housing associations and the NHS: new thinking, new partnerships

By Denise Chevin

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Contents

Foreword 3
Paul Hackett, Director of the Smith Institute

Scope of the report 4

Executive summary 6

Chapter 1: Introduction – housing and health 14

Chapter 2: Facing up to the challenges ahead 18

Chapter 3: Where housing associations fit in 24

Chapter 4: The impact of NHS reforms 28

Chapter 5: Making partnerships work in practice 38

Chapter 6: Integration in action – case studies 48

Chapter 7: Making full use of NHS land and assets 56

Chapter 8: Conclusion 66

Acknowledgments 72

Foreword

Paul Hackett, Director of the Smith Institute

The treatment and care of more people in their own communities and the provision of more support to allow them to stay in their own homes or in specially designed accommodation is vital if our society is to cope with an ageing population and the growing number of people with multiple long-term conditions. Furthermore, given the increase in demand and the consequential rise in healthcare costs, it is essential to secure efficiency savings and productivity improvements wherever possible. Much greater integration of health and housing is widely seen as one way of meeting these challenges, yet progress has been painfully slow and often unnecessarily bureaucratic.

Although in theory there is everything to be gained from the health and housing worlds working closer together, all too often they operate in silos and are disconnected and detached from each other. This report, which captures the views of a range of healthcare and housing professionals and experts, explains why that is so and asks what can be done to remove the barriers to collaboration. That discussion is then followed by perspectives on what works and how new partnerships are reaping the benefits of better integration. In particular, the report breaks new ground by highlighting some excellent pioneering schemes and different types of innovation.

The report does not pretend to offer a comprehensive picture of everything that is occurring between health and housing. What it does provide is a snapshot of current thinking around some elements of the agenda, including using surplus NHS land to improve clinical outcomes. At the very least, we hope the report will stimulate debate across both disciplines and help shape the policy response.

The Smith Institute would like to thank the author of this report, Denise Chevin, who has performed a small miracle in condensing so many interviews into one document. We would also like to thank all those who attended the peer review meeting on the project at Somerset House in May 2014 and those who submitted their comments on the early drafts. In particular, the institute offers special thanks to One Housing Group for supporting the project.

Scope of the report

This report provides a commentary on the many benefits that could flow if social landlords and the NHS worked together to provide new homes and support to improve health, reduce hospital admissions and shorten the length of time people have to remain on hospital wards because there is nowhere else for them to go. It also discusses how innovative approaches to the integration of housing and health can reduce healthcare costs and help manage demand.

The content of this report is largely drawn from interviews with over 50 decision makers and experts from both the health and housing sectors, including hospital managers, housing association chief executives and their heads of care and support, along with representative bodies, private-sector consultants and developers. Their names are listed in the annex. Interviewees spoke openly about their experiences, the barriers to joint working, and what had made partnerships successful. This distillation of views from practitioners provides a unique insight into what is happening on the ground and into the business models and practices that organisations are adapting to make partnerships work. In particular, it offers a range of perspectives on what works, what doesn't, and, perhaps most critically, what needs to change.

The interviews were conducted either face to face or over the phone between March and May 2014. The Smith Institute also held a peer review roundtable discussion to consider the early findings with key stakeholders from both the housing and health worlds. As part of the project the institute also undertook accompanying research on how using surplus NHS land to build supported housing could help meet demand and reduce the costs of care. The research report,[1] which is referred to later in this report, quantifies possible future savings that can be made based on existing land disposal programmes.

The report is divided into three sections. The first gives a general background to the challenges facing healthcare organisations; the second section details recent changes in the NHS and how they impact on housing and health integration; and the final chapters look at the barriers and opportunities to partnership working, with reference to best practice and case studies.

1 Smith Institute *NHS Surplus Land for Supported Housing: Why Now and What Are the Possible Savings* (2014)

Executive summary

Executive summary

- The NHS is in danger of imploding. The squeeze on funding and the increased demands of an ageing population living with multiple long-term conditions are putting severe pressure on the NHS. Unless action is taken, this can only get worse. NHS waiting lists are at their longest in six years.[2] Continuing with the current model of care is forecast to lead to a funding gap of around £30 billion between 2013/14 and 2020/21.[3] The cost of dementia alone is expected to increase from £15 billion a year (2008 figures) to £35 billion a year in the next decade, as the predicted number of sufferers soars.[4]

- It is vital the NHS reduces admissions and moves towards more community-based care. The reforms of the health service are aimed at delivering a shift away from acute units to community and primary/secondary care; to deliver care in the least restrictive setting; to change emphasis from treatment to prevention; to integrate services across health and social care; to encourage greater self-help among patients; and to deliver more efficient and effective care pathways.

- These objectives dovetail with the capabilities, strengths and ethos of the social housing sector. Housing associations have a long-standing tradition of providing housing and support. Through their connections to the community, capability in managing assets and ability to raise capital, they could help to deliver the government's health strategy.

- There is untapped potential for housing and healthcare providers to work together to deliver solutions to help alleviate the crisis in the NHS and offer efficiency savings. This could be in the form of joint ventures to provide new models of supported housing, step-down and reablement facilities, or extra support and care for people in their own homes.

- Housing associations are often in a good position to form innovative partnerships because of their access to capital and asset management capabilities. There is also a long tradition of care provision in the sector. The NHS is often capital-poor but land-rich. Rather than sell off its land to the highest bidder, it may make longer-term sense for trusts to use this asset as equity. A combination of housing's borrowing power and health's assets reduces the risks of developing high-cost

2 http://www.theguardian.com/society/2014/apr/17/nhs-waiting-lists-longest-six-years
3 NHS England *The NHS Belongs to the People: A Call to Action* (2013)
4 Humphries, R and Bennett, L *Making Best Use of the Better Care Fund* (King's Fund, 2014)

specialist housing and increases financial viability for both.

- Supporting those with long-term conditions in appropriate accommodation could help reduce hospital admissions, combat the growing problem of readmissions and deliver a better quality of life. But if this is to happen, the health and social care providers need to include housing as part of care pathways.

- The health benefits of good housing are widely accepted, but it is still proving extremely challenging for housing and housing-related support to form part of the solution when health and social services are establishing care pathways and allocating their budgets.

- There are good examples of innovative partnerships. For example, in north London new facilities provided by One Housing Group, working in partnership with Camden & Islington NHS Foundation Trust, are providing supported living for people with mental health issues who otherwise might have to stay on a hospital ward or in an out-of-borough residential care home. One Housing Group claims the cost of long-term care on an NHS ward is around £3,000 per week; it is delivering a more appropriate level of support for £600 per week.

- Jon Rouse, director general at the Department of Health, says the challenge facing health and care organisations is huge. "New ways of working are needed and there is no better time for housing professionals to engage with health and care decision makers. Housing professionals can make it easy for local decision makers by identifying the housing and housing services that can deliver the health and care outcomes required."

- But, by and large, it is proving challenging to persuade NHS trusts or commissioners to think differently at a time when the health service is undergoing what has been described as the biggest upheaval in its history. Beneficial partnerships are also being thwarted, for example by bureaucracy, perverse financial incentives and very different cultures.

- Prospects for the new Better Care Fund (formerly the Integration Transformation Fund)[5] to catalyse more innovation and integration between social care and health and to make funds go further do not look promising either. Early indications are that

5 The Better Care Fund (formerly the Integration Transformation Fund) was announced by the government in June 2013 to ensure a transformation in integrated health and social care. The fund is a single, pooled budget to support health and social care services to work more closely together in local areas.

the Better Care Fund is unlikely to spur huge innovation in service delivery, at least in this initial round. Clinical commissioning groups and health and well-being boards, which jointly sign off their plans from local authorities, had less than six months to submit plans to NHS England. The indications are that the plans, which are now being reviewed, have adopted a low-risk approach to how they are allocating resources, using them to fund existing services.

- Meanwhile, new research from the Smith Institute prepared alongside this report has shown that potentially billions of pounds could be saved if NHS land and assets were used to build step-down facilities or supported housing that could cut hospital admissions and the length of time spent on hospital wards.

- Although forming new partnerships is challenging, there is optimism among housing and healthcare providers and commissioners that the pressures they are under will force the hand of change. And they are encouraged by the new Care Act, which puts the importance of housing for people's health and well-being on a recognised legal footing. The suitability of living accommodation is now explicitly listed as part of the definition of well-being, which sets the tone for the whole act.

- However, the health reforms and financial squeeze on the NHS have had a mixed impact on innovative working. On the one hand, it has started opening up more conversations between housing and health providers; on the other, the huge upheaval resulting from the reforms has created a hiatus, and even set the agenda back a step, while the new structures settle down. They also mean that much more autonomy has been devolved to NHS foundation trusts, which makes the Department of Health less able to dictate from the centre.

- In theory, clinical commissioning groups should be driving the setting up of more reablement facilities and other types of supported housing. But they are struggling to reinvest any savings in community-based health services, because the demand for hospital-based secondary care is so great. Waiting lists are almost back at the 3 million mark, a figure not seen since 2008.

- The consensus is that the "golden key" enabling housing providers and health organisations to work together has yet to be found. A major part of the problem is that housing is not yet integral to the health and social care integration agenda.

- There are myriad barriers: these range from governance and cultural differences and mistrust, through to perverse financial flows that can disincentivise innovation and

partnership. Though the health impacts of poor housing are understood, there is still a paucity of knowledge and empirical evidence on the benefits and savings that could convince health commissioners to switch resources away from existing care pathways to new, housing-based solutions. Housing associations have a tendency too to overstate the savings without understanding that real savings can be realised only if hospital wards can be closed, or at least more patients treated.

- Trusts and NHS Property Services are under enormous political pressure to sell off their surplus land in order to provide new housing.

Where partnerships work:

- The housing association has understood the needs of its health partner and put forward a clear offer that will create financial benefit – not just to the NHS, but also to the individual health provider. The NHS is not an entity but a collection of "businesses" all trying to balance their budgets, be good employers and lay solid foundations on which to take forward their operations in the future.

- Relationships have been built over a period, with housing associations marketing themselves at health-related events and joining supplier forums.

- There is integrated commissioning between social care and health. The Barker Commission, initiated by the King's Fund in 2013, has called for a step change in integrated commissioning in its recent interim report.

At the strategic level there are a number of welcome developments that give cause for optimism:

- A new concordat is being drawn up by housing and health organisations and the Department of Health to encourage closer working between housing and health. Though it will lack powers, it adds to the mood music.

- The Department of Health is committing £300 million from its budget to provide extra-care housing and other supported housing to help boost levels of specialist housing from current historically low levels. According to figures from the Homes & Communities Agency,[6] building rates for homes aimed at older people are lower now by a factor of three to four than in the 1980s, and the supply of older people's

6 Kevin McGeough, national lead on older and vulnerable people at the Homes & Communities Agency, in a presentation to the Royal Town Planning Institute conference "Planning for an Ageing Population" in Leeds in 2014

housing for sale is at its lowest for 30 years, despite 75 percent of older people owning their own home.

- NHS trusts are bringing in strategic estate partners to make better use of their estates, including the provision of extra-care and reablement facilities and other revenue-generating facilities.

- The Care Act explicitly references housing as part of local authorities' new duty to promote the integration of health and care, while registered providers of social housing are explicitly listed as one of the partners with which a local authority must co-operate when considering and planning for a person's need for care and support.

- NHS Property Services is taking a conservative approach to land for the moment, bringing it forward for sale rather than using it to form joint ventures in the medium term. It might review this policy in future and develop business-case assessments that take into consideration value to the community as well as sales value on the open market.

- There is a case for the Homes & Communities Agency stepping in and becoming more vocal about the better value that could be created to the NHS if trusts were to take a longer-term approach and use land or redundant facilities to provide new types of step-down or reablement accommodation, or specialist housing.

- Research by the Smith Institute shows that over 25 years, savings of £5.9 billion could be realised if trusts and housing providers worked together to develop new care pathways and facilities like Tile House – a specialist housing block offering care support in King's Cross.[7]

Of course, financial pressure, increased competition and the power of the clinical commissioning groups ought to be drivers of change. But for the moment, that is proving a step too far.

Recommendations

On a practical level, to work within the system:

- Housing associations need to be clear about their offer to health organisations, understand financial flows and local health priorities, and think of trusts

7 Smith Institute, op cit

as businesses – marketing their competencies and solutions to the clinical commissioning groups. A number of organisations are working to provide more rigorous evidence of benefits, which is absolutely crucial. But perseverance will be of the essence. Striking up new partnerships will not happen overnight.

