INTEGRATION THAT WORKS
An evaluation of Tile House
Tile House evaluation

October 2014
by Amy Crocker

Delivered in partnership with the London Borough of Camden and the Camden and Islington NHS Foundation Trust

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1. Forewords and acknowledgements

The Care Support Plus model at Tile House is a game changer. The model demonstrates how modern integrated housing can replace a quarter of NHS inpatient beds to the real benefit of customer recovery.

Our strategic partnership with the Camden and Islington NHS Foundation Trust, combined with our attractive, specially designed building has allowed the implementation of the Care Support Plus model to raise the bar in supported housing provision for people with complex mental health problems.

This report outlines how the model delivers significant efficiencies to the NHS and adult social care while producing notable life changing outcomes for customers. As an expression of the impact of health and housing, Tile House has renewed aspiration within our customers and enabled them to begin building independent and meaningful lives for themselves despite complex mental ill health. The model creates a parity of esteem which has never before been realised.

This is a success that we intend to build upon. Our new corporate plan commits the resources to develop a programme to support the progress of the Care Support Plus model into the future.

Kevin Beirne,
Group Director One Housing Group
The Care Support Plus model shows how the NHS can embrace opportunities to work with high quality housing associations to transform care pathways to the benefit of our patients.

Our pioneering partnership with One Housing Group coupled with high quality clinical assurance at Tile House has enabled us to provide genuine alternatives to hospital and out-of-borough placements for patients. The benefits to the Trust and to patients with the most complex needs and highest risks are clear.

We are proud to have pioneered an approach that so effectively delivers our values of a positive and dignified recovery journey for our patients. The success of Tile House means we are committed to making the most of further opportunities to work with talented RSLs to deliver the very best outcomes for our patients across London.

Wendy Wallace

Chief Executive of Camden and Islington NHS Foundation Trust
I am proud of Camden Council’s involvement in, and support of, Tile House, and I’m pleased to have the opportunity to contribute to this report via this foreword.

The results from the review are encouraging. The service is contributing to the achievement of one the Council’s most challenging ambitions, helping to make Camden a place where everyone has a chance to succeed and nobody is left behind. Tile House is tackling long-term inequality and making a real and lasting difference to lives by providing some of the borough’s most excluded residents with access to high-quality local accommodation that is supporting people’s recovery journey.

It is a fantastic initiative. Central to the success of the service is the partnership approach from One Housing Group and Camden and Islington NHS Foundation Trust; they are refining how health, housing and support providers work together by breaking down organisational barriers. Working in this way is ensuring tenants are able get the right support, at the right time, in the right place. The results from this are described in the report. It is helping people with severe and enduring mental ill health and particularly complex needs to live as independently as possible, lead more active and healthy lives, have more choice and control over their lives, and continue to develop the skills to manage daily life in the community as they recover from their illness. By learning or regaining these skills we know people will be able to move on from Tile House into more independent settings, including managing their own tenancies.

In a challenging economic climate Tile House is improving the experience and outcomes from housing, care and support for those living there. It provides a clear sense of direction for the future.

I commend all those involved in this work and would like to thank everyone that contributed to this evaluation.

**Cllr Patricia Callaghan**

**London Borough of Camden**
Acknowledgements

We are grateful for the ready co-operation and assistance given to us in the collection of data by the manager, staff and customers of Tile House and for the advice and support of One Housing Group and Camden and Islington NHS Foundation Trust management in the drafting of this report.

The methodology and review of data in this report has been externally validated by Steve Appleton of Contact Consulting (Oxford) Ltd, who also assisted us with the writing of the report.

Amy Crocker
Associate Head of Service Development
2. Introduction

During 2012, One Housing Group (OHG) and Camden and Islington NHS Foundation Trust (C&I) entered into a strategic partnership to deliver a unique approach to supported housing and recovery for people with complex mental health needs. This partnership, one of the first of its kind, aims to improve the quality of housing and support for customers through implementation of a jointly developed ‘Care Support Plus’ model delivered in high quality, purpose built accommodation at Tile House.

Tile House opened in September 2012 and provides 15 high quality, self-contained supported housing units in the Kings Cross area of London. Each customer has their own flat that is designed to the same specification as our private sale housing. Purpose designed safety features enable us to effectively manage risk, while homely communal areas can be used for workshops and group sessions. Support is delivered in partnership with C&I which provides dedicated, on-site clinical input. An evaluation proposal was jointly developed by OHG and C&I from the outset. This report represents our findings, which covers a two-year period, on the success of the partnership and Care Support Plus model. It also outlines our learning from the model and ideas for future development and wider implementation.
3. Care Support Plus

The ‘Care Support Plus’ model brought C&I and OHG together into a formal partnership, delivering a service based on clear lines of responsibility, but with a shared approach to risk and a partnership approach to management and oversight. The diagram below shows the split of inputs between OHG and C&I, and the areas of enhanced integration. This model delivers a meaningful, recovery-focused, wraparound service for customers. It enables us to work with people with high levels of risk and complex needs who have previously been excluded from supported housing, including those with forensic backgrounds and those who are subject to Section 37/41 of the *Mental Health Act*.

This integrated health and housing model is specifically designed to support the NHS outcomes frameworks by:

- reducing reliance on expensive out of borough care and forensic placements
- reducing hospital admissions, both in terms of frequency of admission, and length of stay
- improving quality of life and outcomes for customers
- providing a high quality independent living environment.

At the same time the model offers considerable value for money through both short term savings in reduced placement fees, and longer term savings through improved and sustained customer outcomes.
The service provides double staff cover 24 hours a day, seven days a week. This is delivered by the OHG staff team, which is comprised of:

- **team manager** – responsible for the overall operation of the service and liaison with the C&I. The team manager leads on referral management, safeguarding and partnership working.

- **clinical lead** – coordinates the relationship between the clinical staff and support staff in the daily running of the service, deputises for the team manager, provides training for staff and case management advice particularly the clinical formulation of interventions.

- **support officers (3.00 FTE)** - responsible for developing risk assessments and support plans in partnership with the care coordinator. Implementing CBT based interventions under the guidance of the clinical lead and clinical psychologist.

- **support assistants (3.00 FTE)** - deliver solution-focused flexible packages of support with an emphasis on recovery and enablement e.g. developing life skills such as cooking, cleaning, paying bills and linking in with community services.

- **night support staff (2.6 FTE)** – provide waking night double cover ensuring support is always available for customers 24 hours a day.

In addition, the dedicated clinical input from the C&I comprises:

- **consultant psychiatrist (0.5 days a month)** – acts as the responsible clinician for all customers at the service (unless awaiting handover from forensic services). Ensures each customer is on the most appropriate medication regime to minimise symptoms without producing distressing side effects.

- **medical trainee (2 days per week)** - works closely with care coordinator to assess and monitor customer’s physical and mental health, liaises with GPs to manage medication and provide management of difficulties under close supervision of consultant.

- **care coordinator (2.5 days a week)** – a community psychiatric nurse responsible for coordinating each customer’s care and support, and providing regular input and support to the staff team at Tile House. They see customers regularly and ensure a comprehensive review of their treatment and support needs is carried out through their annual CPA meeting. They are available on-site to provide more intensive support during periods of relapse or crisis.

- **clinical psychologist (1 day a week)** – responsible for delivering specialist psychological interventions, either one to one or during group work. They also provide training and support for other staff members, as well as guidance for Tile House staff to implement psychologically informed interventions, and oversee the efficacy of these.

- **occupational therapist (1 day a week)** – provides specialist assessment and interventions to address functional impairments. This may be one to one or in a group setting. They develop specific plans with individual customers to address everyday living skills, and provide support and guidance to staff on OT based interventions.

