Housing LIN
Connecting people, ideas and resources

Viewpoint 68

Breaking boundaries: reinventing primary care

This Viewpoint provides insights into some of the current debates and developments in health through the lens of general practice and primary care. It explains the NHS Alliance's vision for extended primary care and for developing social models of health, and presents examples of ways in which housing organisations are already integrating with primary care to improve people's health and wellbeing and reduce pressure on the NHS. It seeks to give insights into why progress can sometimes be slow and includes some 'top tips' for housing providers who want be involved in building social models of health, with primary care.

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1. Introduction - A health service in flux

It is no secret that the NHS is under huge pressure – financially, politically, due to increasing demand and as a result of its dented reputation with the British public – and that these pressures are rapidly changing the shape of our health service.

How that change is managed is of huge political and professional interest. The Health and Social Care Act that produced NHS England, Clinical Commissioning Groups, Health and Wellbeing Boards and shifted public health into local authorities, are just the first phase and, in any case, the formal structures may change again following the General Election in May 2015.[1] Legislation in the shape of the Care Act and government initiatives to promote integration of health and care, such as the Better Care Fund[2] which remains the Government's chosen method despite recent set-backs, might be seen as phase 2 reforms.

At the NHS Alliance we believe that, to be successful, those leading the transformation need to recognise that society's health needs have changed fundamentally and that there are substantial and enduring inequalities in health outcomes in different neighbourhoods. The focus should be on enabling people to secure and maintain their health and wellbeing so that they can live happy and productive lives within the community; not just to cure their illnesses. The health care system needs to allow for difference, since the best route to achieving this will probably be different in different localities. Real change that will deliver better patient care as well as better community health and wellbeing will be more incremental and less centrally defined than either of phases 1 and 2. What we might understand as 'phase 3' reform will take place through a series of small changes rather than a single 'big idea'[3] and it will involve more people beyond those employed by the NHS, including people and communities themselves.

In our view, we can learn some things from another great British institution, the Fire and Rescue Service, which has undergone significant transformation over the last decade or so. Since 2002, the number of domestic property fires in England has decreased by 55% and the numbers dying in fires by 35%.This was achieved by refocusing on preventing, rather than fighting, fires and through proactive and pre-emptive work with communities, housing organisations, health, voluntary sector and others.

2. The primary care paradox

Primary care is a crucial part of any strategic solution for sustainable healthcare. Research, including international comparative studies, conclude that strong primary care is associated with lower rates of avoidable admissions to hospital and fewer potential years of life lost and that it contributes to a better functioning of healthcare systems overall.[4] This consistent finding is leading to calls for a higher proportion of the overall health budget to be spent on primary care[5] and for more commissioning power to be transferred from NHS England – either centrally or from its Area Teams – to clinical commissioners.

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[1] Labour's vision is for Whole Person Care explained in their recent 'One Person, One Team, One System' report: www.yourbritain.org.uk/agenda-2015/policy-review-page/whole-person-care

[2] NHS England pages for BCF: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan and DH pages for BCF: www.gov.uk/government/publications/better-care-fund

[3] Rick Stern's blog 13 August 2014: www.nhsalliance.org/stern-response-nhs-alliance-lilleys-primary-care-focus/

[4] Kringos et al, 2013. 'The strength of primary care in Europe: an international comparative study'.

[5] Currently, only 8% of the NHS budget is spent on primary care. NHS Alliance is calling for this to increase to 10%.

At the same time, primary care has some weaknesses that often cast doubt on its capacity and capability to effect large scale change. The high value of primary care coupled with these capacity issues has been described in recent literature as 'the primary care paradox'.[6] Certainly, primary care in England is presently experiencing a cocktail of:

- ***increased demand***; driven by several long-term trends including a growing older population, treatment of more people with long term conditions in the community and the negative health impacts of increasing wealth and social inequality.
- ***shrinking workforce***; in the 1980s, there were twice the number of GPs than hospital consultants, but there are now more consultants than GPs with too few GP trainees coming through. There has also been a 40% reduction in community nurses.[7]
- ***organisational structures that appear no longer to be fit for purpose***; traditional GP practices, comprising between 1 and 10 GPs may be too small to respond to some of today's NHS challenges. Some have too few staff members to respond adequately to new clinical, administrative and regulatory demands, or are vulnerable to marginal reductions in income or lack the capacity to develop formal links with other services and organisations.[8]

