Managing long-term conditions in the community

Introduction

Joint working between housing and health can reduce pressures on the NHS and improve an individual's overall wellbeing. Housing associations are keen to explore ways of working effectively with the NHS and public health to address unmet health needs among tenants and the communities in which they operate. Some housing associations are also starting to recognise new business opportunities in working with health commissioners and providers in developing integrated models of health, care and support, positioning themselves as healthcare providers or entering into joint ventures with NHS Trusts.

This briefing is one of four documents entitled **Connecting Housing and Health**. They are aimed at housing associations and provide learning on health commissioning and NHS providers. The briefings aim to support housing associations in shaping a health offer, but do not present a step-by-step guide. They sit alongside the **Routes into Health** briefings, which explain the new NHS structures and ways to engage with health.

This briefing provides:

- An overview of the rise in long-term conditions and the resulting pressures on the health system
- Learning on the priorities for commissioners alongside the challenges of commissioning preventatively to manage long-term conditions in the community
- An outline of the different approaches housing associations could take to develop a health offer.

Context

More than 15 million people in England have a long-term condition, making up a quarter of the population[1]. The rise in the number of people with a long-term condition is partly due to the population ageing and partly to advances in medical science which mean more people are surviving serious illness, or are living longer with a life-long condition. Other reasons for the rise are related to lifestyle factors (smoking, drinking, obesity and sedentary lifestyles) and structural factors such as poverty[2].

By 2018, the number of people with three or more long-term conditions is expected to rise to 2.9 million; in 2008 this figure stood at 1.9 million[3]. As a result, demand on NHS hospital resources has increased dramatically during the past 10 years with a 35% increase in emergency hospital admissions[4]. Furthermore, the number of people aged over 85 is growing rapidly with the number of older people with care needs predicted to rise 61% by 2032. The number of people with dementia is expected to more than double during the next 30 years[5]. Currently, 58% of people aged over 60 have a long-term condition[6] resulting in a 65% rise in secondary care episodes for those aged over 75 years[7].

1 Department of Health (2012), Long Term Conditions Compendium (3rd edition)
2,3 ibid
4 Royal College of Physicians (2012), Hospitals on the edge? The time for action
5 Richard Humphries and Laura Bennett: Making best use of the Better Care Fund
6 Department of Health (2012), Long Term Conditions Compendium (3rd edition)
7 Royal College of Physicians (2012), Hospitals on the edge? The time for action

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This pressure is not simply caused by the increase in people who live with more than one long-term condition. It arises because existing health and social care services are struggling to prevent and manage multi-morbidity[8]. Just a small number of patients 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% of all inpatient bed days[9]. And these multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018[10]. If people with long-term conditions were managed effectively in the community, they should remain relatively stable and enjoy a better quality of life with fewer crises and hospital visits.

The NHS perspective

The NHS needs to reduce the demand for emergency health services by enabling people to enjoy a healthy and active life within their communities. At a local level, Clinical Commissioning Groups (CCGs), together with Health and Wellbeing Boards, local government, NHS providers and other partners, will be developing plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Commissioners submitted a first draft of their plans in February 2014, with a final draft submitted for sign-off in June 2014. The substantial demand and financial pressures faced over this five-year period mean that local plans must include transformative reforms that significantly improve the value of health and care provision, as well as more incremental improvements. Housing associations can obtain the five-year plan from each local CCG, who are accountable to NHS England and the public (through local Healthwatch) for enabling people with long-term conditions to manage their own health and have an agreed care plan based on their personal needs.

CCGs are given a budget by NHS England to commission secondary care services, while health and wellbeing boards are given the legal duty to ensure such services are integrated. The creation of the Better Care Fund creates further incentives and resources to invest in better management of long-term conditions. Guidance to CCGs focuses on increasing patients' access to their own health records, care coordination and education around self-care and health prevention, as well as more accessible and consistent services[11]. However, even when CCGs have set priorities to detect long-term conditions early and to manage them in the community, this may not be backed up by a reallocation in resources and funding will be driven by what has been done in the past rather than future needs[12]. There are certain drivers which may influence the pace of change. Firstly, the need to reduce fractured service provision and integrate care around the needs of the person has been at the heart of healthcare policy over successive governments[13], and is currently receiving the national attention it deserves through the creation of the Integration Pioneers. The Integration Pioneers are exploring the barriers to integration through a variety of new approaches from the development of community hubs to integrated care teams based around GPs[14]. For example, South Devon and Torquay Integration Pioneer looks specifically at developing a single point of access to primary, secondary and social care services. The Better Care Fund is intended to support the development of integrated models of care, but it is as yet unclear to what extent the fund will influence future commissioning practice.