Having both OHG and C&I staff on-site enables us to provide a seamless, wraparound service for customers, and to deliver a truly joined up approach to working with complex needs. Recruitment is carried out jointly between the OHG team manager and the C&I service manager. Shared team meetings also take place to ensure a consistent team approach. All staff have worked well together over the past two years, and feedback from both the C&I and OHG staff has shown that the partnership is working effectively. Jasmine Chin, Clinical Psychologist, appreciates the value that working together on-site brings, and how it can “provide a rounded package that addresses all needs in one place”. 

**Tile House evaluation**
4. Tile House in context

A greater focus on services that work across health, housing and social care, that can be delivered in the community rather than hospital and which promote recovery and independence have meant new models of support have emerged. In considering the impact of Tile House, it is important to place its development in the context of current policy in health, housing and social care.

The mental health strategy for England, *No health without mental health*\(^1\), published in February 2011, stresses the importance of housing for mental health and for those recovering from mental health problems in particular. Good quality, affordable, safe housing underpins our mental and physical wellbeing.

In February 2014 the Department of Health launched *Closing the Gap*. This new ‘action plan’ is intended to provide a bridge between the longer term aims of *No health without mental health* and the potential for achieving a number of shorter term ambitions. This includes encouraging developers, with some financial resource, to think specifically about homes that can support people who have a mental illness to live safely and more independently for longer.\(^2\)

Over the past five years increased pressure on NHS and social care budgets has accelerated the focus on creating alternatives to institutional provision. Increasing use of personal budgets has also created opportunities to develop new models of housing support.\(^3\)

Evidence suggests that there are currently not enough specialised housing options available for people with mental health problems.\(^4\) As a consequence housing associations and NHS Trusts need to work together to deliver an integrated pathway that will result in better outcomes for customers.

The pressures and associated demands to maximise inpatient capacity in the NHS are often exacerbated by beds being unavailable, including those which are occupied due to delayed discharges. In many cases a lack of appropriate accommodation is a significant factor in a person not being discharged in a timely manner. The development of housing provision that can provide support to people leaving hospital, either on a short, medium or even longer term basis can assist in effecting more timely discharge.

The *Care Act 2014* gives legislative leverage to improve the quality of care and support. Thus the need to focus on people’s wellbeing and to support them to remain independent for as long as possible is particularly relevant.

As a result of the Any Qualified Provider provisions in the *Health and Social Care Act*\(^5\) the market environment in the NHS and social care is expanding to admit a wider range of providers and to promote joint working with other parts of the NHS as well as independent and voluntary sector providers.

This greater diversity means that the NHS may no longer be the ‘default’ option for commissioners and enable independent providers to achieve greater penetration in a range of service areas. In addition it provides opportunities for commissioners to consider the role of housing associations in the development of a range of housing, care and support services that might complement or transform existing secondary care provision.

Recovery-focused services and the principles of recovery have become a key component of effective mental health services. Recovery is a set of values about a person’s right to build a meaningful life for themselves, with or without the continuing presence of symptoms relating to their illness. Housing providers are now playing an important role in enabling people to recover, maintain tenancies and live more independently, by offering suitable accommodation and support.\(^6\)\(^ 7\)
These are some of the key policy drivers that have influenced the direction of service development and have led OHG to work with the NHS and social care to provide Tile House. The service model is designed to assist with the implementation of these policy imperatives, as well as more local strategic and service ambitions.

5. Who lives at Tile House?

Tile House provides self contained accommodation for 15 customers at any one time. Since it opened in 2012, the service has worked with 19 different customers with complex mental health needs. Four customers were discharged to the service under Section 37/41 of the Mental Health Act, and a further three had substantial previous forensic histories. All customers have spent significant periods in hospital, either through repeat admissions over a number of years, long stay admissions or both. The majority of customers are male (79%), and aged under 60. White British is the largest ethnic group (47%), followed by Black Caribbean (21%) and Black African (21%). A full demographic breakdown is provided in the appendix in Table A1.

Customers experience a range of mental health conditions and some also have current or historic substance misuse. 75% of customers have a diagnosis of psychosis (schizophrenia, bipolar disorder) and 10% are schizoaffective. The remaining 15% have personality disorder diagnoses. All customers have complex needs that necessitate their residing in a specialist community based mental health facility with 24 hour staffing. Customers at the service are primarily from HoNOS clusters 12, 13, 16 and 17, with one customer from Cluster 11 and a further three who have not been assessed in this way. The complex needs that they experience complicate their recovery and may include:

- being non-responsive to treatment
- difficulties with social functioning and everyday living skills
- behaviours that present a risk to others or to themselves
- challenging behaviours
- co-occurring substance misuse
- co-occurring physical health problems.

The Care Support Plus model, 24 hour double staff cover, and purpose designed safety features of the building itself, have enabled Tile House to work with customers who have been unable to move to other services in the Camden Mental Health Pathway. This may be due to their high level of risk, the complexity of their needs, or their level of independent living skills. Very few customers had any experience of managing their own tenancy prior to moving to Tile House, and all had spent many years in registered care or forensic care homes. Fourteen of the 19 customers moved to Tile House from out of borough care placements where they had not progressed in their recovery.
“I feel more independent because I can self medicate, I can come and go to the local shops and my sisters can visit me.”

Ralph, Customer
The graph below shows the common reasons why customers were placed at Tile House rather than alternative supported housing schemes in the borough. The graph highlights that medication compliance was common to all referrals. Engagement with treatment is possible at Tile House through the 24 hour double staff cover and on-site clinical input. Behavioural risk was a factor in almost all referrals. The high level of staff cover, allied to the safety features of the building enable challenging or risk related behaviour to be well managed on-site. This positive risk management is also supported by the on-site clinical team, who were crucial to the majority of referrals in supporting customers to develop the necessary life skills to live more independently and to manage the symptoms of their mental health, such as psychotic episodes, strong persecutory voices and high levels of anxiety.

The case examples that follow illustrate the journeys of customers at Tile House and demonstrate the reasons why they moved here rather than to any other service in the Camden Mental Health Pathway.
Case example: Peter

Peter is a 41 year male who moved to Tile House following a long period in registered care. Peter has a dual diagnosis of schizophrenia and substance misuse, and presented with a number of challenging needs particularly in relation to personal care, money management and safeguarding in the community. Peter believes that he is becoming a robot, and attaches wires, batteries and pipes to his person then wanders out in the community. This resulted in him being viewed as a terrorist threat by the police, and two incidents where he was nearly shot as a suspected suicide bomber. Peter was not able to be referred to other supported housing due to the high level of risk and complexity of his needs.

At Tile House, the combined support of the clinical and OHG staff enables Peter’s needs to be met and the level of risk to be contained. Through joint working with Peter, and involving him in assessing levels of risk, he has agreed to be checked for wires before he goes out in the community, and staff have worked in partnership with the police to ensure that if he does leave the building wearing wires they are aware of this and that he is not a threat. If Peter was not at Tile House with 24 hour waking staff as well as airlock entry doors, it would be very hard to monitor this and he would be at a real risk of being deemed a terrorist threat.

Peter has never addressed his substance misuse, and has no insight into the effect this has on his anti-psychotic medication. At Tile House we have been able to engage Peter in developing a harm minimisation strategy through the input of the clinical staff. This has improved compliance and also ensures that any non-compliance can be picked up straight away. The intensive support model at Tile House also enabled staff to monitor patterns of behaviour and to pick up that Peter was not coping with his £20 daily allowance, but was spending all his money on drugs, which in turn caused him to become aggressive. His allowance was reduced to £5 daily, and since then his behaviour and money management have improved. He now collects his own money from the post office and does his food shopping independently twice a week.