The current big debate in general practice and primary care is focused on how GP practices might best club together to form larger entities that are better able to address these matters and to reduce the considerable stress on GPs and practice staff without becoming distant, bureaucratic and inflexible. There is a balance to be struck between benefitting from economies of scale and maintaining a personal and flexible connection with patients. A variety of models are emerging, including formal mergers to produce 'super-practices', multi-practices, federations and networks that allow collaboration on particular issues and independence on others, values-led cooperatives, and social enterprises that provide certain functions on behalf of GP practices. Different models are starting to emerge in different localities, sometimes led by the CCG and sometimes led by the practices themselves.

Another significant current debate relates to how the boundaries between primary care and secondary care might change and develop. NHS England's very recent NHS Five Year Forward View[9] presents several new models that will emerge over the next few years, including Multispeciality Community Providers and Primary and Acute Care System. NHS Alliance and Foundation Trust Network have formed a collaboration in order to explore and break down some of the historic silos and tensions that continue to hinder innovation in the health service.[10]

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[6] KPMG in partnership with the Nuffield Trust, 2013: The primary care paradox; new designs and models: www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/primary-care-paradox/Pages/primary-care-paradox.aspx

[7] Kings Fund and Nuffield Trust, 2013: Securing the future of general practice, new models of primary care: www.nuffieldtrust.org.uk/publications/securing-future-general-practice

[8] Nuffield Trust, 2013: New models of primary care: practical lessons from early implementers: www.nuffieldtrust.org.uk/publications/new-models-primary-care-practical-lessons

[9] NHS Five Year Forward View, NHS England, Oct 2014: www.england.nhs.uk/ourwork/futurenhs

[10] Integrated thinking for integrated care – NHS Alliance and Foundation Trust Network form new collaboration: www.nhsalliance.org/mediacentre/integrated-thinking-integrated-care-nhs-alliance-foundation-trust-network-form-new-collaboration/

3. NHS Alliance vision for primary care: breaking the boundaries of health

The NHS Alliance's vision for primary care was published in our Manifesto for Primary Care, *Breaking Boundaries*.[11] We believe that primary care can be stronger and more effective if we can break down some actual and metaphorical walls of health institutions that block proactive and preventative routes to making and keeping people well, including boundaries between:

- hospitals and clinicians
- GPs and other primary care professionals (community-based nurses, pharmacists, occupational therapists and the like)
- NHS and non-NHS health and wellbeing providers that have an important contribution to make, such as housing
- professionals and the people, families and communities who they serve.

We want to see GP practices that are connected to the community around them and that have the strategic and financial capacity to work in partnership both with traditional primary care services and community-based organisations. For example, we want to see pharmacies take on bigger roles in medicines and health advice and for housing organisations to play a range of roles in keeping people well, living independently and preventing hospital admission. This is the core message in our recent report *Think Big, Act Now: Creating a community of care*[12] that calls for GP federations to create a new role of 'Community Health Connector'.

We would like to see a patient-led health service as we believe that the real experts are people/patients themselves. And we want to see a transformation in out-of-hospital care for older people.

The medical model of health is well-developed; we want to see social models of health emerge with the involvement of communities and new partners, including housing, in order to reduce and prevent illness, enable people to confidently self-manage their conditions and ultimately reduce demand on the health service.[13] Depending how it's done, we see this shift as part of the solution to the enduring inequalities in health identified by Marmot.[14] And we don't see an alternative route to resourcing health and wellbeing as more people live longer with life limiting illnesses that would have, only a few decades ago, sent them to an early grave.

4. Housing partners in extended primary care

The NHS Alliance recognises housing as a key partner with primary care in building social models of health. We see housing as part of the extended primary care family of providers.

Housing and primary care have much in common: both have a physical presence and deep connection with people and communities; they serve many of the same people and both are feeling the strain as the cost of living crisis and welfare reforms take their toll on their more vulnerable customers (residents/patients); both often have the mutual goal of promoting wellbeing.