- The Department of Health could follow the example of the Department for Work & Pensions and promote more "meet the client" events.

- NHS England could look at introducing a standard contract for smaller organisations to reduce unnecessary red tape and foster easier bidding arrangements.

On a policy level:

- There needs to be greater focus on the need to consider NHS surplus land to improve efficiencies in care pathways, with the development of a new assessment process that takes into account value to the community as well as sale value on the open market. In essence it amounts to a "sixth case" to the Treasury five-case business planning model, which prioritises the proposal's overall value for the local community. This could be accompanied by a set of standards for how local communities and local organisations contribute to this. The Social Value Act 2012 is forcing local authorities to take local need into consideration when awarding contracts, and this could follow a similar principle. This will enable organisations to act genuinely as guardians of public assets and to take account of other issues such as inequalities.

- A new, transitional fund is needed to provide seed-corn money for which clinical commissioning groups and health and well-being boards could bid. This funding could kick-start new thinking and innovative community-led healthcare pilot schemes and provide incentives that would overcome financial barriers to change.

- The second or further round of funding from the Care and Support Specialised Housing (CASSH) Fund to build specialised housing could be targeted at encouraging new public-sector development partnerships – which would encourage trusts to invest land and, in some circumstances, enable the development of what generally is high-cost housing to be financially viable.

Chapter 1

Introduction – housing and health

Introduction – housing and health

The NHS is in danger of imploding. The squeeze on funding and the increased demands of an ageing population living with multiple long-term conditions are putting severe pressure on the health service. Unless action is taken, this can only get worse. NHS waiting lists are at their longest in six years.[8] Continuing with the current model of care will lead to a funding gap of around £30 billion between 2013/14 and 2020/21.[9] The cost of dementia alone is expected to increase from £15 billion a year (2008 figures) to £35 billion a year in the next decade, as the predicted number of sufferers soars.[10]

For the NHS to stand any chance of coping with the increased demands, hospital admissions need to be reduced and more care provided in the community. New reforms and policies have been put in place aimed at setting the NHS on this course. Simon Stevens, the new chief executive of NHS England, has spoken recently about the need to return to providing more care for people in their communities, especially for older people.[11] But one of the vital components of such a policy is still being given little prominence – the importance of appropriate housing.

Housing associations have a long-standing tradition of providing housing and support. Through their connections to the community, capability in managing assets and ability to raise capital, they could help to deliver the government's health strategy.

But housing associations, which currently manage 2.5 million homes, are often hamstrung in expanding what they do by the lack of guaranteed government funding. In fact both councils and housing associations view such financial uncertainty as a major obstacle to building more extra-care facilities for the elderly or other supported accommodation.

The health benefits of good housing are widely accepted, but it is still proving extremely challenging for housing and housing-related support to form part of the solution when the health and social services are establishing care pathways and allocating their budgets.

Just as the benefits of good housing are accepted, so conversely are the detrimental effects of poor housing on health. The effects of poor housing conditions have been

8 http://www.theguardian.com/society/2014/apr/17/nhs-waiting-lists-longest-six-years
9 NHS England, op cit
10 Humphries and Bennett, op cit
11 *Daily Telegraph* interview with Simon Stevens, May 2014

estimated to cost the NHS at least £600 million per year.[12] Despite these costs, some of those interviewed for this report believe the agenda has gone backwards in that complex reforms and restructuring of the NHS have made the sort of relationships that some organisations had enjoyed in the past far more difficult to achieve.

That said, there are instances where housing and health and social care are working in concert – to reduce readmissions by settling older patients when they leave hospital, to provide end-of-life support, or to provide step-down facilities where frail patients can regain their strength and confidence before going home, thus reducing the likelihood of readmission. For example, in a pilot programme involving housing association Gentoo, Durham GPs are prescribing domestic boilers on the NHS for vulnerable households to keep people warm so they do not have to be admitted to hospital when temperatures drop. In north London new facilities provided by One Housing Group, working in partnership with Camden & Islington NHS Trust, are providing supported living for people with mental health issues who might otherwise have to stay on a hospital ward or in an out-of-borough residential care home. One Housing Group claims the cost of long-term care on an NHS ward is around £3,000 per week; it is delivering more appropriate levels of support for £600 per week.

But, by and large, it is proving challenging to persuade NHS trusts or commissioners to think differently at time when the health service is undergoing what has been described as the biggest upheaval in its history. Beneficial partnerships are being thwarted by bureaucracy, perverse incentives and very different cultures, to mention just a few of the barriers. Prospects for the new Better Care Fund (formerly the Integration Transformation Fund)[13] to catalyse more innovation and make funds go further do not look promising either. As mentioned later in the report, the fund (due to be launched in April 2015) risks becoming mired in controversy.

Meanwhile, new research from the Smith Institute prepared alongside this report shows that potentially billions of pounds could be saved if NHS land and assets were used to build step-down facilities or supported housing that could cut hospital admissions and the length of time spent on hospital wards. At the moment, surplus land is sold to the highest bidder. The prospects of using NHS land to form part of the care pathway is discussed in chapter seven. But although forming new partnerships is challenging, there is optimism

12 Davidson, M, Roys, M, Nicol, S, Ormandy, D and Ambrose, P *The Real Cost of Poor Housing* (Building Research Establishment, 2010)

13 The Better Care Fund (formerly the Integration Transformation Fund) was announced by the government in June 2013 to ensure a transformation in integrated health and social care. The fund is a single, pooled budget to support health and social care services to work more closely together in local areas.

among housing and healthcare providers and commissioners that the pressures they are under will force the hand of change. They are encouraged by the new Care Act, which puts the importance of housing for people's health and well-being on a recognised legal footing. Receiving royal assent in May this year,[14] the act introduces a cap of £72,000 on lifetime care costs an individual will pay, a deferred payment system so that individuals will not be forced to sell their homes to pay for care in their lifetime, and a legal right to have personal care budgets. The suitability of living accommodation is now explicitly listed as part of the definition of well-being, which sets the tone for the whole act.

Housing is explicitly referenced as part of local authorities' new duty to promote the integration of health and care. Registered providers of social housing are now explicitly listed as one of the partners with which a local authority must co-operate when considering and planning for a person's need for care and support.[15] The right noises are beginning to come from the top, and recently £300 million has been set aside from the Department of Health budget for the development of supported housing (the so-called Care and Support Specialised Housing Fund).

According to Jon Rouse, director general at the Department of Health:

"The challenge facing health and care organisations is huge. New ways of working are needed and there is no better time for housing professionals to engage with health and care decision makers. Housing professionals can make it easy for local decision makers by identifying the housing and housing services that can deliver the health and care outcomes required."

Merron Simpson, NHS Alliance special adviser on housing, best sums up the state of play:

"I think the NHS is prising the door open a bit – it is an incredibly difficult time for hospitals, with everyone acutely conscious of the finances. And I think there is a recognition we have to do things differently. I see a commitment to transformation, but without a clear idea as to what to do. Inevitably, during this period of change, we'll be seeing elements of randomness for a while. But I think there is room to be optimistic. To use a sporting expression, health is coming on to the pitch – it's not in the changing rooms any more!"

14 The Care Act 2014 reforms the law relating to care and support for adults and the law relating to support for carers, to make provision about safeguarding adults from abuse or neglect.
15 National Housing Federation *The Care Act 2014*, briefing (May 2014)

Chapter 2

Facing up to the challenges ahead

Facing up to the challenges ahead

Commissioners are tasked with delivering a sustainable healthcare system in the face of one of the most challenging times in the organisation's history. An ageing population and increased prevalence of chronic diseases will require a strong reorientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated.[16]

The Health and Social Care Act 2012 ushered through reforms to the NHS, overhauling its structure and introducing greater competition to help drive these changes. These are discussed in more detail in chapter three. However, the ensuing upheaval has been described by interviewees as creating a hiatus.

The challenge for the NHS is difficult and complex. For example:

- When the health service was founded in 1948, some 48 percent of the population died before the age of 65. As the King's Fund recently reported,[17] that figure has now fallen to 14 percent;[18] by 2030 one in five people in England will be over 65.[19]

- When the NHS was launched it had a budget of £437 million (roughly £9 billion at today's value). For 2012/13 it is around £108.9 billion.

- More than 15 million people in England today have a long-term condition, making up a quarter of the population.[20]

- Demand on NHS hospital resources has increased dramatically during the past 10 years, with a 35 percent increase in emergency hospital admissions.[21]

- Furthermore, the number of people aged over 85 is growing rapidly, and the number of older people who have care needs is predicted to rise 61 percent by 2032.

- The number of people with dementia alone is expected to more than double during the next 30 years.[22]

16 NHS England, op cit
17 Oliver, D, Foot, C, Humphries, R *Making Our Health and Care Systems Fit for an Ageing Population* (King's Fund, 2014)
18 Ibid
19 ibid
20 Department of Health *Long Term Conditions Compendium of Information*, 3rd edition (2012)
21 Royal College of Physicians *Hospitals on the Edge? The Time for Action* (2012)
22 Humphries and Bennett, op cit

- Just a small number of patients with more than one illness can consume a huge proportion of resources across acute, community, primary, mental health and social care. People with long-term conditions already account for 70 percent of all inpatient bed days.[23] And these high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[24]

According to the King's Fund: "If nothing changes in the NHS, the result will be significant unmet need and threats to the quality of care."[25] Its independent Commission on Health and Social Care in England (2013-14) concluded that "the problems of the current settlement for health and social care are systemic… and stem from a lack of alignment in entitlements to care, between funding streams, and in organisation/commissioning of care. There is a problem of adequacy, with too little money spent on social care and too much demanded at a time of rising needs."[26]

Reduced resources

At the moment the NHS budget of £108 billion has largely been protected from the government's austerity programme. But even with a protected budget, efficiencies need to be found within the current health spending envelope. The NHS budget is set to rise only in line with inflation, and therefore considerable savings will need to be made. The Institute of Fiscal Studies has shown that even if health spending keeps pace with inflation, real age-adjusted health spending per person will be 9 percent lower in 2018/19 than it was in 2010/11.[27] As Richard Humphries, assistant director for policy at the King's Fund, told us: "The NHS has no real-terms budget increase to speak of for five years; it is staring into a financial abyss."

The NHS has been charged with making efficiency savings (under the so-called "Nicholson challenge") of £20 billion by 2014/15. Yet NHS trusts have increasingly been struggling to meet demand under the current funding settlement. According to Monitor, which regulates England's 147 trusts, the combined deficit of the trusts is £180 million and rising. Almost a third of NHS foundation trusts are forecasting that they will have overspent during the financial year.[28]

The hope has been that more competition and greater targets would drive efficiencies.

23 Naylor, C et al *Long-term Conditions and Mental Health* (King's Fund, 2012)
24 Department of Health, op cit
25 *Transforming Our Health Care System: Ten Priorities for Commissioners*, revised edition (King's Fund, 2013)
26 Barker, K et al *Commission on the Future of Health and Social Care in England*, interim report (King's Fund, 2014)
27 Crawford, R et al "Public Finances: Risks on Tax, Bigger Risks on Spending?" in Emmerson, C et al (eds) *The IFS Green Budget 2014* (Institute for Fiscal Studies, 2014)
28 Branwen Jeffreys "More NHS Trusts Sliding into the Red" on BBC News website, 31 January 2014

However, the gains have been nowhere near what was expected.[29] Instead, productivity improvements have to date been relatively small, averaging only around 0.4 percent per year from 1995 to 2010 (against an expectation of 4 percent per year).[30] Moreover, if the Office for Budget Responsibility's forecasts on spending for the period from 2015/16 to 2021/22 are to hold good, a further 2 percent a year of productivity gains will need to be found in the NHS.

The transformational programme involving patients, staff and the voluntary sector, known as the Quality, Innovation, Productivity and Prevention (QIPP) initiative, sets out how the NHS hopes to meet the Nicholson challenge. Its aim is to provide better-quality services in the most productive and cost-effective way, with a strong emphasis on integration of care.[31] Indeed, one of the main examples given by the Department of Health is reducing expensive admissions by treating people closer to home. One such option would be to look at how housing can play a role in integration.