Case example: Alec

Alec is a 62 year old man who moved into Tile House in August 2012 having spent two thirds of his life either in hospital or residential care. Alec had become deskilled, increasingly dependent on care staff and his level of need was very high. Alec was not engaging in any structured activity and his involvement in the community was very limited. At the time of referral there was no other placement available in Camden that could provide Alec with the required specialised support and the necessary space to redevelop his life skills, whilst also addressing his challenging behaviour. The Care Support Plus model at Tile House provided the ideal environment for Alec to redevelop life skills and engage with other customers, giving him the opportunity to manage in a self-contained flat with appropriate support and clinical input.

When Alec first moved in his behaviour was challenging and he would often be hostile towards staff and have verbal outbursts. His personal hygiene was very poor, and he often wore soiled clothing.

Substantial work was carried out with Alec around boundaries and challenging behaviour and as a result the frequency of his verbal outbursts and hostility towards staff reduced. A care package was put in place that enabled and empowered Alec to better manage his personal hygiene. The occupational therapist supported Alec with meal preparation and Alec was gradually able to prepare meals for himself. Alec is on an appointeeship and had previously had no choice or control over how his money was spent. We worked with him to develop money management skills and promote his independence by giving him a daily allowance so that he could make a choice around what he purchased.

Alec successfully moved on from Tile House in November 2013, and now has his own tenancy in our Roseberry Mansions extra care scheme at Kings Cross.
Case example: Murat

Murat moved to Tile House from an out of borough forensic care placement, and remains under Section 37/41 of the Mental Health Act following a severe attack he perpetrated on his neighbour. Before the attack, he had been living independently in a flat in Camden. Given his young age (32), and the good progress he had made in his previous placement, Tile House was the only option that gave the required level of support in light of the severity of Murat’s crime, and his high level of mental health need, whilst also offering him the opportunity to regain his independence in self contained accommodation. Murat has a strong relationship with his family, and bringing him back in borough has enabled them to better support him.

Murat has a history of cannabis use and non-compliance with his medication. When he arrived at Tile House his level of motivation was very low and he would sleep for most of the day. He didn’t engage with activities at the service, didn’t keep his flat clean and was unable to cook for himself.

Through intervention from both clinical and support staff, Murat now has a much greater understanding of the effects of cannabis on his mental health. As a result, he is no longer using drugs and this has led to a profound improvement in his motivation and engagement with the support available at the service. He is also now fully compliant with his medication, treatment, and blood tests, and is collecting his own medication from the pharmacy. Following intervention from the OT Murat is now able to keep his flat clean and tidy.

A weekly activity planner is drawn up with Murat each week during keywork sessions and he is involved in a number of different activities both in-house and externally, even taking part in our customer talent show, One Talent. His diet and level of physical health was a concern when he first moved in, but he is now going to the gym on a weekly basis with his volunteer befriender, and is also participating in the cooking group run by the OT. Murat engages well with all staff, and is preparing for move on to a step down service through developing his cooking skills and taking greater control over his medication. Murat told us that he feels he has made real progress through the joint support from Tile House and the NHS staff, which has “helped me improve my life and given me more confidence”.

“The Care Support Plus model is an example of how truly integrated mental health support can offer a higher level of positive outcomes for customers in an optimal wellbeing environment.”

Michelle Crouch
Head of Mental Health for One Housing Group
6. The impact of Tile House: key findings

Methodology and hypotheses

To understand and assess the impact of the Care Support Plus model at Tile House, One Housing Group conducted an evaluation of the service. The evaluation commenced when the service opened in August 2012 and concluded in August 2014. The evaluation methodology was developed in partnership with C&I Trust, and uses both quantitative and qualitative data for all customers who lived at the service between September 2012 and 30th August 2014. The methodology and review of data has been externally validated by Steve Appleton of Contact Consulting Ltd.

The central hypotheses being tested in the evaluation are that:

- Tile House was dealing with a comparable population of people to those admitted to in-patient care, both acute and forensic.
- Improvements in customers’ mental health and wellbeing, as well as other outcomes, were achieved through their receipt of care and support services at Tile House.
- The support being provided through the partnership with OHG and C&I has created a more effective use of constrained resources.
- The model enables a reduction in hospital admissions, and ensures that where an admission is needed the length of stay is reduced.

The evaluation has therefore concentrated on improvements in outcomes for customers, alongside the cost-effectiveness of the service. The methodology used for the evaluation has relied on primary and secondary research methods, specifically on a desktop study of data collected by staff at Tile House using agreed data collection instruments developed internally. This quantitative data has been supplemented by a range of qualitative information gathered from interviews with customers and the development of case vignettes.

There is no like-for-like comparator for Tile House, due to the unique Care Support Plus model and purpose built building design. However, where possible we have compared results and outcomes either to the historical patterns of the customers involved, or to customers at our high support mental health service in Camden, Camden Mental Health Supported Housing (Camden MH SH). This service supports customers with complex mental health needs, some of whom are in the same NHS cluster groups as customers at Tile House. The findings are divided into two main sections:

- 6a. No health without mental health
- 6b. Costs and efficiencies
6a. No health without mental health

The data provided below shows the impact of Tile House in delivering the cross government *No health without mental health* outcomes strategy. This contains a number of outcome-based objectives, and we have designed the evaluation to demonstrate the effectiveness of Tile House in contributing to the delivery of the national strategy at a local level.

**More people will have good mental health**

- Reduced hospital admissions

The table below shows the total number of admissions to hospital since Tile House opened. This shows separate admissions and whether or not the customers involved returned to Tile House. The admissions are for a total of five different customers. We compared this with the hospital admissions in our high support mental health service, Camden MH SH.

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th>Number</th>
<th>Returned to TH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical adjustment</td>
<td>2</td>
<td>Yes, Yes</td>
</tr>
<tr>
<td>Voluntary admission</td>
<td>2</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Recall under CTO</td>
<td>2</td>
<td>Yes, Yes</td>
</tr>
<tr>
<td>Admitted under section</td>
<td>2</td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

In spite of Tile House working with customers with more complex needs and with longer histories of institutionalised care, hospital admission rates are broadly similar. However, Tile House customers were more likely to return to the scheme, and to return within a shorter timeframe, than customers at Camden MH SH.

The graph on the right shows the average duration of hospital admissions for customers whilst at Tile House and during previous placements. Admission rates remained very similar, with ten admissions in the two years prior to Tile House, and eight admissions in the two years since Tile House opened. Of particular relevance, however, is the impact Tile House has had on reducing the duration of hospital admissions, as shown in this graph.
In the two years prior to moving to Tile House, nine of the 19 customers had significant hospital admissions, with an average 317 days in hospital; a total of 2,856 bed days. This represents a significantly higher admission rate than that experienced by customers while living at Tile House, where the total amount of time spent in hospital is 404 bed days for a total of five customers; an average of 81 days in hospital for each admission.

- **Prevented hospital admissions**

The model and approach at Tile House has enabled us to prevent many hospital admissions through addressing the signs of early stage crisis and preventing escalation. Having clinical input on-site ensures appropriate hospital admissions where needed, and allows greater in-house management of concerns than alternative supported housing settings. Our evaluation has shown a total of 23 separate occasions where customers presented with behaviour or symptoms associated with their mental health that would have resulted in a hospital admission in any other supported housing setting, but which were contained in-house at Tile House. The pie chart below shows the common presentations reported.