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[11] NHS Alliance Manifesto: Breaking Boundaries: www.nhsalliance.org/about-us/manifesto

[12] NHS Alliance: Think Big, Act Now: Creating a community of care: www.nhsalliance.org/mediacentre/nhs-alliance-launches-major-report-think-big-act-now-creating-community-care

[13] Blog: Want to secure a future for primary care? Embrace a social model of health: www.nhsalliance.org/want-a-secure-future-for-primary-care-embrace-a-social-model-of-health

[14] Marmot Review 2010: Fair society, healthy lives: www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Housing and primary care are natural 'frontline' integrators: frontline housing, neighbourhood and supported housing officers, district nurses, social workers, health visitors, general practitioners, occupational therapists, pharmacists, the fire and rescue service (and others) could work in different ways to keep individuals and communities well. These professionals see people and their families and build relationships with them in their homes and neighbourhoods. Together they have the full picture of people's everyday living circumstances and how those might be impacting on their health and wellbeing. Given the right conditions, they could be powerful players in a more integrated and personalised health and wellbeing service.

Housing organisations are an untapped resource: we see the huge strength of not-for-profit housing services providers as a largely untapped resource in helping people to maintain their health and wellbeing. There is significant scope for doing things differently to improve outcomes for people and to reduce pressure on health services.

Practitioners and policy makers are starting to join the dots with an increasing number of examples emerging. Many of these are housing-led, but there are some examples of CCG-led integration too. Here are just a few of them:

- **Family Mosaic** is researching whether systematic health assessments and targeted 'health and wellbeing' work with its residents over the age of 50, will reduce the burden on GPs and hospitals.
- A GP working in a disadvantaged area of Liverpool regularly prescribes inexpensive home-related measures such as draft-proofing and insulation directly through the local **Home Improvement Agency** for his patients who are private tenants and occupiers and whose health he believes is compromised by inadequate housing.
- **Home Group** places support workers in GP surgeries who work with people who need non-medical support. They help people to navigate the care system, to become independent and manage their health better and find routes to wellbeing. GP attendance has reduced and improvements in people's wellbeing have increased.
- **Freebridge Community Housing** has put in place a hospital to home scheme, funded by the local Clinical Commissioning Group, which provides a suitable and tailored care package helping patients to leave hospital more quickly.
- **One Housing Group and Camden & Islington Mental Health Foundation Trust**, have formed a joint venture. The Group purchased Trust land at market value and built housing for sale on the open market, the surpluses from those sales being reinvested, in this case into new mental health units. This model enables unused NHS land to be sold at market value and for the profits of the new development to be reinvested in improving individual and community wellbeing.

A recent NHS Alliance collaboration with National Housing Federation brought examples like this to the attention of NHS England through its Call to Action on Primary Care[15], and inspired several GPs to develop their approach. Other examples of innovative practice and project developments can be found on the Housing LIN's excellent 'Health Intel' webpages at: www.housinglin.org.uk/HealthandHousing

[15] NHS England: Improving General Practice – a call to action: www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta

5. Transforming care for older people

Part of a new social model must include better care for older people. Frail elderly people are admitted to hospitals too frequently and often remain there too long, the reasons including unsuitable or unsafe homes, inadequate care provision and social isolation. But the consequences of over-staying are both dreadful – older people quickly lose their physical, and sometimes mental, capabilities – and costly. They are also avoidable.

Hospitals are designed to diagnose and treat acutely ill people and heal them where possible. According to a recent intelligence report, 29% of hospital bed days are taken by patients whose admission might have been avoided if their care was better managed[16], a significant proportion of whom will be frail and elderly. People taking up hospital beds could do better elsewhere if only the range and scale of services existed outside the hospital walls. Worst of all, most people would choose to spend their last days at home but instead end up in hospital, at great cost to the NHS and causing so much unnecessary anguish for the dying patient and their family. For most of us, 'dying a good death' involves care and compassion not medical intervention.

The way we currently 'care' for older people is reminiscent of the way we used to care for some of the other most vulnerable people in society – in large psychiatric and learning disability hospitals. Thirty years ago many health professionals were involved in closing institutions that were out of date and, it was widely accepted, had become a central part of the problem in people's care. Although it was far from perfect and was often underfunded, care in the community offered a better life for many outside the walls of the 'institution'. We know that more complex acute illnesses benefit from being treated in specialised centres, but on the whole elderly people more often want and would be much better cared for in the community.