Providing a greater supply of supported housing could reduce the need for and cost of expensive acute hospital provision. International comparisons show that the UK has relatively low levels of supported housing. Although there are difficulties in making comparisons, as many as 25 percent of Danes aged over 65 receive home care. In the UK, by contrast, the figure is just 6 percent.[32] High-level estimates suggest that even with funding from the Care and Support Specialised Housing Fund continuing there is a supply gap of 20,000 to 45,000 units each year of housing catering for people with support needs.[33] Generally, housing designed for older people is in particularly short supply. According to figures from the Homes & Communities Agency,[34] building rates for housing for older people are lower now by a factor of three to four than in the 1980s, while the supply of older people's housing for sale is at its lowest for 30 years despite 75 percent of older people owning their own home.

Meanwhile, adult social care is also said to be in a constant state of crisis.[35] An analysis by *Community Care* of 2014/15 budgets from 55 of the 152 local authorities in England found that planned spending on adult social services was an average of 2 percent down in cash terms from the previous year. When inflation is factored in, this amounts to a reduction of 4 percent in real terms.[36]

29 Roberts, A et al *A Decade of Austerity?* (Nuffield Trust, 2012)
30 Office for National Statistics *Public Service Productivity Estimates: Healthcare, 2010* (2012)
31 Goodwin, N et al *A Report to the Department of Health and the NHS Future Forum* (King's Fund/Nuffield Trust, 2012)
32 Knap, M et al *Dementia: International Comparisons* (LSE/King's College London, 2007)
33 Kevin McGeough, Homes & Communities Agency national lead on older and vulnerable people, in a presentation to the Royal Town Planning Institute conference, "Planning for an Ageing Population", in Leeds, 2014
34 Ibid
35 National Audit Office *Adult Social Care in England: Overview* (March 2014)
36 Community Care, 9 April

The introduction of the Care Act 2014 has given some clarity around the social care "cap" and the introduction of universal deferred payment schemes. However, tensions often arise because care in the NHS is free at the point of delivery, while social care is means-tested by local authorities. This can result in grey areas for long-term conditions such as dementia, where it is not always clear what support is necessary and therefore who pays for it, and this lack of clarity can increase hospital admissions and delay discharges. It is estimated that delayed discharges cost the NHS around £550,000 per day (approximately £200 million per year).[37]

A concerted drive to integrate care (and funding) is needed to overcome these issues. The King's Fund has shown that integrating primary and social care reduces admissions. One of the pioneering authorities is Torbay, where providing integrated care to at-risk older people has led to a reduction in hospital admissions.[38]

Reducing admissions

If the NHS is to cope with increased demand and fewer resources, there is an urgent need to reduce admissions – and ultimately to close hospital wards. There has already been a significant reduction, particularly in mental health. In England for example, over the period 1979-2012, the number of beds used for acute care fell by 35 percent, for maternity by 58 percent, for geriatric care by 65 percent, and for mental illness and learning disability by 74 percent and 96 percent respectively.[39]

If people with long-term conditions are managed effectively in the community, they are more likely to remain relatively stable and enjoy a better quality of life with fewer crises and hospital visits. The Nuffield Trust has estimated that there has been a 50 percent rise in potentially avoidable admissions over a 12-year period. Such admissions already form a major proportion of NHS urgent care costs, estimated at £1.4 billion per year. With an upward trend, the cost to the NHS is forecast to rise further.[40]

This provides an opportunity for housing associations to offer community-based services to reduce demand for A&E and to improve the discharge rate, thereby freeing up the capacity needed in hospitals to deal with more acutely ill patients. More than 70 percent of homeless people, for example, are being discharged from hospital back onto the streets, damaging

37 NHS Confederation *Briefing* no 248 (September 2012)
38 Purdy, S *Avoiding Hospital Admissions: What Does the Research Evidence Say?* (King's Fund, 2010)
39 John Appleby, chief economist for health policy at the King's Fund, on the King's Fund blog, 15 March 2013 (http://www.kingsfund.org.uk/blog/2013/03/hospital-bed-its-way-out)
40 Blunt, I *Focus on Preventable Admissions: Trends in Emergency Admission for Ambulatory Care Sensitive Conditions, 2001 to 2013* (Nuffield Trust/Health Foundation, 2013)

their health and resulting in significant levels of readmission.[41] Furthermore, it is estimated that delayed discharges are costing the NHS £200 million per year.[42]

As the National Housing Federation points out: "NHS providers may feel there is no alternative but to detain patients as there is no suitable accommodation for them to be discharged to."[43] This leads to blockages in the care pathway that prevent transfer of service users from high-intensity services, which acts as a barrier to patients' recovery. Alternatively, it can lead to expensive out-of-area placements. Analysis by the National Mental Health Development Unit found that in 2009/10 around £690 million was spent on out-of-area services in England.[44]

41 Homeless Link, Saint Mungo's and Inclusion Health *Improving Hospital Admission and Discharge for People Who Are Homeless* (2012)
42 NHS Confederation, op cit
43 National Housing Federation *Partnerships with Housing to Improve Mental Health Outcomes*, Connecting Housing and Health briefing (2014)
44 National Mental Health Development Unit *In Sight and in Mind: A Toolkit to Reduce Use of Out of Area Services* (2011)

Chapter 3

Where housing associations fit in

Where housing associations fit in

The reforms of the health service are aimed to deliver a shift away from acute units to community and secondary/primary care; to deliver care in the least restrictive setting; to change emphasis from treatment to prevention; to integrate services across health and social care; to encourage greater self-help among patients; and to deliver more efficient and effective pathways. These objectives dovetail with the capabilities, strengths and ethos of the social housing sector. As the Housing Learning & Improvement Network put it: "With new duties on integration outlined in the new Care Bill, it is increasingly recognised that recovery from illness and maintenance of good health is determined by a range of factors outside health services. Evidence from the field shows that when agencies involved in housing, health and social care work together they have more success than when acting alone."[45]

Michael Laing, director of social care and independent living at Gateshead Council, says that where housing and adult social services and public health work closely together there is a great deal of potential: "There is huge scope around integration, and social care has a great deal to learn from the housing world, where the norm is to have a regime of customer focus and value for money. Housing associations operate in areas where there is inequality. They are in an ideal position to know what customers' needs are. There is a real opportunity for housing organisations to approach social care with an offer rather than ask what we can do – but they need to understand how we work."

Many housing associations have always provided care and support and are looking to work with health commissioners and providers in developing integrated models of health, care and support. Others are keen to leverage their asset management skills and considerable financial capacity to create joint ventures with NHS trusts in order to help finance new facilities for reablement, or more supported housing, which has the potential to generate savings for the NHS. "The general view is that a hospital bed can cost anything from £2,000 to £4,000 per week (out-of-area beds can cost more). A small adapted flat would cost, say, £500 to £750 per week," says Gwynne Furlong, a non-executive director of Lancashire Care NHS Foundation Trust and a board member of Progress Housing Group. His hospital trust is currently working up proposals for step-down facilities. "In theory the hospital trust could do the work themselves, but many trusts do not have the capital resources, or feel that they are better used elsewhere."

45 Housing Learning & Improvement Network *Integration: Healthy Partnerships* (2014)

Housing associations
Altogether housing associations in England provide about 2.5 million homes for more than 5 million people. They are non-profit-making organisations regulated by the Homes & Communities Agency (and the Greater London Authority in London). Turnover in the sector was up 9 percent at £13.8 billion in 2011. Housing associations turned in an increased surplus after tax in 2012 of £1.79 billion. The gross book value of the sector's assets stands at £118.1 billion. In 2012 housing associations raised around £4 billion from the capital markets.[46]

A main driver for housing associations to partner with health is to use their expertise in community services to improve health and well-being for residents and communities. The operating context for providing community-based housing, care and support services is changing dramatically. There have been significant cuts to capital investment in affordable and specialist housing; reductions in local authority funding mean preventive housing-related support services have been heavily reduced; and social housing tenants are experiencing significant uncertainty as a result of welfare reform.

As a response to welfare spending reforms, some housing associations are choosing to invest more of their own resources in supporting their residents to ensure they remain in their own homes and sustain their tenancies.

As Jake Eliot, policy leader at the National Housing Federation, comments: "Welfare reforms have thrown up considerable challenges for the housing sector. Cut-backs from local authorities to preventive support services and the shake-up of benefits for local residents means more and more providers of housing with care and support are revaluating their offer and refocusing their role and remit. As a result of this, many housing associations are keen to develop practical partnerships with NHS providers to use their expertise in providing homes and support in a more focused way to improve health and well-being and deliver social value."[47]

Housing associations can potentially offer solutions that provide services in people's own homes and communities, which in theory chimes with the Department of Health's objectives. The department's 2009 National Dementia Strategy, for example, called for:

- monitoring the development of models of housing, including extra-care housing, to meet the needs of people with dementia and their carers;

46 Heywood, A *Investing in Social Housing: A Guide to the Development of the Affordable Housing Sector* (Housing Finance Corporation, 2013)
47 National Collaboration for Integrated Care & Support *Integrated Care and Support: Our Shared Commitment* (2013)

- staff working within housing and housing-related services to develop skills needed to provide the best-quality care and support for people with dementia in the roles and settings where they work; and
- a watching brief over the emerging evidence base on assistive technology and telecare to support the needs of people with dementia and their carers to enable implementation once effectiveness is proven.[48]

More recently, in *Integrated Care and Support: Our Shared Commitment*,[49] the NHS and other health bodies stated: "We know that well-designed housing is a key factor in facilitating timely discharge from hospital and avoiding admissions to hospital or a residential home in the first place and maintaining independence."

So, for example, housing associations can bring capital investment and work directly with a trust to develop community-based long-term rehabilitation services for people with complex mental health conditions, providing support to assist their eventual rehabilitation in the community.

Work carried out by the National Mental Health Development Unit showed the different ways in which housing services, if consistently applied, could reduce the costs of the psychosis pathway by £400 million a year.[50] As shown later in the report, innovative partnerships between housing associations and trusts in respect of secondary care also provide evidence of significant savings in the area of mental health.

48 Department of Health *Living Well with Dementia: A National Dementia Strategy* (2009)
49 National Collaboration for Integrated Care & Support, op cit
50 Appleton, S, van Doorn, A, and Molyneux, P (eds) *Mental Health and Housing: Housing on the Pathway to Recovery* (National Mental Health Development Unit, 2013)

Chapter 4

The impact of NHS reforms

The impact of NHS reforms

While on paper there is much to be gained from partnerships between housing and health, the path to collaboration appears to be strewn with obstacles that make the tie-up difficult. Not the least of these are the recent reforms to the NHS. These have created a complex structure, which on a practical level can make it difficult for potential partners to navigate, as well as producing a hiatus in promoting fresh ideas while the new regime beds in.

According to some housing associations, the reforms and the money that flow through the NHS have created perverse financial incentives that can work against reducing costs to the NHS as a whole. Sarah Clee, head of older people's services at housing and care body Midland Heart, describes how difficult it can be to get a grasp of the way the reforms have changed the healthcare system. The NHS, she says, "is not a single business – it's a concept and lots of individual businesses. Things don't link up – even more so since the foundation trusts were set up."

Jeremy Porteus, director of the Housing Learning & Improvement Network, comments: "It is certainly challenging for housing associations to know where best to fit into the new arrangements. With increasing demand on health services and a financially tighter operating framework, the NHS is in a state of flux. At the same time, there are lots of groups jostling for position and it often depends who holds the balance of power – in some areas it's the clinical commissioning groups and local authorities, and in others it lies with the hospital trusts. For the most part housing is being excluded, as acute and non-acute, primary and social care begin to shape their new landscape of integrated care. This means that there is an urgent need to be on the pulse of what's happening in local health economies and find ways to put housing on the map."

According to Rebecca Cotton, director of mental health policy at the NHS Alliance, the key is ensuring commissioners take a strategic approach and think about housing and health needs in a joined-up way. While there are examples of joined-up services being commissioned around the country, she says that there is still a long way to go: "We all know that having a safe and settled place to live is vital to having good mental health, and for recovery. We know that where housing and health work well together, not only can significant savings be made but, most importantly, people using services can be supported to live more independent lives."