**Prevented admissions**

- Repeated breaking of boundaries
- Inappropriate sexual behaviour
- Suicidal ideation
- Threatening behaviour
- Strong persecutory voices
- Medication non-compliance
- Withdrawal and isolation
- Heightened distress and anxiety

**Reduced hospital admissions by 2,452 bed days over two years**
A strong emphasis is placed on the prevention of crisis, and the model at Tile House enables a consistent approach between clinical staff and Tile House staff. All customers meet with the psychologist who builds a history of their patterns and triggers. Coping mechanisms are developed, based on cognitive behavioural therapy (CBT) interventions, and these equip customers and staff with the tools to manage triggers and increased acuity and risk. Crisis plans are in place for all customers, and are developed jointly between the psychologist and OHG clinical lead, who ensure that each customer’s keyworker is fully aware of the individual approach.

Where crises do occur the close partnership with the NHS means that we can involve the psychiatrist and care coordinator straight away. Crisis plans can be enacted, monitored and adjusted in real time to accommodate fluctuations in each customer’s mental health. The unique safety features of the building, including a front facing office, airlock doors and sensitive use of CCTV, ensure that this is a safe environment in which customers can be monitored, and the clinical team can feel confident in allowing customers to self-manage early crisis without need for a hospital admission. Having a psychologist based on-site ensures they fully understand the set up and functioning of the service, and can therefore develop crisis plans that are tailored to the scheme and individual customer to ensure maximum efficacy.

Case example: prevented admissions

Mark has a history of several suicide attempts, one of which had resulted in serious permanent physical harm. This stems from severe auditory hallucinations and paranoid beliefs during most of his life. Mark had found talking about this difficult in his previous placements, and had often isolated himself. When Mark moved to Tile House, the OHG clinical lead worked closely with him to develop a positive relationship and encouraged him to attend the in-house hearing voices group with which he began to engage well. This enabled him to feel able to speak to the clinical lead and psychologist when his persecutory voices increased and he began to experience suicidal feelings, and gave them the opportunity to explore this with him, and reaffirm his crisis plan and coping strategies. The psychologist and care coordinator worked with all staff around containing a suicide crisis and how to approach the voice hearing experience in a non-challenging way. Mark’s suicidal feelings continued for approximately two weeks before they subsided. The crisis was contained in-house through therapeutic intervention by the on-site clinical team with no change of medication or hospital admission being required.
Incidents

Over the last 12 months a total of 24 incidents have been reported by the service. A breakdown of incident types is shown in the pie chart below. Verbal aggression, damage to property and inappropriate sexual behaviour were the most frequently reported incidents. The seriousness of the incidents reflects the level of risk and challenging behaviour present at the service. The threshold for reporting verbal aggression at the service is high, and incidents reported under this category represent threatening behaviour that is directed at an individual or individuals. The Care Support Plus model at Tile House, and the ability of the staff team to effectively deal with challenging behaviour, has meant that all incidents have been managed effectively and none have resulted in eviction from the service.

In the same period, our Camden MH SH service reported 25 incidents, a similar amount to Tile House. However, the level of severity of the incidents is generally lower than those reported at Tile House, with the majority being admissions to hospital, verbal aggression or missing person reports. The capacity of Tile House to effectively monitor access to the building has resulted in a reduction in incidents involving visitors to the scheme. The building design enables us to safely manage high level incidents, effectively manage risk and contain behaviour to ensure that customers and staff are safe, and that the service continues to function effectively. For example, the incident of arson in January 2014 may have presented serious problems for other services, but at Tile House the high specification fire alarm and sprinkler system ensured the fire was extinguished in under a minute. No fire damage was caused, while in an alternative scheme this incident had the potential to result in serious injury and damage to the building. As a result, no warning or eviction proceedings were enacted for this customer.

Nature of incidents reported

- Verbal aggression
- Damage to property
- Inappropriate sexual behaviour
- Fire - false alarm
- Physical assault
- Death
- Arson
- Medication recording error
- Admission to hospital - physical
- Burglary
- Missing person
- Substance misuse
Effective management of anti-social behaviour has also contributed to the low number of incidents at the service. Common challenges presented by the customer group include begging, indecent exposure, substance misuse, verbal aggression and threatening behaviour.

The unique service model at Tile House means that this behaviour can be tackled utilising a joined up team approach. Each customer receives an ABC behavioural analysis to understand the causes of the behaviour in their thoughts and emotions, and to enable staff to intervene in the thoughts and not the behaviour. This is explored during a professionals’ meeting chaired by the clinical lead, and involving the customers’ key worker, psychologist and also the occupational therapist where relevant. This focus on prevention is documented in a clinically formulated crisis plan for each individual customer that sets out the measures in place to tackle the behaviour. After any incident, the plan is reviewed and adjusted where needed with the aim of developing the customer’s ability to self-regulate. Where customers consistently engage in anti-social behaviour acceptable behavioural contracts and warning letters would be considered to ensure there is a consequence for the behaviour, with eviction only being utilised as a last resort.

Case example: incident management

When Terry first moved to Tile House, he presented with extremely challenging behaviour with frequent occasions of verbal aggression towards staff and other customers. He moved to the service directly from hospital, where he had also been abusive towards staff, often barricading himself in his room to avoid medication and appointments. Terry was receiving his appointeeship money in quite large amounts and would then binge on drugs and alcohol. He was non-compliant with his medication, and underweight due in part to his drug use, money management difficulties and refusal to seek support when he was hungry.

The staff approach to managing risk and reducing incidents was to look at what was causing the aggression, and to put measures in place to prevent recurrence. A measured approach was taken, with the whole team responding in a consistent way. Firm boundaries were put in place and his aggression was challenged to ensure he was aware that this was not acceptable behaviour. The Safer Neighbourhood Team was involved to ensure Terry was aware of the potential consequences of his behaviour. Terry is very distrustful of people he does not know, but having a consistent staff presence, and clear role definitions enabled him to build a rapport with the staff team far more quickly than he has in the past. Staff identified that hunger was often a key factor, with Terry acting out rather than communicating the way he was feeling and seeking support. Staff worked with him to arrange for food deliveries and help him prepare food. They also liaised with the GP for Terry to be prescribed supplement drinks. Terry’s finances were also reviewed so that he now receives a daily allowance, and does not spend all his money on drugs resulting in him going hungry. These interventions made a huge difference to Terry and his behaviour has improved substantially.
• Establishing boundaries

Effective management of boundaries has proved essential to containing risky behaviour and minimising incidents at the service. All staff receive training in appropriate boundary setting from the psychologist and clinical lead. A congruent team approach is taken, so that all staff are enforcing boundaries in the same way, not using them as a punishment but as a way of enabling customers to develop new ways of relating to other people. In addition, the on-site presence of the psychologist ensures that staff at the service benefit from regular clinical input from a professional who knows the service, the staff and the customers and has observed the behaviour themselves. Regular peer support sessions are facilitated by the psychologist and give all staff the opportunity to talk about any concerns and express frustrations or the emotional impact of upholding boundaries with challenging customers.

Case example: anti-social behaviour

Wayne has a history of sexually inappropriate behaviour that had gone unchallenged for over 30 years prior to moving to Tile House. When he first moved to the service there were several instances of him exposing himself to staff and customers in communal areas, culminating in him masturbating in front of staff and the police being called. Investigation into his behaviour by the forensic team found that although he was unwell, he did know what he was doing. Following each incident a consistent approach was adopted by the whole team to ensure the behaviour was challenged appropriately. All incidents were recorded and reported, a ban was put in place for him using the communal lounge, and this zero tolerance approach was explained to Wayne. His medication was reviewed by the psychiatrist, and the service received support from the C&I who took his case to a risk panel. This behaviour would have resulted in Wayne being evicted from other supported housing schemes, but the model at Tile House enabled us to continue to work with him. This has been challenging, as he struggles to engage, and will normally only listen to staff for period of five to ten minutes. As the behaviour had not been challenged before, it had become normal to him, but through consistent intervention Wayne now understands that this is not acceptable and will not be tolerated. This protects him and his vulnerability, particularly when out in the community, and there have been no major incidents since April 2014. Jigsaw are also now engaging with him and working in partnership with the staff team at Tile House.