The alternative is real investment in care outside hospital because upholding human rights and dignity, rather than outdated institutions, is the right thing to do. Hospitals are already adapting, treating more people, more quickly, with a third less beds than 10 years ago. And 'health and social services investment' has been diverted through CASHH[17] into new homes suitable for older people and people with long term conditions. However, the efforts currently being made are far too small in scale compared to the future needs of a rapidly aging population, and the national policy and funding frameworks are not currently in place to deliver on the ground. Much closer collaborations between health and housing will be required, for example in order to deliver more suitable housing for older people, and a greater social and financial return, through development of NHS land. If we can get that right, it is just possible that when we look back, thirty years on from now, we will be amazed that we still thought of today's provision as anything approaching adequate.

6. Building social models of health – a journey

GPs at a turning point

We are now seeing many examples of housing organisations stepping beyond their traditional boundaries and into the health and wellbeing arena, with some significant wins for communities. This is very encouraging, but it is only the first stage on a long journey. The

[16] Dr Foster Hospital Guide: Fit for the Future? 2013: http://download.drfosterintelligence.co.uk/Hospital_Guide_2012.pdf

[17] DH web pages for Care and Support Specialised Housing Fund (CASSH): www.housinglin.org.uk/Topics/browse/HousingExtraCare/FundingExtraCareHousing/DHCapitalFundingProgramme/CASSHF2013-15/

type of transformation we are talking about is way beyond the experience of most general practitioners and most will be unable to envision what a 'social model' of health might look like or their role in bringing it into being.

However, GPs are becoming demoralised and deeply dissatisfied from long hours and trying to cope with what feels like an unstoppable wave of demand. One 'Open Letter' to Simon Stevens describes 'new levels' of cognitive dissonance that GPs are experiencing: http://gurudox.com/2014/04/02/open-letter-to-simon-stevens/. Many are now at a point where they are prepared to think differently about how they do their work.

Also, while the potential roles for housing organisations are typically overlooked by general practice, well-led Health and Wellbeing Boards are starting to have an influence in some places. Some are using this structural change as an opportunity to form integrated neighbourhood teams that bring community-based health, care and other professionals together to deliver better-tailored primary care to individuals and communities.

Sticking points for GPs

Those housing organisations that are prepared to go on this journey need to be aware of some of the 'sticking points' they are likely to come across when trying to work with GPs. These include the following:

- GPs feel responsible for their patients. 'Letting go' and sharing responsibility with others in the community, and patients themselves, is a huge step for most GPs to take.
- CCGs are having to make a conceptual, emotional and practical leap from looking for national guidance to taking their lead from what's going on within the localities.
- Commissioning housing and other 'non-traditional' services providers to provide health-related services is counter-intuitive, although increasing numbers of CCGs are starting to commission from housing and other community partners and consortia.
- GPs are looking for a broker for their patients - it is not reasonable to expect them to build relationships with all the housing providers in their area and they often don't know where to start.
- Over 80% of people live in private homes and often these homes cause the most difficulties, eg. hazardous, damp or in disrepair, fuel 'poor', overcrowded, unadaptable or inaccessible.
- The NHS will typically only fund measures if they can be certain that savings will be made elsewhere – this is not the same as delivering social value or a social return on investment.
- The difficulties of information sharing between organisations that inhibits a joined up approach to identifying and responding proactively to health and wellbeing issues.

Some promising health-led partnerships

We believe that some big, bold partnerships will be required to take this forward.

One promising example is EPIC – Extended Primary Integrated Care – which has recently been awarded additional funding through the Prime Minister's Challenge Fund[18] to develop in all 46 GP practices across Brighton and Hove. It aims to tackle problems accessing general practice by not just looking inwards, at their systems and processes, but outward to the wider community. It will use the range of skills of appropriate health, social care, housing and third sector professionals, freeing up GPs to focus on more complex, harder to reach patients.

[18] Information on PMs Challenge Fund: www.pcc-cic.org.uk/article/prime-ministers-challenge-fund-pilots-0

In a few areas, housing has been co-opted onto integrated primary care teams enabling greater levels of integration as plans progress. For example, Blackburn's major housing provider Together Housing Group has recently joined the four new Integrated Primary Care locality panels being built around groups of GP practices, each serving between 30 and 50,000 population. This will allow them to work much more closely with GPs and primary care specialists to deliver integrated health and wellbeing solutions across a range of issues, making scale-up much more feasible.