NHS reforms

The NHS reforms are aimed at reducing hospitalisation, improving care, and opening the door to more private-sector involvement and competition in the NHS. The two key

bits of legislation that paved the way for these approaches are the Health and Social Care Act 2012 and the Care Act 2014, which was granted royal assent in May 2014. To make sense of what is working and what is not, it is important to understand the structure and the money flows. As more than one interviewee observed, the NHS is not an entity as such but a collection of "businesses" all trying to balance their budgets and meet their targets.

The Department of Health and NHS England

The secretary of state for health still has ultimate responsibility for the provision of a comprehensive health service in England and for ensuring the whole system works together to respond to the priorities of communities and meet the needs of patients. The Department of Health is responsible for strategic leadership of both the health and social care systems, and it is trying to pave the way for greater working between housing and health and social care as part of its integration strategy. It is working with housing organisations to draw up a concordat or memorandum of understanding to encourage this to happen. However, the Department of Health no longer manages the NHS: this falls to NHS England.

Formerly established as the NHS Commissioning Board in October 2012, NHS England is an independent body, at arm's length from the government, which has overall charge of the health service in England. Its role includes overseeing the operation of clinical commissioning groups; allocating resources to clinical commissioning groups; and commissioning primary care and specialist services. The focus of NHS England remains on the delivery of high-quality care and the achievement of excellent outcomes for patients, which "means focusing less on what is done for patients, and more on the results of what is done".[51] The new NHS England chief executive, Simon Stevens, has also said the NHS needs to return to the use of "cottage hospitals and treating people in their communities, particularly the elderly".[52]

Clinical commissioning groups

Primary care trusts used to commission most NHS services and controlled 80 percent of the NHS budget. On 1 April 2013 primary care trusts along with strategic health authorities were abolished and replaced by 221 clinical commissioning groups. CCGs are given a budget by NHS England to commission secondary care services, while health and well-being boards (see below) are given the legal duty to ensure such services are integrated. CCGs control around two-thirds of the NHS overall budget – about £65 billion.

The amount allocated to each CCG is determined by a national funding formula. On average, each commissions services for 226,000 people, and some work in groups. CCGs can

51 NHS England *Everyone Counts: Planning for Patients 2014/15 to 2018/19* (2013)
52 *Daily Telegraph* interview with Simon Stevens, 29 May 2014

be supported in carrying out commissioning functions by commissioning support units. These can help in service redesign, as well as actual commissioning functions, such as procurement, contract negotiation and information analysis. CCGs receive their funding via a grant from NHS England.

Clinical commissioning groups are led by GPs, with an elected GP chair, and can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities, or private-sector providers. Meanwhile GPs also have a central role in delivering more integrated and personalised care to help manage long-term conditions, and in implementing policies that target at-risk individuals with appropriate interventions. As the National Housing Federation advises,[53] "If housing associations want to influence service provision, it is best to consider individual care pathways using the financial imperative of the QIPP (Quality, Innovation, Productivity and Prevention) programme to highlight how housing associations can improve individual outcomes."

However, early indications from those interviewed were that CCGs were, for now at least, sticking to what they know works rather than innovating.

NHS trusts

NHS trusts are increasingly seen as the organisations that will provide routes into health for housing associations. By the end of 2014 all NHS hospital trusts had been expected to become foundation trusts. Those with foundation trust status have more financial and operational freedoms and are given ownership of their land and assets. However, it is becoming apparent that a number of NHS trusts are not financially sustainable and will not achieve foundation trust status, which is likely to lead to increasing numbers of mergers and service configurations. As the National Housing Federation advises,[54] "NHS trusts are the major providers of healthcare in this country. Housing associations should recognise this as an opportunity to demonstrate to NHS providers not only their skills and expertise, but also their capital and access to finance that can enable NHS trusts to transform existing services."

As discussed later in the report, there are opportunities for housing associations to enter into a joint venture around asset development, using existing trust land for new homes. The NHS trust would facilitate this as part of the reconfiguration of services. Housing associations could combine their traditional house-building programme with health outcomes by delivering new homes and health facilities on NHS trust estates.

53 National Housing Federation *Routes into Health: Clinical Commissioning Groups and Commission Support Units*, briefing (2013)
54 National Housing Federation *Routes into Health: Working with NHS Trusts*, briefing (2013)

Health and well-being boards

Health and well-being boards are charged with improving local health and social care and reducing health inequalities. Every "upper-tier" local authority has established an HWB to act as a forum for local commissioners across the NHS, social care, public health and other services. The boards are intended to strengthen working relationships between health and social care and encourage integrated commissioning of health and social care services.

They sit within the local authority, although responsibilities for delivering many of their functions – such as encouraging healthy lifestyles, enabling older people to live at home, and integrating service delivery – are shared between agencies. HWBs have a minimum membership of a councillor, a representative of the local Healthwatch (Healthwatch England, the umbrella body, is the national consumer champion in health and care for children and adults), a representative from the clinical commissioning group, the director for adult social services, the director for children's services, and the director for public health. Boards have a role in scrutinising the plans, intentions and activities of CCGs. They have the ability to challenge CCGs on their priorities and plans, if they believe these are not consistent with local needs or in line with other strategies.

The jury is still out on how much sway health and well-being boards will actually hold over health commissioning. A King's Fund survey last year found that "there is little sign as yet that boards have begun to grapple with the immediate and urgent strategic challenges facing their local health and care systems".[55]

Housing associations' efforts to be represented on HWBs have so far been mixed. A recent King's Fund survey asked if boards included a housing lead, and 31 percent did. This, the fund said, "is quite a low percentage and perhaps surprising given the increasing recognition of the important contribution made by housing to health and well-being".[56] Arguably, having housing representation around the table has to be better than not having it, and some of those interviewed for this report can relate to the positive effect this has had. However, generally the sentiment is that representation has not necessarily translated into influencing commissioning, or at least not yet. According to Peter Forrester, director of advisory services at Serco Health and former primary care trust chief executive at Northamptonshire Heartlands: "CCGs have to take account of what health and well-being boards are saying, but I'm yet to see commissioning decisions by CCGs significantly impacted by health and well-being boards."

He adds: "Health and well-being boards are not developed well enough yet with cohesive

55 Humphries, R and Galea, *A Health and Wellbeing Boards: One Year On* (King's Fund, 2013)
56 Ibid

strategies to influence commissioning plans." Andrew van Doorn, deputy chief executive of housing charity/think tank HACT, says that the clamour by housing associations to get a seat on an HWB has been a little misplaced. Housing associations, he says, have been "obsessed with these boards, but so much of what goes on is controlled by the CCGs".

Public Health England

The role of public health has transferred from the former primary care trusts back into the fold of local authorities, with a ring-fenced annual grant of £2.3 billion from central government. Public Heath England monitors the progress of health and well-being boards along with government. Encouragingly, it has appointed a housing adviser, whose role is to scope out what the organisation should be doing around housing, with a view to providing information, support and guidance to directors of public health and HWBs.

Gill Leng, who has this new role, says: "Our focus at the moment is on developing a systems-based approach to meeting the needs of people who are homeless and have multiple health needs. We're also seeking to ensure that the home environment and role of the housing sector is considered in commissioning and plans for integration to meet the needs of other households, such as the older population, people with long-term conditions and so on."

She adds: "It is important to understand 'who lives where' and who is best placed to do things differently. The majority of poor-condition homes are owner-occupied or privately rented – solutions to this aren't easy but will be necessary to achieve ambitions for health and care closer to home and better outcomes."

Greater private and third-sector involvement

Much of what is called primary care – GPs, dentists and pharmacists, for example – is already run by private businesses on behalf of the health service. Mental health services have operated in a mixed market with voluntary provision for some time, but the health reforms paved the way for more NHS services to be opened up to greater competition from private and third-sector providers. This is monitored by the new regulator, Monitor, which is responsible for regulating foundation trusts and has a duty to set prices for NHS care with NHS England and to enable integrated care.

The new health legislation permits the use of "any qualified provider", which will ensure contracting out to private and third-sector providers that meet conditions of price, safety and quality. So while it is this new environment that provides opportunities for housing associations, it also provides competition.

Housing associations could partner with NHS trusts to tender an existing service, or add

value by redesigning a care pathway to integrate housing and care. In addition, an NHS trust could review its current services and seek a subcontractor to lead an aspect of the care pathway or to integrate elements of the service. Indeed, there is nothing to stop a housing association bidding to take over a failing NHS trust.

There is an expectation of more competition. Stephen Hughes, a partner in law firm Bevan Brittan, says: "Certainly trusts have to start doing things differently because savings are so critical, but when you combine things that are happening – the introduction of the Better Care Fund, the fact that many contracts let three years ago are coming up for expiry, and the rationalisation of the estate – these are big drivers for change."

The Care Act

The Care Act 2014 is significant in bringing housing into the picture. It makes clear that housing is a health-related service. Housing is explicitly referenced as part of local authorities' new duty to promote the integration of health and care, and registered providers of social housing are now listed as one of the partners with which a local authority must co-operate when considering and planning a person's need for care and support.

The main thrusts of the act are: a £72,000 cap on the lifetime care costs an individual will pay; national eligibility criteria to ensure that everyone across England is eligible for the same level of social care wherever they live; a requirement of local authorities to introduce a deferred payments system with the aim that individuals will not be forced to sell their homes to pay for care in their lifetime; and giving local authorities a new legal responsibility to provide a care and support plan (or a support plan in the case of a carer).

The Better Care Fund and integration

The £3.8 billion-a-year Better Care Fund (originally called the Integration Transformation Fund) for 2015/16 has been seen as offering more hope for the integration of housing into the care agenda. Sir David Nicholson, former chief executive of NHS England, described the pooled budget as "a game changer" for the way patients would receive care. However, this is looking unlikely for the first year, as the fund includes no new money.

The Better Care Fund is intended to support the development of integrated models of care in order to cut both overcrowding in A&E units and the number of people admitted for hospital treatment. But it is as yet unclear to what extent it will influence future commissioning practice and guidance, as the funding is non-specific. Early indications are that the fund is unlikely to spur huge innovation in service delivery, at least in this initial round. Clinical commissioning groups and health and well-being boards, which jointly sign off their plans from the local authorities, had less than six months to submit plans to NHS

England. The indications are that the plans, which are now being reviewed, have adopted a low-risk approach to how they are allocating the cash, with the clear emphasis on spending their money on what they are doing already.

NHS England stated: "There is recognition of housing – that better local services keep people out of hospital. But the plans we've had so far don't have much detail about housing, though that's not to say it's excluded."

According to Richard Humphries, assistant director for policy at the King's Fund: "The Better Care Fund on its own will not be a game changer – a more realistic timeframe is needed with genuinely new money to meet the double running costs of transforming the model of care."

The need for a transformation fund was a common refrain to help CCGs break out of what they do already. Stephen Clarke, director of consultant Earth Regeneration, said this should be something CCGs and trusts have to bid for. "The NHS needs a new innovation fund as a way of driving change."

The Department of Health's view on integrating housing and health

Q&A with Jon Rouse, director general for social care at the Department of Health

What is the Department of Health's position on the contribution good housing provision can make to improving health and reducing hospitalisation? And, in that vein, saving money for the NHS?
We recognise the vital role housing can play in supporting older and vulnerable people to maintain good health, independence and improve quality of life. And this is supported particularly in the Care Act, where we have made it very clear that housing is a health-related service and how important housing is in delivering integrated care.

And are there any particular areas where you think closer working relationships would benefit the NHS most?
The role of housing and housing-related services in the delivery of better outcomes for people and in supporting them to meet their needs is vital, for example in reducing the risks of falls through adaptations, protecting against the effects of cold, enabling earlier discharge from and readmission to hospital, and reducing ill health associated with loneliness. The links to housing and housing-related services are clear.

How much is getting closer working between health organisations and housing

providers a priority for the Department of Health?
Disjointed care is a source of huge frustration for patients and staff alike. In order for people to receive high-quality health and care support, local organisations need to work in a more joined-up way; and joining up the services provided by NHS organisations, the local authority and the housing sector is very important.

We are committed to breaking down barriers between health, social care and support. Care and support that is "integrated" has the potential to make measurable improvements in outcomes, including individuals' experience of services they use and the efficiency with which services are delivered.

The Better Care Fund is the biggest-ever financial incentive for local areas to integrate services and improve outcomes and experiences for individuals. It offers a substantial opportunity to bring resources together to address immediate pressures on services and integrate health and care services.