Case example: establishing boundaries

When Elizabeth arrived at Tile House her behaviour was very chaotic and unboundaried. She would walk into the staff office and other people’s flats without knocking and demand that things be done ‘now’, often getting verbally abusive when she did not get her way. Through the input of the psychologist and support staff in developing appropriate boundaries for Elizabeth, and how to enforce these, the staff team have been successful in challenging and changing her behaviour. Elizabeth was involved in agreeing how her behaviour would be managed, and staff have repeated the arrangements to her on occasions where she has continued to act out. Elizabeth’s behaviour has improved dramatically, as has her engagement with staff. The Safer Neighbourhood Team also met with her to discuss her behaviour in the local community, where she had been begging for money and cigarettes, and agree boundaries for managing this. Elizabeth told us that she finds the “daily contact with staff very useful”, and that “the atmosphere at Tile House is more positive” than her previous placement which also helps her mental health. She has been able to be more independent here than in her previous accommodation because she can come and go as she pleases and her mum can visit her frequently.
More people with mental health problems will recover

Tile House offers customers a safe, homely environment from which to build foundations for independence and recovery. Each customer’s self contained flat is built to the same design specification as our private sale housing, and the building’s safety features promote an environment where customers and staff feel able to take appropriate risks in developing independence. Our ethos of choice, empowerment and recovery is embedded in the support and clinical interventions that each customer receives during their time at Tile House.

In addition to structured key work sessions and one to one input from clinical staff, Tile House offers a range of daily activities and group work opportunities run by different professionals to allow customers to focus on key areas in a less formal setting. These include a life skills group run by the occupational therapist, a wellbeing group, run by the psychologist and clinical lead, as well as more social activities such as the art group and cycling club. Groups benefit from psychological and/or OT input either in their design or delivery, and encourage social interaction and promote engagement.

Customer engagement in groups and activities at the service has gradually increased since the service opened, with attendance at one or more groups ranging from eight customers per month in August 2013 up to 14 customers per month since April 2014. Clinical staff benefit from being on-site and fully aware of the activities that take place, and feedback from the occupational therapist has confirmed how useful this is in developing individual support plans with customers.

The table below shows the average initial score, the average score after one year and the difference between these, as well as the highest and lowest scores and most frequent scores at each point. This shows improvement in all areas after one year, with the most significant improvements being for laundry, home maintenance and shopping.

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th>Personal care</th>
<th>Meal preparation</th>
<th>Medication management</th>
<th>Laundry</th>
<th>Home maintenance</th>
<th>Finances</th>
<th>Shopping</th>
<th>Using public transport</th>
<th>Functional communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest initial figure</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lowest 1 year figure</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Highest initial figure</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>9</td>
<td>7</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Highest 1 year figure</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Mode initial</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Mode 1 year</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Average initial</td>
<td>5.55</td>
<td>4.28</td>
<td>3.11</td>
<td>3.67</td>
<td>3.78</td>
<td>4.72</td>
<td>4.61</td>
<td>7.11</td>
<td>4.72</td>
</tr>
<tr>
<td>Average 1 year</td>
<td>7.72</td>
<td>6.72</td>
<td>4.78</td>
<td>6.78</td>
<td>6.78</td>
<td>6.78</td>
<td>7.44</td>
<td>8.33</td>
<td>7.17</td>
</tr>
<tr>
<td>Difference</td>
<td>2.17</td>
<td>2.44</td>
<td>1.67</td>
<td>3.11</td>
<td>3</td>
<td>2.06</td>
<td>2.83</td>
<td>1.22</td>
<td>2.45</td>
</tr>
</tbody>
</table>
All customers at Tile House benefit from the input of our on-site occupational therapist who assesses each customer in order to implement individually tailored interventions. The communal kitchen and living area at Tile House are designed to enable effective group work as well as one to one interventions.

In order to monitor each customer’s progress, Activities for Daily Living (ADL) assessments were carried out using the C&I occupational performance report that was adapted for Tile House by the OT and clinical lead to give a quantitative measure. The on-site OT carried out individual assessments on nine key ADL areas with each customer when they moved in, at the six month point and then again after one year. Each assessment fully involved the customer, and also included OT observation of the customer performing key tasks.

The overall average ADL score for all customers on moving into Tile House was 4.05, but after one year this had increased to 6.37.

The graph below shows the change in average ADL scores for each category between customers moving into Tile House and after receiving the service for one year.

**Average ADL progress**

The ADL score improved from 4.05 to 6.37 in one year
• Positive risk-taking

The building design and service model provide the ideal setting for customers to be enabled to take positive risks in order to become more independent and self-reliant. The 24 hour, double cover staff presence, combined with use of CCTV, airlock doors and front facing staff office enables us to effectively monitor each risk, while the on-site clinical team ensure that we can react to changes immediately, and any adjustments that need to be made can be actioned swiftly. Staff receive training and support from the clinical team to work positively with risk, and to be aware of the limits of risk taking for each individual customer. These limits vary over time, and staff work with the clinical team to review and adapt plans accordingly. We have found that the clinical professionals involved are more confident in allowing customers to take risks when they are doing so in the environment at Tile House. It is not necessary to risk assess and plan for a long period between appointments as they are seeing the customers on a weekly basis. This has been particularly the case for changes in medication, where we have benefited from the on-site CPN care coordinator who can manage any negative impacts of changing medication.

Common areas where customers are able to take positive risks to be more independent include money management, collecting medication from the pharmacy, travelling to appointments, doing their own shopping and taking responsibility for visitors to their flat.

Case example: positive risk-taking

Roy is a 43 year old male with a diagnosis of paranoid schizophrenia, which causes him to become very thought disordered and experience severe social anxiety. Before Tile House he had lived in a care home for seven years, where he did not go outside due to his high level of anxiety. When Roy moved in he was unable to manage his medication independently, and would not leave the building.

Roy worked closely with the clinical psychologist around his anxiety and measures were put in place by the rest of the staff team to support him, such as accompanying him on short walks. Roy and the psychologist developed a self help pack which includes what works for him to keep his anxiety low. Roy met regularly with the care coordinator, and gradually built attendance at in-house group activities. A phased approach was taken to Roy managing his own medication, with him gradually taking more responsibility.

During his time at Tile House, Roy has developed insight into his mental health and social anxiety, and has effective coping mechanisms in place that have enabled him to become more stable. Roy now goes to the shop alone, and is fully self medicating. He told us that he now feels more independent and goes out regularly. His sisters come and visit him often and he goes to stay overnight in the family home. He feels he has particularly benefited from the cooking group as he is now able to make a cup of tea or coffee for his mum when he goes home to visit. Roy is now waiting to move on to a lower support service.
• **Medication management**

A crucial aspect of readiness for move on from Tile House is the customer’s ability to manage their medication independently. We have worked with each customer to support them to take more responsibility for their medication, with 13 of the current 15 customers being responsible for collecting their medication from the pharmacy, and attending depot and blood test appointments independently. Due to the high level of risk involved with some customers at the service, moving them towards greater self medication has proved very difficult. However, three current customers are either fully self medicating or partly self medicating, and a further two customers who have moved on were self medicating at the point at which they left the service.

All customers have had their medication reviewed since being at Tile House. With the exception of the customers who are on a Section 37/41, the monitoring capabilities afforded to us by the building design and service model have enabled the psychiatrist to feel able to reduce or change many of the customers’ medication. Nine customers have had their medication changed, with a further two having their existing medication reduced. This has had a positive impact on all customers, with only one occasion where the change had to be reversed. Customers have felt empowered by the change in medication and more involved in planning how their mental health will be managed. A reduction in side effects has enabled customers to be more active and more engaged in their support, the service and their local community.