At a strategic level, some CCGs, jointly with their local adult social care commissioners, are reviewing local residential and nursing care pathways and looking to make best use of sheltered housing or explore the possibility of investing in extra care housing. Central London CCG, working together with Westminster City Council and NHS West London CCG, is planning to improve existing and build new care homes and extra care housing enabling people to stay in their homes as they become more frail and have higher levels of care need.[19]

Top tips for housing services providers wanting to go on this journey

The housing sector is very hard to understand and is much less standardised than GP practices and primary care, making it difficult for busy GPs and CCGs to understand what housing can do in their locality and who to talk to. Housing services providers can help the process along in a number of ways. Here are some suggestions.

1. Assume that GPs, CCGs and other health partners are pushed for time – make sure you start the conversation with a few myth-busters or 'big facts' about your organisation or partnership and what it could do that make them sit up and take notice. Don't start from the beginning, it will take too long!
2. Put some effort into understanding what matters most to your GP practices, and develop a proposal that responds to it.
3. Work out how your offer to health might fit into one of the new models listed in the NHS Five Year Forward View, and use that as the context of your conversations.
4. Identify who is leading your GP practices and aim to talk to them. This might be the CCG, although increasingly it may be the GPs and managers leading local networks or federations who provide care rather than CCGs who commission it. For example, Brighton and Hove Integrated Care Service (BICS), a social enterprise, would be a good place to start in that part of the country.
5. Don't expect your GPs to be well connected to the Health and Wellbeing Board or Strategy. In some areas the link through the CCG is good but there is little connectivity in others.
6. Operate together with other local housing providers. GPs find it hard to know why there are so many housing providers, what each does and who they should be talking to. Putting together a single locality health and wellbeing 'offer' from housing that is concise and coherent and that addresses the preoccupations and priorities of local health partners, can work.
7. Start with just one or two focused pieces of work, initially, expanding your portfolio later on.
8. Develop a personalised approach to wrapping services around particular GP patients with particular illnesses (morbidities). Eg. you could offer a specific service to address cold, damp housing inhabited by children with asthma.

[19] www.centrallondonccg.nhs.uk/news/central-london-and-west-london-clinical-commissioning-groups-and-the-council-transforming-care-for-older-people.aspx

9. If you are a major housing provider in a locality, then you can develop a community leadership role around health and wellbeing. This might involve offering up advice relating to an area of work without necessarily expecting to win every contract or it might involve leading or being part of consortia, winning and delivering contracts with others.

7. Breaking boundaries and beyond

The NHS Alliance has set out on a journey to support a radical reinvention in primary and community-based care. A recent NHF survey showed that seven out of ten GPs believe housing support services are crucial to patient health and many of them also believe they save the NHS money, but over 80% are unsure how to commission such services.[20] We want to change that and to enable GPs to access suitable housing and community-based health and care solutions. In particular, we would like to see progress made in relation to:

- reducing hospital admissions and readmissions
- making better use of NHS land
- reducing demand on GPs and A&E
- co-creating health and wellbeing with patients and communities
- providing GPs with ways of addressing the problem of cold damp homes
- developing social models of health.

We are a bridge between health and housing, opening the door to housing organisations and mediating important conversations with health organisations at national and local level. We have a long history of engagement with Department of Health, NHS England, Public Health England, NHS Clinical Commissioning, Foundation Trusts Network and others, as well as having many connections with GPs and clinical commissioning groups. We want housing and other community-based professionals who believe they can be part of the solution to join us and our partners in shaping the general practice and primary care service of the future.

Joining us on this journey

Joining the NHS Alliance is the best way to participate and have an influence on our work and we will prioritise communications with our members.

For more information on membership: www.nhsalliance.org/join-us

To join, please visit: www.nhsalliance.org/join-us/membership-form

[20] www.housing.org.uk/media/press-releases/gps-unsure-how-to-commission-vital-support-services

Note

The views expressed in this paper are those of the author, and not necessarily those of the Housing Learning and Improvement Network.

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About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing Learning and Improvement Network (LIN) is the leading 'learning lab' for a growing network of housing, health and social care professionals in England involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

In addition, to participate in our shared learning and service improvement opportunities, including 'look and learn' site visits and network meetings in your region, visit: www.housinglin.org.uk/Events/ForthcomingEvents

For further information about the Housing LIN's comprehensive list of online resources on health and housing, visit our 'Health Intel' pages at: www.housinglin.org.uk/HealthandHousing

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