And what are you doing to promote better working relationships?
We are working with NHS England, Public Health England, the housing sector and the Association of Directors of Adult Social Services on a partnership agreement to set a framework for working together to deliver better outcomes for people and to set the context for more cross-sector partnership working.

The agreement recognises the critical role housing plays in determining health and well-being and the role that good housing can play in preventing or reducing the need for more formal health and social care interventions.

How much do you think achieving better working relationships between housing and health will ultimately depend on better integration between housing and social care budgets?
Integrated care and support means person-centred, co-ordinated care and support, tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care (focused on organisations and structures), to a more holistic approach to health that puts the needs and experience of people at the centre of how services are organised and delivered. Housing and the suitability of housing is a vital part in that integration.

Integration can be achieved in many ways. Shared funding is one way; integrated organisational structures, joint commissioning, staff working more effectively together, or joint assessments are just some other examples of how integration could be achieved.

What scope do you see there might be in the future to use NHS land to build new models of supported housing?

Disposal of surplus land benefits both the NHS and the public. The NHS obtains income for reinvestment in new facilities, which contributes to reducing their running costs. The public obtain better health facilities and much-needed new housing (for which a considerable proportion of surplus is used), and increased construction reduces unemployment in that sector. However, it is important to note that the majority of land used to deliver NHS services is owned by NHS organisations which make decisions locally on how it can best support their delivery of high-quality clinical services. They have considerable freedom of action to do this, and the department is not able, quite correctly, to control their actions.

When selling surplus land, the NHS has to work with local planning authorities for planning approval for suitable alternative uses for the sites. Such new development should be in accordance with the local plan and policies therein, which may seek to deliver a number of affordable homes for an area or guide developers to provide other specialist accommodation to meet known local needs.

Do you have any messages to housing providers in terms of improving or going about setting up successful partnerships with health organisations?

The challenge facing health and care organisations is huge. New ways of working are needed, and there is no better time for housing professionals to engage with health and care decision makers.

Chapter 5

Making partnerships work in practice

Making partnerships work in practice

In an ideal world, issues around homelessness, the need for housing support and investment in existing housing would all be fed into health and well-being boards. The possible outcome could be that spending is prioritised to reflect these needs, based on sound evidence.

By and large, we are a long way off from this scenario, but there are numerous examples around the country of health and housing associations working together. And among those interviewed for this report there exist degrees of optimism that the pace of integration will pick up. But this is offset by frustration that the positive potential of housing providers is not harnessed more widely.

Asked to describe the progress made in integrating housing and health, a number of those interviewed came to similar conclusions. Domini Gunn, director of health and well-being at the Chartered Institute of Housing, says: "We are making strides in terms of integration, and you see housing increasingly mentioned in legislation, like the Care Act 2014, and the Department of Health's *Transforming Primary Care*. There is a growing recognition that maintaining independence at home is dependent on housing being fit for purpose. But the fact that integration doesn't happen is partly down to the lack of understanding of the role of housing in the health and social care sectors, and their capacity to engage with the housing sector."

Merron Simpson, special adviser on housing to the NHS Alliance, concurs. "Integration is slow – and there is a degree of frustration in the housing sector. You have to remember, when talking about the NHS, it's not one body but many different organisations. And when there is a problem it has a tendency to be solved within the boundaries of what's already understood."

Andrew van Doorn, deputy chief executive of HACT, says that health itself has to pull off a major integration exercise between primary and secondary care. "I expect the process of forming partnerships will be a grind for some while, but then I don't think much will happen unless care pathways are redesigned to become much more community focused."

Other barriers to new partnerships

As already highlighted, the NHS reforms have slowed innovative thinking to a great extent as the health service gets to grips with the new structure. But there are also deep-rooted issues that prevent joint working and innovation from flourishing.

One of the most common problems mentioned by interviewees about joint working is

confusion over the way the money flows through the NHS.[57] As one housing adviser puts it: "This can mean that although a joint venture may save money on paper, it might actually end up causing the health provider to lose income."

The consensus view is that the health reforms make the trusts operate more like businesses. Acute hospitals, for example, get paid on a tariff for the work they do, which can throw up perverse financial incentives. Hospitals, for instance, do not want to run with empty beds on a ward as it means they lose money, so offers from housing associations to trusts need to ensure that new care pathways can avoid this problem. But as our interviewees all said, we are a million miles from that currently.

Peter Forrester, of Serco, argues that ultimately the NHS saves money if it can close down hospital wards. However, he says, politically that is highly sensitive. "In theory, if I'm a CCG what I want is not to keep people in hospital but to get them out quickly. So in theory I might use my commissioning power to put pressure on an NHS trust to get people out of hospital. But the NHS trust may say there is nowhere else for them to go. There has been a massive underinvestment in re-enablement services."

However, there is a clear sense too that housing organisations need to make their offer to health clearer. Sarah Clee of Midland Heart, which is involved in providing reablement facilities, says: "Housing associations need to step up their marketing efforts. They need to raise their profile and get themselves in front of people who are decision makers – and change their rhetoric. The private-sector approach is much more valid now than it's ever been."

For partnership working to succeed, learning more about each other's sectors was a common refrain. As Patrick Vernon, health partnership co-ordinator at the National Housing Federation, puts it: "Housing associations need to understand the service pressures, clinical priorities, and governance and accountability structures of NHS trusts. Equally, the NHS also needs to understand the role of housing in terms of its investment and business model in delivering affordable homes and a range of care and support services in the community."

It has to be mutually beneficial

Shaun Clee, chair of the mental health network at the NHS Confederation, and chief executive of 2gether NHS Foundation Trust, discusses the ingredients for successful partnership working.

57 The NHS payment system is based on an agreed national tariff for different types of inpatient, outpatient and primary care. There is a nationally set price or tariff for each procedure, based on an average of all hospital costs for that procedure. There are separate tariffs for elective and emergency care.

There are three key things people need for good mental health: a roof over their head, a good social network and economic power. It's impossible to develop services that treat people without taking care of those things.

There are lots of examples through the mental health network – lots of good examples of housing and health organisations working together.

But housing providers have to remember – we're all now competing for the same business, and for a reduced pot of money. Not many organisations are actually charitable: they are massive organisations, all trying to find ways to make savings, while being successful employers and successful businesses.

We need to try and find partnerships and joint pathway connections that benefit patients and residents and that also provide increased offer and value for the funder.

The implication is that there is greater need for collaboration, but these ventures have to be mutually beneficial. Housing associations do tend to have an over-simplistic view – they talk about savings to the NHS but don't think about what that proposition means in terms of revenue loss to that provider.

Smart organisations get to know each other and then when the opportunity arises it's easier to relate to what we might be able to do together. That takes effort and networking.

Senior leadership has changed in health over the last 10 years, but if you know there's that kind of churn, you need to think about how you sustain those relationships beyond the CEO.

Different cultures

Housing and health may have similar aims in the sense that they are about helping people. However, there can be major differences in their operational cultures that make working together difficult.

Public Health England's Gill Leng explains: "Often there is a problem in that housing associations are not able to present enough evidence to show the benefits of the solutions they are proposing. The NHS and Public Health like things to be systematic, with long-term evaluations with peer review. This is not what housing tends to do."

Family Mosaic is one of a number of organisations that have embarked on a programme of rigorous evidence gathering. As part of its work to save the NHS £3 million each year, it

is running an 18-month research project with the London School of Economics which is now halfway completed. This builds on research that showed 71 percent of Family Mosaic households with tenants over the age of 50 contain someone with a long-term health condition. Half of these have multiple conditions.

Yvonne Arrowsmith, group operations director of Family Mosaic, says: "Housing is learning how to demonstrate and prove the results of our achievements; in contrast, a lot of what we previously reported was generally anecdotal. Health is interested in validated research. That's what they need in order to make the business case."

She adds: "There isn't a great track record of housing and health integration, but I would say it's better now than ever before. Housing is not short on good ideas – it just needs to get in front of the right people, and you do need to jump through hoops to get talking. It's not helped by the fact that NHS personnel move around because of the frequent reorganisation. Health is very hierarchical – titles mean a lot. But having come from health myself, I would say that doors are opening. I sit on an HWB and certainly think CCGs and public health are interested in what we do; it's just that it will take another year to disentangle from existing commitments. There's no doubt though that to pull it off, you have to put in huge time and investment – and some may think it's just not worth it."

Papworth Trust navigates new governance rules

The Papworth Trust, like other housing associations and charities around the country, runs a home improvement agency that helps disabled and older people adapt their homes to make them safer and more accessible. The agency also offers home-from-hospital schemes funded by the NHS, and the charity wishes to further expand these types of health services. However, it is required to comply with more stringent standard NHS contracts in some of the areas in which it operates, which it says is proving highly bureaucratic and almost unworkable, as many of the criteria seem to its staff to be irrelevant and inflexible.

"We're being asked to supply details of information such as who is the anti-terrorism lead, and hospital infection rates – the sort of things that are irrelevant to us," explains Helena Harris, director of operations at the Papworth Trust. "There is simply no differentiation between small and large contracts."

Harris says the trust is excited by the prospects of working more closely with health bodies, but points out that it is "extremely difficult to find your way around at the moment".

She adds: "The arena is all very confusing; it depends on geographic areas and how they are choosing to do things. We have found that the organisations we have spoken to are generally too inhibited by tight budgets to trial anything innovative."

The Papworth Trust has been involved as a supplier to contracts involving the Department for Work & Pensions, which have proven to be more straightforward. "With those contracts, there has often been a prime contractor who has then subcontracted to other suppliers. The DWP has been extremely helpful in organising events and bringing people together – and I think the health service should go down that route.

"When you are trying to create a market, someone has got to take the lead in making it happen."

On the health side, trusts are frustrated that housing associations do not understand how money flows and appear to have no knowledge of commissioning. As one hospital manager comments: "If they want to improve integration, then they need to stop the message they are giving out – that 'we want your land'!"

Peter Molyneux, chair of South West London & St George's Mental Health Trust, agrees that there remains a widely held view that housing associations are looking for NHS land. "I am not sure that the contribution that housing associations can bring to a provider's supply chain is yet fully appreciated or articulated. Successful integration will depend on housing and health redesigning care pathways together and building on each other's strengths."

He says that one of the barriers to greater integration between housing and health is that organisations manage risk and quality in different ways. He says: "Housing associations need to ensure that the way they manage quality passes any scrutiny by a potential health partner or regulator."

The lack of knowledge of how each sector operates and their differing cultures is a common refrain.

According to Merron Simpson of the NHS Alliance, "Housing organisations can offer a lot, but need to be more in tune with what local health priorities are. And social/affordable providers house less than 20 percent of the population: GPs and hospitals are more worried about patients in private homes, especially the private rented sector. Also, associations offer very much a patchwork coverage – it can be hard for health organisations to know who to talk to."

Is investment in supported housing too risky for housing associations?
In theory, with an increasing population of older people there is a bigger need (and market) for care and support services. However, a number of housing associations have withdrawn from the sector. Cuts to the Supporting People grant[58] and the general uncertainty over local authority funding has arguably made care and support a risky sector for housing associations.

A number of respondents commented that deals with housing associations were not as common as they were 10 to 15 years ago and that in the past there was a greater knowledge in the medical sector of what housing associations did. The NHS was also able to offer longer-term contracts.

Jeremy Porteus of the Housing Learning & Improvement Network says: "Housing associations have got out of specialist supported housing for a number of reasons – cuts to local authorities and adult social care budgets; uncertain long-term revenue streams; welfare reform; rising wage costs; more regulations for staff training. All of these things make it a higher-risk business. Organisations are not averse to adapting and/or innovating but a number have had their fingers burnt and are therefore considering ways to limit any further exposure to risk."

One such organisation is B3Living. Its chief executive, John Giesen, explains: "In the past, we built and funded an elderly scheme for the NHS. But it ended up being mothballed and eventually leased to an organisation providing respite care. The NHS doesn't plan long-term; it works on a short-term business plan. We're long-term. We provide independent living and flexi-care accommodation. But the cut to the Supporting People grant makes us think twice about building something new – we don't know where the funding will come from in the future."

Forming innovative partnerships with hospitals is challenging. Just making contact is extraordinarily difficult. One of the biggest problems is that the NHS is constantly changing, and people move on. In contrast, housing professionals can work for the same organisations for 30 years.

"Geography is also a problem – half of an association's residents may be using London hospitals; the other half, Hertfordshire. Hospitals that our residents use are not always where we operate."