• **Readiness for move on**

Since Tile House opened, three customers have moved on from the service. Two of these were planned moves, whilst the third was unplanned following a serious incident at the service and subsequent hospital admission.

Of the current 15 customers at Tile House, 11 have been at the service for approximately two years. Five of these customers are ready for move on to lower support, without 24 hour double cover, as are an additional three customers who have been at the service for 18 months. A significant barrier to move on, however, is in relation to medication, as customers need to be able to self medicate at the lower support schemes. For customers at Tile House, due to the high level of need and risk involved, self medication is often not fully achievable, and the service is currently exploring ways around this with the clinical team and supported housing providers. A recent joint review of all customer’s move on options identified five customers for move on to step down high or medium supported housing, and a further three for sheltered or extra care housing.
Case example: positive risk-taking

Margo is 43 years old with a diagnosis of schizoaffective disorder. She has been receiving support for her mental health since she was five and has had numerous lengthy hospital admissions throughout her life, alternating with long periods in residential care. She is extremely vulnerable and is susceptible to financial and sexual exploitation. She has a history of prostitution, substance misuse, suicide attempts and non-compliance with medication. She has had numerous failed placements as she was been verbally and physically abusive to staff, and this continued in the first month that she was at Tile House.

Since moving to Tile House, the intensive support and on-site therapeutic intervention has enabled Margo to stabilise her mental health and incidents of verbal or physical abuse have ceased. She is seen on a regular basis by the care coordinator, psychologist and consultant psychiatrist. All staff at Tile House have supported Margo to gain greater insight into her mental health especially the importance of compliance with medication. A significant piece of work has been carried out with her around her relationships and developing insight into her sexual health and sexual behaviour. She now accesses sexual health clinics, and makes sure if she is going out at night that she lets staff know and takes a mobile phone with her. Margo suggested that she would find a women’s group useful and this group has been set up and runs on a regular basis. Margo has had one hospitalisation in her two year stay at Tile House. This admission followed a review of her medication and lasted 35 days, significantly shorter than her previous admissions which have lasted a year or more. She was discharged back to the care of the clinical team at Tile House where she has continued to thrive.

Margo is now at the point where she is moving on from Tile House to somewhere with lower support, which is a big move for her. Her daily living skills have improved, and she is now keeping her flat clean, budgeting well and staying on top of bills. Margo is fully compliant with her medication, and managing her visitors to the service much better. She has developed appropriate relationships with the other customers she is living with, something she has struggled with in previous placements where she gained friends through barter and offering favours. Margo is much more active, both in the service where she engages in group activities, and in the local community where she attends day centres and goes swimming.
### Customer outcomes

Our customer database, 'my personal support', records all information on the work we carry out with our customers and the progress they have made towards achieving their individual goals. The table below shows the percentage of goals that customers have achieved in the different Communities and Local Government (CLG) outcome areas. Also shown for comparison are the goals achieved by customers at our Camden MH SH service.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator</th>
<th>Achieved (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tile House</td>
<td>Camden</td>
</tr>
<tr>
<td>Be healthy</td>
<td>Assistive technology/aids and adaptations</td>
<td>90.91%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Better manage mental health</td>
<td>93.44%</td>
<td>88.42%</td>
</tr>
<tr>
<td></td>
<td>Better manage physical health</td>
<td>86.01%</td>
<td>80.43%</td>
</tr>
<tr>
<td></td>
<td>Better manage substance misuse</td>
<td>86.67%</td>
<td>65.52%</td>
</tr>
<tr>
<td>Be healthy total</td>
<td></td>
<td>89.01%</td>
<td>83.65%</td>
</tr>
<tr>
<td>Economic wellbeing</td>
<td>Maximise income, including correct benefits</td>
<td>87.50%</td>
<td>90.38%</td>
</tr>
<tr>
<td></td>
<td>Obtain/participate in paid work</td>
<td>100.00%</td>
<td>88.24%</td>
</tr>
<tr>
<td></td>
<td>Reduce overall debt</td>
<td>92.86%</td>
<td>78.38%</td>
</tr>
<tr>
<td>Economic wellbeing total</td>
<td></td>
<td>89.71%</td>
<td>86.31%</td>
</tr>
<tr>
<td>Enjoy and achieve</td>
<td>Contact with external services/groups</td>
<td>81.13%</td>
<td>81.32%</td>
</tr>
<tr>
<td></td>
<td>Contact with family or friends</td>
<td>90.91%</td>
<td>87.93%</td>
</tr>
<tr>
<td></td>
<td>Leisure/cultural/faith/informal learning activities</td>
<td>77.78%</td>
<td>78.43%</td>
</tr>
<tr>
<td></td>
<td>Participate in training and/or education</td>
<td>68.75%</td>
<td>74.34%</td>
</tr>
<tr>
<td></td>
<td>Participate in work-like/voluntary/unpaid work</td>
<td>64.29%</td>
<td>71.64%</td>
</tr>
<tr>
<td>Enjoy and achieve total</td>
<td></td>
<td>78.40%</td>
<td>77.91%</td>
</tr>
<tr>
<td>Make a positive contribution</td>
<td>Greater choice and/or involvement and/or control</td>
<td>93.94%</td>
<td>81.68%</td>
</tr>
<tr>
<td>Make a positive contribution</td>
<td></td>
<td>93.94%</td>
<td>81.68%</td>
</tr>
</tbody>
</table>
The table above shows the positive impact that the Care Support Plus model has had on customer outcomes in a number of areas, particularly those relating to health, both physical and mental, substance misuse, and staying safe. Outcomes relating to participation in education and training, or voluntary work are better for Camden MH SH than Tile House. Tile House customers have often experienced barriers to engaging in these types of activities due to the high level of risk and the ability of training and education providers to accommodate this. The service runs a range of activities in-house to enable customers to pursue their interests where possible. Lower outcomes may also be a reflection of where Tile House sits on each customer’s recovery journey. Customers are being stabilised and prepared for step down to a lower support service, where a greater focus on education and training may be more successful.

### Social inclusion distance travelled

Social inclusion levels are entered on ‘my personal support’ for each customer using a 15 point scale. A score of 1 is given for no involvement in any activity up to a maximum score of 15 for full-time paid employment. This is carried out each time a support plan review is completed to measure distance travelled.

Social Inclusion levels either improved or stayed the same for all but one of the 19 customers who have lived at Tile House. Levels improved for 47% of customers, and we anticipate this figure improving further in future when barriers to accessing education and training are overcome.
“Living at Tile House has improved my life and made me feel better.”

Evie, Customer
More people with mental health problems will have good physical health

- **Engagement with primary health services**

  All customers at Tile House are registered with a local GP, and are encouraged to engage with them for any health concerns. Two customers have also engaged in the stop smoking programme and this goal is incorporated in their support plan. Fourteen out of the 15 current customer cohort have received an annual physical health check. One customer has refused to participate in this, despite repeated attempts by the staff team to encourage him to engage.

  The service runs regular groups and activities aimed at promoting broader physical wellbeing, which are well attended by customers at the service, with between five and seven customers engaging each month. This includes the cycling group, funded through our Customer Enterprise Fund, as well as nutrition workshops and cooking groups. Input from the occupational therapist ensures that these activities are tailored to the individual customer to optimise successful outcomes.