[8] Humphries R and Bennett L (2014), Making Best use of the Better Care Fund, The King's Fund
[9] Naylor et al (2013), Long-term conditions and mental health, The King's Fund
[10] Department of Health (2012), Long Term Conditions Compendium (3rd edition).
[11] NHS England (2013), A Call to Action: Commissioning for Prevention
[12] Smith J et al (2013) Commissioning high-quality care for people with long-term conditions, Nuffield Trust
[13] Imison, Naylor and Mabin, Under One Roof: Will polyclinics deliver integrated care? King's Fund, 2008
[14] http://www.scie.org.uk/publications/integratedworking/integration-pioneers.asp

Secondly, in some areas (like Cambridgeshire and Peterborough), CCGs are slowly moving towards commissioning a care pathway to a lead provider. CCGs are struggling to reinvest any savings in community-based health services such as re-ablement and post-discharge support because the demand for hospital-based secondary care is so great. However, this does force different services to work together to provide a joined up approach across geographic and organisational boundaries. In this scenario, the lead provider (likely a foundation trust or a partnership of trusts and private healthcare providers) provides the full range of health services in the care pathway. They also have a key role in coordinating the care for that particular client group. Their remit is not just for community services, but will include responsibility for patients who have to be admitted to hospital in an emergency, people with mental illness, and end of life care. Currently the focus is on measuring and paying for activity, such as hospital admissions. Commissioning a whole pathway changes this focus to improve quality and outcomes through supporting investment in community services, improving the way in which services are funded and delivered. This presents an opportunity for housing associations to work in consortium with their peers to demonstrate a wide reach across the local authority or CCG area, working as a subcontractor to the lead provider to help deliver the contract.

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Thirdly, general practice has 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.

The NHS Year of Care programme demonstrated how to deliver personalised care in routine practice for people with long-term conditions, using diabetes as an exemplar[15]. It led to the development of the House of Care, which considered all people with long-term conditions (not just those with a single disease or in high-risk groups) and assumes an active role for patients, with collaborative personalised care planning at its heart. However, GPs – some of whom will also be clinical commissioners – are increasingly concerned about increasing workloads: demand is rising; access targets are hard to meet, and practice income is falling[16]. There is also national funding available to support the development of seven-day, 'eight till eight' primary care services. This means there is scope to provide primary care services that are more flexible and innovative in their delivery. Housing associations could work with a CCG to develop an offer to the local NHS England area teams who commission primary care to deliver support to reduce demand and support better self-care in the community.

Developing a health offer

Before developing a health offer, housing associations need to assess their current services, understand local health pressures and priorities, and decide which approach fits strategically with the direction of their organisation. Health commissioners do not have the solutions to achieve preventative, integrated care, and the large scale transformation of the health system will take years to achieve. If housing associations viewed the NHS as business partners, rather than commissioners of healthcare, they could partner up to bid for contracts, providing a strong integrated care package. Housing associations need to be proactive in shaping an offer and need to be prepared for a long-term investment of time and effort to build engagement plans and relationships with health. It may take years of investment and evaluation to demonstrate measurable impact on the causes of health inequality and poor health outcomes.

[15] Year of Care: Report of findings from the pilot programme, 2011

[16] NHS Alliance (2013), Breaking Boundaries

Some housing associations will be focused on improving the health needs of their existing tenants, working closely with NHS providers and commissioners to raise awareness of unmet need and then on meeting it. A housing association may need to invest their own resources in a pilot model to demonstrate their potential to meet desired outcomes in cost-effective ways. Other housing associations will be interested in developing their organisation as an integrated healthcare provider. Either way, this is about developing a new service offer to meet health outcomes frameworks. Housing associations should ensure that there is a clear service offer that is measurable, marketable and tradable to NHS providers. The organisation should be clear about whether it is looking to be a sub-contractor, to be a partner in the redesign of a particular pathway, or whether they have the skills and balance sheet strength to be part of a joint venture.