58 Supporting People is the government programme for funding, planning and monitoring housing-related support services, aimed to improve the quality and effectiveness of the support services at a local level.

Lack of funding halts Housing & Care 21's health scheme

With 97 percent of its residents older people, Housing & Care 21 is one of the largest not-for-profit providers of extra-care housing. It sees being involved with the health agenda as central to its business strategy. One of the projects it instigated was a pilot scheme that ran over three years at two of its extra-care housing schemes, with a total of 80 tenants. These were based in Bristol and had the support of the Bristol NHS, North Bristol Trust and Bristol City Council. It involved designating staff from Housing & Care 21 to provide support to tenants, some of whom had dementia, when they went into hospital and then in settling them back at home when they were discharged. They acted almost in the role of a close relative, providing continuity in explaining to hospital staff about their needs and their history. And when they were discharged they would be provided with a continuation of care.

An evaluation of the scheme was certainly favourable. Housing & Care 21 provided care support to 16 hospital admissions at a cost of £4,000. This saved 27 bed days and another 125 bed days were saved through managed readmission, which meant that the NHS saved £55,000 on Housing & Care 21's 16 tenants.

The scheme was partially funded by the Department of Health's voluntary-sector Innovation, Excellence and Strategic Development Fund (which for 2013 was worth a total of £5.5 million). However, despite its success, the scheme was discontinued because of lack of funding.

"Everyone talks about integration, but the reality is everyone is trying to protect their own budgets," says Dr Claire Keogh, research and evaluation officer for Housing & Care 21.

Department of Health-funded supported housing

With pressure to reduce costs and accommodate the needs of an increasingly ageing population, there is an urgent need to build more supported and specialist housing in both the social and the private sectors. There is also a need to increase step-down and reablement facilities to help reduce length of stays in hospital and reduce readmissions.

The Department of Health is currently trying to accelerate the development of a specialised housing market. In 2012 it launched the first phase of a £300 million fund which has been seen as a significant boost to the specialised housing market and sets out a longer-term vision for closer integration across housing, health and social care. It said at the time: "Housing plays a critical role in helping older people and disabled adults to live as independently as possible, and in helping carers and the wider health and social care system offer support more effectively. However, evidence suggests that there are currently

not enough specialised housing options available for these groups, especially for those who wish to own their own home."[59]

The Department of Health has now allocated funding to build more than 3,500 new homes. It has also announced that £43 million from the Care and Support Specialised Housing (CASSH) Fund is intended to support the construction of a small number of housing projects for people with mental health problems or learning disabilities by 2017.

Successful bids for the first round of the CASSH Fund were announced in July 2013: some 86 providers, outside London, are set to receive around £101 million to develop more than 3,000 affordable homes for older people and adults with disabilities or mental health needs.

The second round of the CASSH Fund is intended to stimulate interest in private-sector specialist housing. However, the market has been slow to take off due to issues such as higher costs per square metre (because of communal areas that cannot be realised in a sale) and concerns about the community infrastructure levy. According to one interviewee, planning for supported housing is in fact getting harder following the introduction of the Care Act, as it entails local authorities having to contribute for care where previously this would have been fully funded by the resident.

59 http://www.homesandcommunities.co.uk/ourwork/care-support-specialised-housing-fund

Chapter 6

Integration in action – case studies

Integration in action – case studies

If healthcare is to do more for less, it will need to offer housing solutions for those who have long-term conditions but do not need either full-time residential care-home support or long-term hospitalisation. At the moment, such people end up in these places because there is nowhere else for them to go. Few disagree that this represents a serious waste of resources. However, making the change is hard, and both housing and health professionals need to learn from each other. We have collected the following case studies to demonstrate how integration can work in practice.

One Housing Group and Camden & Islington NHS Foundation Trust
A new solution is being pioneered in north London by One Housing Group and Camden & Islington NHS Foundation Trust. They have come up with a care package for people with mental health issues, which they are calling "Care Support Plus".

Tile House, which opened in 2013, provides 15 high-quality, self-contained, supported-housing flats and is the first formal joint initiative between One Support (Part of One Housing Group) and Camden & Islington NHS Foundation Trust. Residents have high support needs and are on the border of long-term hospitalisation and residential care-home placement. The block was specially built for the partnership, on an adjacent site to other One Housing Group housing in King's Cross.

One Housing Group provides care and support to the residents, who have shorthold tenancies; Camden & Islington NHS Foundation Trust provides additional mental health support to staff and dedicated psychiatric input, for which it receives a fee from One Housing Group paid for from the placement fees. One Housing Group receives revenue through housing benefit and personal budgets from adult social services.

Tile House has generated significant cost savings through reduced hospital admissions, improved outcome and greater independence. The service is estimated to have saved the London Borough of Camden £300,000 during the first year just in saved placement fees (fees paid for residential care provided outside the borough). Kevin Beirne, One Housing Group's group director for housing care and support, points out that this type of accommodation costs £600 per week from a housing association, whereas a hospital bed costs £3,000 per week.

Wendy Wallace, chief executive of Camden & Islington NHS Foundation Trust, says it has been possible to achieve this because of integrated commissioning between social care and health. She says the project is a "win-win situation" for both health and housing: "It means we can discharge people with more complex conditions safely, enabling them to live

more independently. In a similar way we can bring people back from expensive out-of-borough placements. There has been learning on both sides; we have brought in additional standards around clinical governance, which we are much stronger on, and One Housing raised our expectations in terms of housing standards." She says that the trust is exploring setting up similar schemes in other boroughs.

Beirne says: "The important thing is to ensure that you are clear what outcomes you want to deliver and then have the systems and processes in place to deliver the priorities for all partners."

South Yorkshire Housing Association as a healthcare contractor

"Pooling opportunities between health and social care represents a real opportunity for us," says Juliann Hall, director of care for health and well-being at South Yorkshire Housing Association. "We've been bracing ourselves for a decline of Supporting People grant, but opportunities are emerging around integration." The association has high ambitions, hoping to become a prime healthcare contractor competing with the likes of Serco.

Hall says the organisation spent a year rebranding its care and support business, which is now called LiveWell to emphasise support and care. The housing association also has a place on two local health and well-being integration advisory boards, which Hall says "has opened doors for us".

She says: "We have a good reputation and a good track record, including our LiveWell at Home scheme, which is designed to deliver efficiencies to the health and social care system by reducing hospital admissions among the elderly."

The organisation is also leading on a bid to invest £6 million of lottery funding as part of a £70 million initiative called Ageing Better, aimed at tackling loneliness among older people. South Yorkshire Housing Association is the only housing association leading the Ageing Better bid for its area and is working in partnership with the CCG and the local authority.

Midland Heart, Good Hope Hospital and Heart of England NHS Foundation Trust

Housing and care provider Midland Heart has developed an innovative partnership with the Heart of England NHS Foundation Trust and Good Hope Hospital in Birmingham to open a new service, Cedarwood, to support patients who are medically fit and due to be discharged but need additional support to get back on their feet before returning home.

Midland Heart has redeveloped an existing ward at Good Hope Hospital in Sutton

Coldfield to provide a 29-place private, purpose-built reablement facility. It began taking referrals in November 2013 and has since supported more than 300 people. Sarah Clee, head of older people's services at Midland Heart, explains: "It's a facility for 29 over-55s who are medically fit for discharge but who, if they went home, are likely to soon be back in A&E. The biggest issue is that they lose confidence after a fall or stay in hospital. What we do is build confidence, get them active with day-to-day tasks and help them prepare meals, and get them interested in food again so they can cope successfully when they go home. We also join up with social services.

"On average the new facility is shortening the hospital stay by six days, with readmissions also reduced. Rooms consist of a single bed, chair, sink, and wardrobe; but the bathrooms are shared and there is a communal lounge and dining area. Residents are cared for by our staff – with a nurse popping in as needed alongside therapies (the same way as would a district nurse).

"The hospital paid for the redevelopment of the ward and Midland Heart have a three-year contract to operate the facility, getting paid on occupancy. There have been issues in terms of getting the flow-through right. People ready for discharge are signed off by a joint assessment team, who decide where is the most appropriate place for people to go from a range of options that make up the hospital's response to managing people in the best environment."

Clee acknowledges that the arrangement still needs some refinement but adds: "Any contract has the potential to be risky, and as such we're both feeling our way. We're both determined to make it work."

Bolton at Home's alarm and telecare service

Bolton has been running a community alarm and telecare service, which provides support and assistance 24 hours a day, 365 days a year, for over 6,000 customers across Bolton. The Careline service also provides "lifting" services for older people who have falls and are uninjured but unable to get up, and who would otherwise have to wait for an ambulance. "For us to respond to a fall costs approximately £54; for the ambulance service it's reportedly £250," says Julie Riley, customer support manager at Bolton at Home. The service is currently discussing further support for people where the North West Ambulance Service has responded to calls about falls, so as to ensure they continue to be safe and well at home.

The organisation received funding from the Bolton Foundation Trust to help speed up hospital discharges by installing alarm equipment at short notice to ensure people can return home safely. The housing association also receives funding from the local

authority. "We are trying to make the service fully self-funding, as Supporting People grant is disappearing," says Riley.

Chief executive Jon Lord says that the reorganisation of the health service has set back the integration agenda, as CCGs don't always understand the value of supported housing. But he is hoping this may now change with the setting up of a health and housing group across the borough, which draws representatives from housing organisations, CCGs and HWBs.

Bolton at Home is also funded by Public Health England to run several health initiatives on some of its housing estates. The schemes are staffed with health development workers employed by Public Health England but who work out of neighbourhood centres run by the housing association.

Progress Housing Group's lifting service

Like Bolton at Home, Progress Housing Group offers a lifting service to help residents who have fallen in their homes but are uninjured and require assistance. The housing association teamed up with North West Ambulance Service NHS Trust, the NHS Falls Prevention Service and Age UK Lancashire with the aim of helping to reduce the number of ambulances responding to non-injured fallers. It trained special staff in moving and handling techniques, and during a six-month pilot helped 200 customers across the Fylde and Wyre area in Lancashire who had fallen in their homes to get back up on their feet, reducing the need for an ambulance to attend.

Bernie Keenan, executive director for housing, community and support services at Progress Housing Group, says: "The lifting service has also seen a dramatic reduction in response times to a call-out of this nature, with our average response time being 27 minutes, whereas an ambulance, which cannot prioritise an uninjured faller, takes up to 122 minutes to arrive. It costs us £130 per lift call-out, whereas it would cost the ambulance service £260." The pilot has been extended for 12 months (until early 2015), funded partly by the health services and partly by the housing association. However, Progress says that long-term funding remains very uncertain.

The housing association also provides a 24-hour monitoring and emergency service to more than 8,000 people across Fylde and Wyre boroughs. The service was one of only 22 in the country to have reached the Telecare Services Association's highest, "platinum" standard.

Northfield Village Care Hub

The quality and thinking in terms of design and provision of specialist housing has improved, according to Roger Battersby, managing partner of PRP Architects, which recently

produced a report highlighting emerging trends in housing and care for older people.[60] These include the emergence of care hubs within existing residential communities to provide integrated services. One such development is being built in Northfield Village, Staffordshire. It has a range of services on one site, including extra-care apartments, a centre for dementia care, a health centre, a GP surgery, and a pharmacy, as well as affordable general-needs housing, housing for people with learning disabilities and a community hub with a cafe, restaurant, bar, hairdresser, shops, and community rooms.

The project is a partnership between Staffordshire County Council, Wrekin Housing Trust, Choices Housing Association and Galliford Try.

Housing and health in Kent

A joined-up strategic approach to housing and health can be found in Kent, where infrastructure is in place to ensure that the benefits of good housing are fed into the health and well-being boards. The strategy shows how housing, often governed by policies at a local level, and health, which works at a unitary level, can communicate. The Kent Joint Policy & Planning Board for Housing is a strategic partnership between health, housing and social care and its aim is to identify links between the priorities of district housing authorities and those of partner health and social care agencies, and to lead on health issues related to housing.

The Kent Housing Group, with members from all of the major social housing providers in Kent and Medway, the Homes & Communities Agency and Kent County Council, works closely with the Kent JPPB and they have agreed to joint protocols and policies.

Much of the work of the JPPB has focused on improving the wider social determinants on health in order to reduce health inequalities for vulnerable groups. The JPPB (whose chair is always a head of housing) also promotes partnership working across the two tiers of authority in Kent, with a view to providing consistency of approach. It also contributes a housing chapter to Kent's joint strategic needs assessment.