- **Substance misuse**

  Since Tile House opened, five customers at the service have presented with needs relating to substance or alcohol abuse. Engaging them with treatment services has proved challenging and actual engagement with those services has fluctuated between 20% and 75%. All five customers were at the pre-contemplation stage of the Cycle of Change when they moved to Tile House, and had not considered addressing their substance misuse in the past. They are all now in the contemplation stage, with some moving between this stage and the preparation stage as their engagement with in-house sessions and external drug and alcohol services fluctuates. Customers who have not engaged with services have benefited from support provided in-house. This may be through attending the wellbeing group run by the psychologist, discussing alcohol use with the psychologist or key working in one to ones, or keeping an alcohol diary with support from their keyworker.

More people will have a positive experience of care and support

- **Living environment**

  Tile House provides an aspirational environment of high quality self contained supported accommodation, which is ideal to support customers in making choices about their lives, and engaging in activities that fulfil these choices. Feedback from customers has demonstrated how this environment has helped them feel more positive about the future and more motivated to take greater control over their lives and become more independent. William told us that Tile House was “more comfortable and spacious than his previous accommodation” and that he feels more independent and likes being able to personalise his flat. James also valued having his “own space” and being able to furnish his flat with his own things. In particular, having staff based at the front of the building, so he can see them when he arrives or leaves the building makes him feel safer. Raymond told us “I don’t want to move on earlier than I should. I like it here. I love it: space, location, flat. I love my freedom.”

  “I don’t want to move on earlier than I should. I like it here. I love it: space, location, flat. I love my freedom”
• **Engagement and involvement**

Establishing and maintaining positive relationships, and engaging in social activities are fundamental components to the underpinning philosophy of the service and the importance placed on not just living with a mental health diagnosis but living well. Prior to moving to Tile House, the majority of customers lived in services that were very institutionalised, with little engagement in social and community activities. All customers at Tile House have engaged in activities either at the service or externally. Although for some their engagement is sporadic, two thirds of customers regularly engage in a hobby or leisure activity. Between six and 10 customers have also engaged positively with friends and family each month.

All customers have engaged with the clinical professionals at the service on at least a monthly basis. Everyone engaged with the care coordinator, while between six and nine customers engaged with either the OT or psychiatrist or both. All customers engaged with the OHG clinical lead.

Most customers engage well with the service and get involved in discussions and making decisions about the service they receive. There is a strong sense of community, both within the service and within the local King’s Cross regeneration area. Groups take place at the service on a daily basis and each customer has an individual weekly activity planner to promote engagement. Two thirds of customers are regular attendees at house meetings and other consultation forums, and have used them to suggest a range of group and social activities which have now been implemented, including:

- men’s and women’s groups
- a day trip to Brighton
- wellbeing group facilitated by the psychologist and clinical lead
- picnic in the park
- hearing voices group.

**Fewer people will suffer avoidable harm**

- **Safeguarding alerts**

Since opening in August 2012, there have been six cases of potential abuse that have been raised and investigated. All safeguarding alerts were dealt with quickly and effectively utilising a partnership approach between OHG and C&I. Two of these were substantiated, and joint work was carried out between OHG, C&I and the Safer Neighbourhoods Team to promote the wellbeing of the customers involved and ensure they remained safe.
6b. Costs and efficiencies

The Care Support Plus model aims to deliver a more effective means of utilising resources through:

- reduced hospital admissions, both in frequency and duration
- enabling customers placed in out of borough placements to move back in borough
- promoting the development of independence, recovery and daily living skills to enable customers to move on to lower support in the future.

The service is funded through adult social care contract income, with OHG subcontracting the clinical inputs from C&I. Customers have moved to Tile House from a variety of different hospital and community settings:

<table>
<thead>
<tr>
<th>Previous placement</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered care, in borough</td>
<td>1</td>
</tr>
<tr>
<td>Registered care, out of borough</td>
<td>9</td>
</tr>
<tr>
<td>Forensic care, out of borough</td>
<td>5</td>
</tr>
<tr>
<td>NHS rehab unit, in borough</td>
<td>2</td>
</tr>
<tr>
<td>Private hospital ward</td>
<td>1</td>
</tr>
<tr>
<td>NHS psychiatric ward</td>
<td>1</td>
</tr>
</tbody>
</table>

Initial referrals were targeted at customers who had been placed out of borough. While this has created positive benefits in terms of move on options and access to support networks for the customers involved, it may not have resulted in such significant cost savings as more recent referrals which have been increasingly from NHS placements.

The following table shows the difference in costs between Tile House and previous customer placements in terms of individual placement costs, hospital admissions, and overall costs. For validity of data, costs for the two customers who have been at the service for less than six months were excluded. Previous placement costs are based on actual costs for registered care, forensic care and private hospital, and approximate costs for NHS rehab and psychiatric wards set out in the PSSRU Unit Costs of Health and Social Care 2013. Costs of registered care placements varied widely, depending on whether the placement was in or out of borough, with the lowest annual cost being £30,514 and the highest £65,179.

| £4.4k pa saving compared to previous placement equates to 1,295 bed days |
PSSRU unit costs used of £342 per bed day for standard inpatients, £528 per bed day for forensic or secure wards.

This shows an average per-placement per-customer saving of £21,298 per annum. The overall annual saving at Tile House is £443,964 compared with previous placement costs and hospital admissions. This equates to 1,298 NHS bed days using the PSSRU unit costs. This demonstrates the considerable value that Tile House can bring to both local authority spending on care placements and NHS spending on hospital beds. When the same calculation is applied to the three customers on Section 37/41 who have been at Tile House for between 18 months and two years the savings are even more pronounced, with costs being more than 50% lower per annum at Tile House compared with their previous placements.

The success of Tile House in reducing hospital admissions delivers further cost savings both in the short term, in actual NHS costs, and in the longer term in ensuring customers do not become deskillled through long term hospital stays. The table shows the total cost of hospital admissions for customers at Tile House in the two years prior to move in, compared with the total cost since they have lived at Tile House. A two year period was used to allow for fluctuations in mental health over time. The majority of customers were at Tile House for two years, and where this is not the case results have been extrapolated to reflect a two year period. The overall cost to the NHS in the year prior to customers moving to Tile House was £527k compared to £71k in the two years at Tile House.

Comparing costs for social care is more difficult as there is no like for like comparator. The cost of the average social care placement prior to Tile House was £44,016 compared to £36,920 for Tile House. However, the costs of Tile House include the clinical inputs of the care coordinator, psychologist, psychiatrist and occupational therapist, which would incur additional costs in residential care placements. The quality of the interventions provided is also different, with Tile House focussing on skills development and recovery towards moving on to lower support, where many customers would not have had this opportunity in their previous placement.

<table>
<thead>
<tr>
<th>Cost area</th>
<th>Before Tile House</th>
<th>At Tile House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement (per customer per annum)</td>
<td>£58,218 (average)</td>
<td>£36,920</td>
</tr>
<tr>
<td>Hospital admissions (average per annum)*</td>
<td>£355,845</td>
<td>£71,649</td>
</tr>
<tr>
<td>Overall annual cost (for 17 customers)</td>
<td>£1,143,253</td>
<td>£699,289</td>
</tr>
<tr>
<td>Overall annual cost for customers on Section 37/41</td>
<td>£249,641</td>
<td>£110,760</td>
</tr>
<tr>
<td>Overall annual saving</td>
<td></td>
<td>£443,964</td>
</tr>
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</table>

* PSSRU unit costs used of £342 per bed day for standard inpatients, £528 per bed day for forensic or secure wards.
We have therefore projected costs over a five year period to better illustrate the potential savings to adult social care of the Care Support Plus model. Using the average placement cost set out above, the social care costs of 15 customers remaining in their placement for a five year period would be £3,301,200. If the same group of customers were placed at Tile House for a three year period before stepping down to lower support for a further two years, the overall cost for the five year period would be £2,093,707. This shows an overall saving of £1 million over five years.

