioner–provider pilots that combine the commissioning of care for a designated population with the provision of some or all of these services.

This latter form of ICP, with its implied redefinition of the 'commissioner–provider' split makes ICPs a potentially important innovation in the organisation of health service planning and delivery.

The care workforce has become increasingly fragmented with a growth in specialisation and professionalisation. Care provision is also fragmented between formal and informal provision – home, private care settings and state provision. This requires a complex web of formal and informal knowledge and skills to be mobilised in support of care for individuals as they move along a pathway or through different stages of health and well-being. Changes in health and social care, signalled by the Localism Bill, may at least in the short-term increase the fragmentation of both provision and skills development. So a model is needed that focuses skills where they can be most effective and does so as coherently as possible.

In mental health there is no longer any particular imperative to have a large number of community teams such as early intervention teams, admission avoidance teams, assertive outreach teams, rapid discharge teams or community mental health teams. Many of these staff could be redeployed in in-patient settings as a replacement for agency and bank staff. Active consideration is being given as to whether community maintenance could be done in primary care with rapid access to acute services. This argues for a new approach to workforce that i) has fewer professional demarcations and ii) that sees a more mutual relationship between the user and the carer.

> *"It's not helpful to talk about developing health services or social services. It's about developing community services."*
> – Director of Adult Social Care

CONCLUSION

Hopefully, national outcome measures will reflect what service users are looking for in terms of somewhere that feels safe, offers a positive therapeutic experience, an element of choice, care closer to home together with a pathway to training and employment. Contracts need to specify outcomes in a way that can only be delivered in partnerships between mental health providers and community based services. There are opportunities for GP Led Commissioning Consortia to think strategically about how they repatriate people or prevent them being referred out of area. Health and Well-being Boards have a key role to play in bridging the gap between NHS expenditure in mental health and investment in supported housing services.

The Mental Health Strategy can only be delivered if there is a new relationship with housing. Mental Health FTs could work with their clinical teams and redesign pathways with housing providers. The times offer a real opportunity to deliver the levels of integration that have often been discussed but patchily implemented on the ground. The challenge will be to develop a compelling narrative and to enable providers to innovate. This will involve commissioners taking a strategic approach to the delivery of outcomes. FTs will need to recognize the strengths of different professional groups and manage the risks inherent in taking responsibility for the whole supply chain. That way we can meet the expectations of users to support them on their journey to recovery whilst managing the financial pressures.

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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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