Lesley Clay, joint planning manager, who co-ordinates the actions of the board, says: "The JPPB has been recognised as the link to the HWB with regard to cross-cutting issues in housing, and was invited to write a health inequalities plan for housing in Kent. The resulting document – *Think Housing First* – is the first housing health inequalities plan in the country and identifies the contribution by housing providers to the health agenda. The action plan is now the JPPB's delivery plan. This is a 'living' document and can incorporate

60 PRP Architects *Integrated by Design – Housing and Care for Older People in the UK: Current Provision and Emerging Trends* (2014)

other actions as they arise. *Think Housing First* is currently being added to the agendas of the local health and well-being boards, which also have representation from CCGs."

One of the most successful examples of joint working with health is the Horizons Project. This is an intensive housing scheme for people with a severe and enduring mental health diagnosis who need good-quality accommodation and bespoke support services, and was a practical response to the closure of some beds in a mental health inpatient facility.

The Walton housing and health well-being neighbourhood

One of the most interesting prospects of real integration is coming out of Liverpool, where development agent Placesrp is galvanising support for what director Paul Patterson describes as a new "housing health and well-being neighbourhood for people with long-term conditions, such as dementia". The neighbourhood, in the Walton area of the city, will provide the physical housing environment to enable the NHS and council social care services to deliver integrated care to the homes, promoting self-care and enabling people with long-term conditions to live independently for longer.

The development is on a former hospital site (now in private hands). Placesrp will develop the housing health and well-being neighbourhood in partnership with the NHS, local government and a housing association. The aim is to commence the 215-unit development in phases, starting with a dementia-led approach. The self-care health and social care operations will be delivered through collaboration between all three partners (the CCG, Liverpool Council and the housing association). The funding structure for the development will be a combination of private investors and housing association investment. According to Patterson, the development has a semblance to Simon Stevens' "community cottage hospital". The benefit for the NHS and the local authority "is that this innovative approach to out-of-hospital self-care will deliver significant cost efficiencies and new ways of working to compensate for major social care budget reductions".

The council may also be taking an investment interest as part of its "invest to earn" scheme, which aims to bring 1,000 homes in the city back into use. The commitment from the health bodies is at present being worked up – but the focus is on forming a joint venture, with the NHS providing care cover to the neighbourhood. The likely start on site is aimed to be towards the end of 2014.

Chapter 7

Making full use of NHS land and assets

Making full use of NHS land and assets

The NHS is under pressure to rationalise its estate, in order to reduce overheads, generate capital and bring forward land for housing. According to the Department of Health's land disposal strategy,[61] annual returns submitted to the department show that the total land area of the NHS estate has fallen from 8,600 hectares in 1999/2000 to 7,461 in 2009/10.

Although there has been some rationalisation, there is still reckoned to be ample scope to do more. A recent report from consultant EC Harris concluded: "The total 'wasted' space within the NHS estate is still greater than the size of London's Hyde Park. On average this gives a cost of some £407 million in facilities management and estates spend alone. This equates to the annual running costs of a large-scale district general hospital."[62]

There is also believed to be far more scope in making greater use of land.[63] So, for example, construction and property consultant WSP said that redeveloping existing NHS buildings to include floors of apartments above the service buildings could provide 77,000 new homes in London.[64]

The consultancy pointed to a recent report by the London Health Commission, which found that between £50 million and £60 million was being spent annually on maintaining NHS buildings that were either not used or not fit for purpose. It has been reported that more than £11 million in PFI payments are made for Central Middlesex Hospital and the building is currently only 38 percent in use.

Anecdotally, developers from both profit and not-for-profit sectors are understood to be frustrated by what they perceive as inertia or perverse incentives for trying to do things differently. Stephen Clarke, a director with Earth Regeneration, is involved with trying to create step-down facilities for homeless people. Despite securing funding from the Homeless Discharge Fund, he claims that setting up the facility in empty hospital space is proving problematic. "A number of these large hospitals in London are sitting there with extra space that could be used as facilities for homeless people. But it is difficult to

61 Department of Health *Disposal Strategy – Land for Housing* (20011)
62 EC Harris *Delivering Better Healthcare Outcomes More Efficiently* (2014)
63 Around 85 percent of NHS land is owned by the new trusts, which are able to reinvest the income from land sale. Other land has now been taken over by NHS Property Services, which is responsible for 11.5 percent of the estate including assets like GP surgeries, health centres, etc.
64 WSP's estimation is based on its analysis of 79 individual existing NHS buildings in London, allowing for 100 square metres per apartment and using a mixed-height overbuild development strategy, with a combination of six, 12, and 18 storeys. It considers only hospital buildings without A&E facilities, which would cause specific planning and construction issues.

implement strategies because of the way money flows. Generally there is a great deal of semi-redundant space, which is costing the taxpayer money. There are some good examples of hospitals using space imaginatively, but hospitals simply aren't penalised for leaving the space like that."

NHS Property Services

NHS Property Services was formed on 1 April 2013 and took over land that was not transferred to NHS trusts and foundation trusts, plus some historic NHS land being disposed of by the Homes & Communities Agency. It is responsible for 11.5 percent of the NHS estate, including assets like GP surgeries, health centres, office properties and former asylums. It has 4,000 assets, of which half are leasehold and half freehold, and an inherited disposal programme from the primary care trusts.

Kieran Kinsella, head of acquisitions and disposals, says the not-for-profit agency completed sales on 44 assets in its first year and exchanged contracts on a further 35. It is expecting to sell 119 in 2014, with 75 to 80 coming forward in the next two to three years. Its activity is guided by the government's strategic land and property review, which is to free up land to help build 200,000 homes. NHS Property Services has sold land for 600 homes already and expects to sell land to build 1,400 homes this year. Its policy generally is to work up planning consent before sale. Receipts go back to the Department of Health for reinvestment into the health economy.

Kinsella says: "We dispose of surplus land no longer required for clinical use. The decision on when a property is surplus to clinical requirement lies with the clinical commissioning groups."

The organisation has been accused of lacking imagination, particularly not exploring land to provide equity stakes in partnerships. Says Kinsella: "We're not averse to joint ventures in principle, but it's not on the radar just yet. We've only been in operation for 12 months. Joint ventures by their very nature are complicated, with differing risk profiles that have to be managed, requiring particular skill sets. We may consider more innovative arrangements in the medium term."

Using NHS land to improve clinical efficiency

One solution to these challenges of increasing specialist housing, as well as step-down and reablement facilities, is to use NHS land or assets to facilitate this type of development.

Currently, NHS organisations are being encouraged to sell off their surplus land to provide housing and use the receipts for investment in new healthcare facilities. Though this is

clearly welcome to trusts, particularly those that are in financial difficulties, it provides a one-off injection of capital after which the land is lost forever. An alternative option is for assets and NHS land to be used as equity in developments that can make savings in care pathways. This way supported housing could become more financially viable, and it could lead to a long-term revenue stream for the trusts if they used the land to provide equity stakes. Moreover, providing housing for older people, as opposed to land sales, may garner the support of local residents. This would enable trusts to deliver the services and facilities that local residents need. It would also create a public asset that actually strengthens the balance sheet rather than weakening it. Such a model has the potential to deliver on the Department of Health's plans for efficiencies through quality, innovation, productivity and prevention.

Using NHS land differently could deliver significant savings with little upfront cost to the government. New research from the Smith Institute (see box) shows that over a 25-year period the NHS could save as much as £5.9 billion from using surplus NHS land to build supported housing (the housing association or provider could fund the build programme by cross-subsidy through private sales on the rest of the land). The savings are based on the reduction in costs of accommodation that can come from building more units like Tile House in North London which is pioneering a new type of supported accommodation and although it was not actually built on NHS land, it serves to demonstrate the potential benefits of innovative thinking and partnerships (profiled in the case studies chapter).

However for savings to be realised the NHS would have to reduce inpatient provision. As the recent history of NHS reforms has shown, such a move may face strong resistance from the public. Moreover, trusts need to see the financial benefit of such innovation.

If the NHS is to make savings, or treat more people without budgetary increases, then acute wards will need to close. Using land and facilities to provide support for older people could prevent the political outcry that scuppers this. Kevin Beirne of One Housing Group says:

"We would certainly like to see the NHS thinking differently and create services that help manage care pathways. Housing associations are often in a position to do joint ventures if the NHS puts in land. That makes it more viable to raise capital if there is equity in a scheme. It could mean that some of the land is sold for private and affordable housing, in which case the trust would get a share of the developers' profits."

Some trusts are forming joint ventures with housing developers, including housing associations, to support capital input for re-provision and refurbishment. This way they can develop their supply chains to deliver new facilities, create public assets that strengthen the balance sheet, and contribute to deficit reduction, delivering a model that uses the

public estate in a more commercial and creative way.[65] Working in partnership in this way can be particularly attractive in areas of low land value, where developing housing that is designated as being for older people or people with mental health problems may be the only realistic way of realising any value from it.

Peter Molyneux, chair of South West London & St George's Mental Health Trust, says that by creating a third-party vehicle any NHS land is invested rather than disposed of. "A housing association puts in an equal amount of equity. The NHS has 50 percent of the seats on the board and can determine what return it wants and what form of accommodation will create the most value."

Using surplus NHS land for supported housing

The Smith Institute undertook an analysis of how using surplus NHS land to build supported housing can help meet demand and reduce the costs of care. In particular, the research aimed to quantify possible future savings that can be made based on existing land disposal programmes, the price of building supported housing, and the relative costs of acute care and care provided through supported housing.

Data suggests that treating someone in a supported housing unit rather than in an acute ward could save NHS trusts around £220 a day for those with mental health problems and £144 for older people. There is significant scope to provide more cost-effective and arguably better-quality services through supported housing. Various studies have also shown the potential to reduce delayed discharges and readmissions.

Despite the demand for such services, new supported housing would need to be built. Using surplus NHS land could provide not only the land required for the supported housing to be built but also the funds to subsidise the build costs (unlike other early-intervention programmes, it offers the opportunity to meet up-front capital costs). Using average build and land costs, an estimated level of subsidy and land required to build supported units can be arrived at. Factoring these build and land costs shows that over 25 years £1.6 million could be saved per supported housing unit built for those with mental health problems, and £1 million for older people (assuming inpatient provision is reduced). On current values (ignoring inflation), over a 25-year period this would provide an annualised return on investment of 7 percent for mental health supported housing and 5 percent for older people. Given that the calculations ignore inflation, these yields are arguably higher than just selling the land and investing elsewhere.

65 National Housing Federation *Creative Use of NHS Estate* (April 2014) (http://www.housing.org.uk/publications/browse/creative-use-of-nhs-estate/); http://www.onehousinggroup.co.uk/sites/default/files/One%20Housing%20Group_Roundtable%20Report.pdf

While significant savings can be demonstrated per unit, this does not show how much scope there is to use surplus NHS land. At present NHS trusts are under increasing pressure to sell surplus land to help spur housing development and realise cash locked up in land. As part of the government's push, data is published on the amount of land that is currently being disposed of. The latest data shows that NHS trusts will have sold 740 hectares over a five-year period, providing land for just under 15,000 homes. However, some of these housing developments are highly concentrated, and some sites are too small for supported housing. Taking these factors into account, the Smith Institute estimates that land is currently being used to develop an estimated 367 homes per year for market sale or rent which could instead be used for supported housing. To calculate the aggregate saving to the NHS, the model assumes that this number of homes would be built each year for 15 years (with the first 1,000 being for those with mental illnesses).

Over a 25-year period, the NHS could save as much as £5.9 billion. While more detailed work needs to be undertaken, this analysis suggests a considerable rate of return (over the longer term) above what might be expected from investing in other asset classes. Moreover, using NHS land for supported housing might not only save money (year in, year out) and provide a better service, but also deliver public assets that strengthen balance sheets rather reducing them.

Prospects for change

Given the drive to bring land into use to raise capital receipts, it is perhaps not surprising that interviewees commented on the lack of imagination and long-term thinking in the use of NHS land for other purposes. Ironically, before the abolition of primary care trusts, many had established locally based joint ventures between public and private sectors under the LIFT programme, which has since been discontinued.[66]

Conor Ellis, a partner in the health group at EC Harris, says: "We need to start thinking of surplus land in terms of local need and long-term need – there is a huge shortage of care beds."