Access: Health commissioners are increasingly looking to prevent and manage multi-morbidity rather than single diseases. Knowing who these people are is essential to being able to change how services and resources are used. Housing associations may provide housing to a higher proportion of people with multiple long-term conditions. People living at higher levels of deprivation are more likely to live with a debilitating condition; with more than one condition, and for more of their lives[17]. People in the poorest social class have a 60% higher prevalence than those in the most affluent social class (Department of Health 2012)[18]. Recent research by Family Mosaic showed that 92% of their residents aged over 65 years have one or more long-term conditions, with a third also experiencing depression and a similar amount with anxiety. These conditions cost the NHS up to £4.7 million every year[19].

Insight: Housing associations can provide good insight for commissioners on ways of managing long-term conditions and the wider determinants of health. With a history of providing support and working with vulnerable clients, housing associations recognise where costs build up in the health and care system, and know how to manage services for vulnerable people that ensure admissions to acute services are avoided, enabling people to recover or maintain their independence in their community. Housing associations can share a lot of data about their tenants and customers, ranging from CoRE (Continuous Recording), which monitors lettings and socio economic data of social housing tenants, to detailed information about their customers' health and wellbeing.

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Assets: Housing associations are able to bring their existing assets and access to capital finance to transform services in community settings. Housing associations could provide appropriately designed specialist housing to enable people to remain independent and receive health, social care and support services in their home rather than have to move to more institutional settings. This provides better outcomes at lower costs for people and their carers than traditional high cost nursing and residential care. Housing associations have buildings with shared space, which could (with the permission of their residents) be used to host health services and provide better access to primary care and resources that support tenants to manage their own health. They also have staff who manage the properties, collect rent and intervene in instances of anti-social behaviour. We are in regular contact with tenants and other clients, and in a position to monitor their use of health services, identify where somebody is failing to cope with a condition or where that condition may have gone undiagnosed, and provide preventative interventions or support self-care.

[17] The Marmot Review (2010), Fair Society Healthy Lives
[18] Department of Health (2012), Long Term Conditions Compendium (3rd edition)
[19] Family Mosaic (2013), Health begins at home

This briefing sets out the following approaches to health:

1. **Identifying unmet need and targeting support**
2. **Community health hubs**
3. **End of life care**

1. Identifying need and targeting support

Housing associations could train housing management staff and use housing management systems, to recognise undiagnosed long-term conditions, from mental health to dementia, offering support to manage the condition and develop healthy behaviours. Housing associations could also work with public health teams to share data via NHS numbers to gain an understanding of where their existing clients might be disproportionately accessing primary and secondary care services, allowing them to target existing resources at those people and signposting them to relevant services provided in-house or externally. Housing associations could place a support worker in a GPs surgery to enable patients to receive holistic care for a long-term condition or a recent diagnosis. They could also support GPs by signposting people with long-term conditions to available support and with additional training, could even deliver initial dementia diagnostic tests, helping to improve diagnosis rates and easing the pressure for GPs.

The Quality and Outcomes Framework may see some surgeries funding a local housing association to provide holistic support in their surgeries, helping patients who are also their tenants, or to whom they could also offer housing advice and support. This will be on a small scale, but will help housing associations to evidence the impact of their offer. Housing associations could also achieve closer working with primary care providers through joining multi-disciplinary teams, which contain a range of primary care staff, from GPs to social workers, to promote an integrated approach to care.

Housing associations are able not only to access people living in conditions of health inequality, but as a trusted provider of housing and community services, they are more likely to influence their behaviour. Housing associations themselves provide a number of services aimed at improving personal and community wellbeing. These include intensive support, telecare and telehealth services, debt advice services, employment skills, social clubs and healthy living courses. Working with public health and the CCG, housing associations could evaluate the impact of these interventions to provide clear evidence of what works.

> **"Housing associations themselves provide a number of services aimed at improving personal and community wellbeing."**

While the NHS, and CCGs are unlikely to fund this type of provision, it may be possible to get small amounts of funding through individual GP surgeries or public health teams to support this work. This is about demonstrating the impact of a variety of housing interventions, from adaptations to support, on health outcomes. Improving the understanding of the sector's ability to monitor and target support to manage long-term conditions and tackle health inequality will provide commissioners with new models for tackling multi-morbidity.

2. Community health hubs and reablement

Housing associations could offer up premises to a CCG to host a hub in an area of health deprivation, identifying those at greatest risk. Partnering with NHS providers (primary care and community healthcare) they could provide holistic healthcare and support, enabling people to self-manage long-term conditions and make healthy lifestyle choices. Hubs might be physical (a centrally-located set of community and primary care services with easy access to everything a person needs in one place) or virtual (a highly-trained support worker who is able to coordinate, manage, change and evaluate care around the specific needs of a patient). NHS England is moving towards joint arrangements with CCGs for commissioning general practice services. They are also reviewing the current system of general practice premises reimbursement to identify opportunities for improving value for money and to promote more innovative use of estates. For housing associations this means they can shape an offer to use that estate to develop a holistic primary care centre, which includes support on housing and provides a coordinated approach to managing someone's care needs.