“The launch of Tile House really demonstrates how we can bring together the skills of both the NHS and the independent sector to deliver something better for service users.”

David Plummer
Associate Director
Business Development
Camden and Islington
NHS Foundation Trust
“The Care Support Plus model has provided huge benefits for people with long term mental health problems who may have remained in care homes or in hospital. With genuine partnership working between One Housing staff and the clinical team, we are able to manage risk far more effectively and develop creative and innovative ways of supporting customers.”

Stephen Smith, Team Manager, Tile House
7. Conclusions

This evaluation has sought to highlight a range of areas where the model of service, combined with the unique partnership approach between One Housing Group and Camden and Islington NHS Foundation, have resulted in improved outcomes both for customers and the wider health and social care system in Camden. The information that has been gathered and presented in this report enables us to reach a number of conclusions about the service:

That the nature of need among the customers living at Tile House is complex and of a level that would not usually enable other forms of supported housing to offer the nature of support needed. The reasons for referral demonstrate that customers frequently exhibit issues relating to compliance with treatment/medication, some who have a forensic component to their mental health history, who have a history of placement breakdown, often present high levels of risk (often in relation to self harm), and require clinical input to manage their mental health. These factors combine to create a customer group that presents challenges in the management of risk and the meeting of often multi-factorial need. The customer group is similar in composition to those individuals who are in hospital environments or in more secure or specialist placements. It is through the partnership approach of Tile House and through the service model that customers can be supported to achieve recovery and independence.

In terms of reducing hospital admissions, it is necessary to look at admission duration as well as volume. There have been eight admissions to hospital among the customer group at Tile House, this compares with ten admissions among that same group in the two years prior to Tile House opening. This is a relatively small reduction, however, the service has been successful in enabling those customers who have been admitted to hospital to return to the service on discharge. In other forms of supported housing an admission might lead to tenancy breakdown, often with a negative impact on longer term recovery goals. Tile House has shown that its ability to manage complex need and risk means that it has been able to continue working with customers and that hospital admission is not regarded as a failure on the part of the service or the customer.
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Tile House has shown that its ability to manage complex need and risk means that it has been able to continue working with customers and that hospital admission is not regarded as a failure on the part of the service or the customer.

In the two years since Tile House opened, the number of occupied bed days for the five customers who had admissions has fallen to 404 with an average of 81 days in hospital for each admission. This is a significant reduction and has ensured that customers were in hospital for a shorter time, and were able, in the main, to return to Tile House, thereby easing pressure on the capacity of NHS inpatient services in Camden.

The avoidance of admission is also a key feature of this evaluation. There were 23 occasions when a customer might usually have been admitted to hospital. The unique partnership approach between OHG and the clinical team from the C&I has meant that on-site support and input has been appropriately utilised to manage and avoid crisis and mitigate the need for more expensive hospital admission. This is due to the range of skills and expertise within the staff groups, both within OHG and the C&I as well as the design features of the building.
The approach of staff at Tile House enables them to work with customers to manage their risk and challenging behaviour. The incidents reported have tended to be of a serious nature, but have been well managed. The number of incidents reported by the comparator service is only one higher than at Tile House, but importantly the level of seriousness of incidents is lower. **This is a further demonstration of the ability of Tile House to work with customers who present higher levels of risk and more complex challenges that traditional forms of supported housing.**

Tile House has been successful at engaging customers in a range of activities and groups. These are intended to assist in the achievement of recovery and the goal of independence. This is particularly the case in relation to Activities for Daily Living where customers average score for ADL has improved from 4.05 to 6.37. **The service demonstrates that a recovery approach delivered in partnership between housing support staff and clinical colleagues from the NHS can be effective in achieving participation and the achievement of recovery for the customer.**

In relation to improving customer outcomes, the evaluation demonstrates the impact that being at Tile House has had compared to the comparator service across a range of areas. Customers are better able to manage their mental and physical health and better equipped to manage their substance misuse. In terms of their financial wellbeing they are better able to manage their finances including reducing their debts. Customers are also demonstrably more in control of their decisions and choices. **Tile House has also prepared customers to move on to other forms of accommodation and to avoid eviction from the service.**
Tile House has been successful at engaging customers in a range of activities and groups. These are intended to assist in the achievement of recovery and the goal of independence. This is particularly the case in relation to Activities for Daily Living where customers average score for ADL has improved from 4.05 to 6.37.

The service demonstrates that a recovery approach delivered in partnership between housing support staff and clinical colleagues from the NHS can be effective in achieving participation and the achievement of recovery for the customer.

Compared with the customers’ previous placement costs, Tile House has saved the system £443,964 per annum. This is even more encouraging given that this includes the costs of the clinical support that is such a key factor in the model of service and which would often attract additional costs for other forms of supported housing or specialist placement.

The overriding conclusion of this evaluation is that Tile House is an effective and efficient service. The partnership between OHG and the NHS is an example of innovative practice and of a commitment to integrated working across sectors. This approach has enabled the service to support a range of customers with complicated and high levels of need and risk in a safe and effective way. Outcomes for customers have improved across a range of areas and the service is contributing to the meeting of wider outcomes imperatives. From a financial perspective the service is offering value for money, is more affordable and is contributing to system wide efficiency and productivity.

Most importantly of all Tile House is offering a service tailored to the needs of its customers, and enabling a group of people who have found it hard to accept support in traditional settings to have the benefits of settled, safe and supportive housing.
8. Future actions for consideration

In considering the results of the evaluation and the conclusions drawn from both the quantitative and qualitative data, there are some areas for OHG to consider for further work or particular action;

The partnership approach is effective in achieving service delivery and better outcomes and as such opportunities to create similar partnerships between OHG and NHS Trusts should be pursued.

Commissioners of health and social care should be encouraged to consider the benefits of the Tile House approach in realising not only savings to their local systems but also the contribution it can make to promoting and delivering better outcomes and recovery for customers.

One Housing and its partners should consider this evaluation and its conclusions to further improve the service and the outcomes it achieves. Most notably work is needed to improve the impact the service can have in enabling customers to engage in education and training, in managing their medication and treatment and further reducing incidents.
The availability of property from which to deliver services such as Tile House remains challenging, not least in relation to capital resources, but also in relation to the revenue resources needed to run them. OHG should work with NHS Trusts to explore the opportunities to better utilise their land and estate to create the circumstances through which similar services can be developed.

Tile House is a success, but it will be important to continue to evaluate the service to ensure that it continues to operate effectively.
Appendix

Table A1 - Customer demographics

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No.</th>
<th>Gender</th>
<th>No.</th>
</tr>
</thead>
<tbody>
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<td>Asian/British - Other</td>
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<td>Female</td>
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</tr>
<tr>
<td>Black/Black British - African</td>
<td>4</td>
<td>Male</td>
<td>15</td>
</tr>
<tr>
<td>Black/Black British - Caribbean</td>
<td>4</td>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Black/Black British - Other</td>
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<td>22-35</td>
<td>5</td>
</tr>
<tr>
<td>White British</td>
<td>9</td>
<td>36-45</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>46-60</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>61-70</td>
<td>2</td>
</tr>
</tbody>
</table>

References

1. Department of Health February 2011, No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, HM Government
2. Closing the Gap - priorities for essential change in mental health Department of Health February 2014
4. Homes & Communities Agency www.homesandcommunities.co.uk
5. Health and Social Care Act TSO 2012
6. Supporting recovery in mental health NHS Confederation 2012
7. Housing and mental health NHS Confederation 2011
8. The coroner’s verdict into the death at Tile House was inconclusive
9. To arrive at this figure, we have used the placement costs of other OHG step down services within the Camden Pathway
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