Richard Darch, founder of Healthcare Partnering, agrees: "Trusts are taking a very shallow approach to surplus land. They look to achieve the value of what it's worth as evaluated by a district valuer rather than do a full cost-benefit analysis of care pathways in terms of providing sheltered accommodation and care. There's an absolute lack of innovation and strategic thinking, and the asset is increasingly being lost. It's not good nationally or strategically. There are a few examples – but they are too sporadic – where a trust put in

66 The LIFT programme delivered more than 300 buildings, with over 800,000 square metres of space, which are used by communities throughout England.

equity by way of land in 50:50 deals and shares profit."

However, according to Stephen Hughes, partner in law firm Bevan Brittan, "It's still early days for estate partnership, but the pace of change has noticeably speeded up. Trusts are having to do things that they wouldn't have done before, as the need to make savings is so critical."

Some of these trusts are specifying a strategic partner that can help facilitate a number of new projects. For example, in a tender in January 2014, the Isle of Wight NHS Trust said it was seeking a strategic partner to deliver strategic business and estates services and to access private-sector capital where required to finance new projects. These may involve the delivery of a sub-acute facility for post-acute care and rehabilitation and a retirement village.

Two of the schemes that have been tendered so far have been won by Ryhurst: its partnership model has led the way, with the company developing the first whole estates partnership in the NHS. Its managing director, Stephen Collinson, says there is an appetite for developing facilities that are being considered by trusts: specifically, selling land for housing; generating commercial income from land through retail, complementary healthcare provision or car parking; or improving the efficiency of asset performance to enable an investment in clinical services. Collinson says: "Our job is to work out what's best for the trust as their partner. That could involve bringing in housing associations to provide supported housing. A lot of people do want to make it work."

Shane Dineen, director of business development at property specialist Capita Symonds, says that selling off parts of hospital estates is not always possible and some land is not worth a great deal, depending on the location. Hospital trusts are beginning to explore a number of different solutions – and in this respect mental health trusts are more developed along this path than acute trusts – ranging from the provision of accommodation for staff, to university facilities, to partnering with pharmacies.

However, Dineen concludes: "Making more efficient use of NHS land requires a different mindset in the NHS – there is no room for operating in traditional silos. Operating a hospital on a city-centre site with older care accommodation is going to be much cheaper than accommodation in a hospital. It is then up to the CCG and trust to work out the money flows, and it may be they split the savings."

There are a small but growing number of voices suggesting that NHS land should be used to lever health benefits and that this should become the default option as a means to providing better value for the taxpayer over the longer term. Under the current structure this is

unlikely to happen, though it is encouraging that NHS Property Services could develop a strategy along these lines at some time in the future (see box). It is understood that the Department of Health is also working on a document advising that there are many ways to use assets to their full potential, aside from straight disposals.

What the advocates for reform are calling for is a firmer commitment to speed up the pace of change. As one health adviser put it, "There are pockets of good things happening, but there is a lack of strategic policy." Richard Darch advocates a common appraisal system for land, which he says would provide an incentive for making the best use of it. Others argue that it would make sense for the Department of Health to impose a requirement that disposal of NHS land should have a health benefit.

Townlands Community Hospital: Henley-on-Thames

Richard Darch of Healthcare Partnering describes an innovative health development in Henley, for which he acted as a consultant.

Proposals for a new community hospital to replace a dilapidated health facility on the Townlands site in Henley-on-Thames have been through various iterations for over 15 years. Numerous business cases have not been able to progress for affordability reasons, and at one point the hospital was identified for closure.

However, in 2010 the then Oxfordshire PCT decided to take commercial advice on how a new facility could be delivered and the much-required investment made in a modern and safe healthcare environment. This has led to an innovative solution that delivered significant value for money to the NHS.

Townlands Hospital sits on a 6.5-acre site close to Henley town centre and is recognised as attracting prime land values. Part of the site accommodates listed buildings that were required to be retained.

A commercial structure was designed that split the site into three parts. This allowed for one part that had the site of the original hospital to be sold freehold, and for the listed buildings to be refurbished. With additional development around them, they were designated for private elder housing, including extra-care. The second part was sold on long leasehold to the Order of St John for the development of a care home, including Alzheimer's care. The receipts from these two transactions were then used as a pre-payment on a lease to a developer to build and maintain a new community hospital. The tenants of the new hospital include a community services foundation trust, an acute trust and a national hospice operator.

The result of this commercial transaction is that the intrinsic value of surplus land has been used innovatively to modernise the estate. The result is that the total revenue impact of the new hospital is below that for the current dilapidated buildings.

The NHS therefore absolves itself of a liability, has delivered a new community hospital at lower running cost than the old hospital, creates a health campus bringing together health and social care, and provides a new amenity focused on wellness at the heart of a community.

Chapter 8

Conclusion

Conclusion

There is untapped potential for housing and healthcare providers to work together to deliver solutions to help alleviate the crisis in the NHS and offer efficiency savings. This could be in the form of joint ventures to provide new models of supported housing, step-down and reablement facilities, or extra support and care for people in their own homes.

Housing associations are often in a good position to form innovative partnerships because of their access to capital and asset management capabilities. There is also a long tradition of care provision in the sector. The NHS is often capital-poor but land-rich. Rather than sell off its land to the highest bidder, it may make longer-term sense for it to use this asset as equity. A combination of housing's borrowing power and health's assets reduces the risks of developing high-cost specialist housing and makes it more financially viable for both.

Supporting those with long-term conditions in appropriate accommodation could help reduce hospital admissions, combat the growing problem of readmissions and deliver a better quality of life. But if this is to happen, health and the social care providers need to include housing as part of care pathways.

However, the health reforms and financial squeeze on the NHS have had a mixed impact on innovative working. On the one hand, it has started opening up more conversations between housing and health providers; on the other, the huge upheaval resulting from the reforms has created a hiatus, and even set the agenda back a step, while the new structures settle down.

In theory, clinical commissioning groups should be driving the setting up of more reablement facilities and other types of supported housing. But they are struggling to reinvest any savings in community-based health services because the demand for hospital-based secondary care is so great. Waiting lists are almost back at the 3 million mark, a figure not seen since 2008.

The consensus is that the "golden key" enabling housing providers and health organisations to work together has yet to be found. A major part of the problem is that housing is not yet integral to the health and social care integration agenda. That is arguably evident in the intransigence of many trusts towards innovative land schemes. The fact of the matter is that both trusts and NHS Property Services are under enormous political pressure to sell off their surplus land for housing to help meet government promises. The appetite to do things differently and the necessary skills sets to deliver land deals are all too often missing.

That is not to say that there are no good examples of partnership working, or to deny the optimism in some quarters that the financial pressures will inevitably lead to change. But this will take time and a huge amount of effort, particularly on the part of housing providers, who need to make the running.

Innovative projects featured in this publication have often come about because the health provider has been receptive to new solutions and headed up by a driven and visionary individual. This was certainly the case with One Housing Group's Tile House project in north London. However, other initiatives have been driven by a "coalition of the willing", such as the Kent strategic partnership which includes 12 local housing authorities and eight healthcare organisations. In other places, like Liverpool, a combined effort is being made to create new health and well-being neighbourhoods. This could be the new type of virtual cottage hospital that Simon Stevens has called for, allowing older people with long-term conditions to be treated in their communities.

At the strategic level there are a number of welcome developments that give room for optimism:

- A new concordat is being drawn up by housing and health organisations and the Department of Health to encourage closer working between housing and health. This comes after a new mental health crisis care concordat that has been drawn up by the Department of Health and more than 20 healthcare and local government bodies which is relevant to housing providers.[67]

- The Department of Health is committing £300 million from its budget to provide extra-care housing and other supported housing.

- NHS trusts are bringing in strategic estate partners to make better use of their estates, including the provision of extra-care and reablement facilities.

- The Care Act explicitly references housing as part of local authorities' new duty to promote the integration of health and care, while registered providers of social housing are explicitly listed as one of the partners a local authority must co-operate with when considering and planning a person's need for care and support.

However, the key policy directed at more integrated working – the Better Care Fund – does not look, from the plans already submitted, as if it will drive integration over and

67 Department of Health *Mental Health Crisis Care Concordat: Improving Outcomes for People Experiencing Mental Health Crisis* (2014)

above what is there already. Importantly, the fund is not new money but comes out of the existing health and social care budgets. The plans of clinical commissioning groups and health and well-being boards are understood to be extremely conservative, with this cash being allocated to fund existing service provision. It is of course still early days.

The debate about utilising NHS land meanwhile rumbles on. Research by the Smith Institute showed that over a 25-year period indicative savings of around £5.9 billion could be expected if trusts and housing providers worked together to develop new care pathways and facilities. The Institute's research concludes that land deals with housing associations represent value for money and offer better healthcare outcomes.

However, NHS Property Services is taking a conservative approach to land for the moment, bringing it forward for sale rather than using it to form joint ventures in the medium term. It might review this policy in the future and develop business-case assessments that take value to the community into consideration alongside sales value on the open market. There is a case for the Homes & Communities Agency stepping in to be more vocal about the better value that could be created to the NHS if trusts were to take a longer-term approach and use land or redundant facilities to provide new types of step-down or reablement accommodation, or specialist housing.

Of course, financial pressure, increased competition and the power of the clinical commissioning groups ought to be drivers of change. But for the moment, that is proving a step too far. Creating a faster momentum for change will require action at both the practical and policy levels.

On a practical level, to work within the system:

- Housing associations need to be clear about their offer to health organisations, understand financial flows and local health priorities, and think of trusts as businesses – marketing their competencies and solutions to the clinical commissioning groups. A number of organisations are working to provide more rigorous evidence of benefits, which is absolutely crucial. But perseverance will be of the essence. Striking up new partnerships won't happen overnight.

- The Department of Health could follow the example of the Department for Work & Pensions and promote more "meet the client" events.

- The NHS England could look at introducing a standard contract for smaller organisations to reduce unnecessary red tape and foster easier bidding arrangements.

On a policy level:

- There needs to be greater focus on the need to consider NHS surplus land to improve efficiencies in care pathways, with the development of a new assessment process that takes into account value to the community as well as sale value on the open market. In essence it amounts to a "sixth case" to the Treasury five-case business planning model, which prioritises the proposal's overall value for the local community. This could be accompanied by a set of standards for how local communities and local organisations contribute to this. The Social Value Act 2012 is forcing local authorities to take local need into consideration when awarding contracts, and this could follow a similar principle.

- It seems that the Better Care Fund will not drive innovation to the extent needed, because clinical commissioning groups and adult social services are often reluctant to take the risk of cutting existing services. A new, transitional fund is needed to provide seed-corn money for which clinical commissioning groups and health and well-being boards could bid. This funding could kick-start new thinking and innovative community-led healthcare plot schemes.

- The second or further round of funding from the Care and Support Specialised Housing (CASSH) Fund to build specialised housing could be targeted at encouraging new public-sector development partnerships, which would encourage trusts to invest land and, in some circumstances, enable the development of what generally is high-cost housing to be financially viable.

There are myriad barriers to successful partnership working. As discussed, these range from governance and cultural differences and mistrust, through to perverse financial flows that can disincentivise innovation and partnership. Though the health impacts of poor housing are understood, there is still a paucity of knowledge and empirical evidence on the benefits and savings that could convince health commissioners to switch resources away from existing care pathways to new, housing-based solutions.

Mutual understanding is thin on the ground. Healthcare professionals often claim housing associations have a tendency to overstate the savings from partnership working, through land deals for example, without understanding that real savings can be realised only if hospital wards can be closed, or at least more patients treated. For housing association professionals, the NHS is perceived as inward-looking and overly complicated, and trusts are seen as too focused on the short term and difficult to work with.

However, as this report demonstrates, new thinking and new partnerships are happening. As the health reforms bed in, the likelihood is that there will be more collaboration, not less. Intense pressure on trust budgets will of course make planning for the long term hard, but the evidence is growing to show that short-termism cannot solve the bigger, demand-led healthcare challenge. Sir David Nicholson said at the end of his eight-year tenure as chief executive of NHS England that in its current form "the NHS is unsustainable". Few would disagree. The challenge for health and housing professionals is surely to work together, with local government and other service providers, to find new ways to help make the system not just more sustainable, but also better.

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