"NHS England is moving towards joint arrangements with CCGs for commissioning general practice services."

Housing associations could also explore building partnerships with a community or mental health trust to enable them to base specialist nurses within their services to tackle severe and chronic health problems among people with chaotic lives. This type of service would support more flexible health delivery in supported housing schemes, hostels, through drop-in services, or even directly on the street, preventing avoidable admissions to accident and emergency departments. A housing association could also work with a CCG to develop an offer to an NHS trust to redevelop a district hospital or use existing physical assets to provide step-up accommodation, such as a crisis house or community reablement service. This type of service prevents hospital admissions by providing intensive support to manage a health crisis in the community, ensuring the client is able to return home after a short period in care.

3. End of life care

Many more people are dying at older age and will be more likely to have complex needs and multiple co-morbidities as a result of long-term conditions such as respiratory, cardiac and neurological diseases. 75% of deaths are from non-cancer/long-term/frailty conditions[20]. 40-50% of those who died in hospital could have died at home[21]. People with a life-limiting illness often require specialist palliative care to manage pain, agitation, or shortness of breath that would otherwise result in a hospital admission. End-of-life care is particularly poor for people with dementia[22], resulting from excessive interventions (such as tube feeding and the use of restraints) or a lack of pain control, malnutrition and dehydration[23].

CCGs are moving away from incentivising better end of life care through Payment by Results, towards creating approaches such as the House of Care (mentioned above), as well as using existing incentives such as the QIPP (quality, innovation, productivity and prevention) programme. This would help bring a range of providers together and promote integrated working, such as commissioning the whole end of life care pathway out to a coalition of providers, including housing associations.

[20] National Audit Office (2009), National End of Life Care Intelligence Unit
[21] National Audit Office (2009), National End of Life Care Intelligence Unit
[22] David Oliver, Catherine Foot, Richard Humphries (2014), Making our health and care systems fit for an ageing population, The King's Fund
[23] Hughes J et al (2007). 'Palliative care in dementia: issues and evidence'. Advances in Psychiatric Treatment, vol 13, pp 251–60.

"40-50% of those who died in hospital could have died at home."

Developing formal partnerships with NHS community trusts offers patients better support and co-ordination, particularly relevant when ensuring people are able to die at home. Housing associations could take on a care coordination role, assigning a liaison co-ordinator who organises the care package to suit the patient's needs. The aim is to improve co-ordination of services so that unnecessary hospital admissions can be prevented through ensuring clear communication between key stakeholders and the smooth transfer of care between providers. Housing associations could also work with a trust to develop a palliative care unit in an existing specialist scheme, where care and support services are already available 24 hours a day, bringing in community nurses and specialist palliative care training. To do this, a housing association needs to be able to share risk with the NHS, which will enable them to take on any patient and formalise a partnership agreement. For more details on how to develop the governance structures required for this, visit the Federation's **health partnership hub**.

Useful resources

The Department of Health has produced the third edition of the ***Long Term Conditions Compendium***, which provides evidence for improving care and outcomes for people with long-term conditions.

The King's Fund has produced many useful resources on long-term conditions, including the report ***Delivering better services for people with long-term conditions***, which describes a co-ordinated service delivery model – the 'house of care' – that aims to deliver proactive, holistic and patient-centred care for people with long-term conditions.

The King's Fund briefing on the Better Care Fund, ***Making best use of the Better Care Fund,*** offers an evidence-based guide to aid the discussions between clinical commissioning groups, local authorities and health and wellbeing boards on use of the fund.

The NHS Confederation and the Royal College of GPs produced a report ***Making integrated out-of-hospital care a reality***, which provides a set of principles to lay the foundations for delivering effective integrated out-of-hospital care, each underpinned by a range of drivers and enablers. Examples of housing associations developing partnerships with health can be found on the case study section of the National Housing Federation **Health Partnership Hub**.

The Federation has produced a **briefing paper on the creative use of NHS estate** which outlines the disposal process for NHS estate and sets out possible approaches housing associations can take to access land.

The Federation has produced a **briefing paper on quality governance** which explains the key elements of good quality assurance for partnering with NHS providers.