

HOUSING LIN POLICY BRIEFING

New Health and Social Care Structures – What are the Opportunities for Housing?

1.0 PURPOSE AND INTRODUCTION

- 1.1 The purpose of the paper is to ensure that those working in housing are up to date with the new terms, what they mean and the implications for effective joint working between housing providers and the health and social care system.
- 1.2 Over the last 10 years, the government has led nine major changes to the organisational structures and financial frameworks in health and social care. This is usually discussed in a combination of three main ways :-
- Generic terms such as modernisation and reform;
 - Policy initiatives such as Commissioning a Patient-led NHS;
 - Systems changes such as Payment by Results and Practice Based Commissioning.
- 1.3 The speed with which these changes have been introduced has been rapid as part of the comprehensive reform agenda or 'perpetual revolution' as some commentators have put it. Given the pace of change it can be difficult for those working in partnership or with a desire to work in partnership to be sure which of the changes act as drivers or inhibitors to successful engagement between different sectors and different types of organisation.
- 1.4 This briefing sets out the policy context in which these changes have taken place, the new architecture and the key terms that are now being used in the NHS and in social care.

2.0 HEALTH AND HOUSING: THE POLICY BACKGROUND

Health Challenges of the 20th Century

- 2.1 In the nineteenth century the main threats to human health, in Britain, were from infectious diseases caused by poor nutrition, overcrowding, pollution and poor sanitation. The early pioneers of public health saw the provision of good quality social housing as a key weapon in tackling the underlying causes of ill-health. This led to an acceptance that rehousing was an effective health intervention and that residential change, in and of itself, could alleviate

suffering, cure illness, improve access to health and social care or enhance quality of life.

- 2.2 Certainly, moving someone from insecure temporary housing to secure permanent housing or from an overcrowded to a less overcrowded situation is likely to improve their health. This approach follows from the belief that risk factors can be managed through the systematic specification of particular improvements. If these are consistently implemented, it is argued, it is possible to predict a particular set of health outcomes. This can be seen in the relationship between particular housing conditions (damp, cold and mould) and clusters of occupants' ill health (asthma, coughs).
- 2.3 In the succeeding one hundred years, social housing providers have played a significant role in preventing ill-health by providing people on low incomes with good quality housing and by responding to the demands for greater independence by people with a range of support needs. Through regulation and good practice efforts have been made to improve the accessibility, energy efficiency and overall quality of the housing that is built. Local authorities have played a key role in improving the housing stock through group repair schemes and programmes to bring the homes of vulnerable older occupiers up to Decent Homes standards.

Health Challenges of the 21st Century

- 2.4 In the twenty first century the health challenges we face are different. While the diseases of poverty are still with us they have been joined by those that are associated with different work patterns, different diets and an ageing population. Mental health, neurological diseases (such as Alzheimer's Disease), coronary heart disease, cancer and diabetes are the main threats to health in this century. With the possible exception of mental health problems these are not diseases that people traditionally associate with poor housing conditions. However, improving the quality of someone's housing, the quality of the neighbourhood in which the housing is set and their sense of community has a significant impact on their ability to make the choices necessary to avoid some of these diseases. It can also have a direct impact on their ability to manage long term health problems.
- 2.5 Housing organisations will want to build on their current achievements and develop new approaches to the health challenges of the twenty first century. They are key players because they house many people who experience the worst health inequalities. They are essential players in the development of strong and cohesive communities.

3.0 RECENT POLICY DEVELOPMENTS

- 3.1 The health and social care has changed in response to the Government's reform agenda from a state funded public service to one based on commissioning from a mixed economy of public, private and voluntary / third sector providers in a more competitive economic environment. The expectation is that service improvements and increased public satisfaction come from an increased choice of providers each offering more responsive and appropriate services.

- 3.2 The debate about public service delivery is one in which the language changes as the different participants develop their thinking. However, there are three consistent themes for health and social care organisations:-
- *Putting the Customer First* - the increasing personalisation of services;
 - *Engagement and choice* - patients designing services and making healthy choices;
 - *Localisation* - delivery of care closer to home and local decision making.

Putting the Customer First

- 3.3 *The Health and Social Care Act*¹ places a duty on health organisations to involve and consult patients and the public. They must consult people on their proposals and report on what changes they have made to their proposals in the light of the public's response. This greater focus on engagement is driven by a belief that:-

- involving users in the design of services will make them better used;
- engagement will balance consumerism and social justice;
- self care and self determination lead to better health outcomes.

- 3.4 *Tackling Health Inequalities : A Programme for Action*² introduced the concept of the "fully engaged scenario" in which the level of public engagement in relation to health is high, life expectancy goes beyond current forecasts, health status improves dramatically, use of resources is more efficient and the health service is responsive with high rates of technology uptake. It identified a number of interventions to reduce smoking in manual groups, tackle cold and damp housing and increasing safety at home for older people as well as working to reduce hospital admission and excess winter deaths.

- 3.5 *Choosing Health : Making Healthier Choices Easier*³ encouraged people to make better choices about their lifestyle, and consequently their health. *Our Health, Our Care, Our Say*⁴ commits the NHS to supporting the 15 million people with long-term conditions to take control of their conditions. The Whole Systems Long Term Conditions Demonstration sites are designed to encourage greater use of telecare, telehealth and new ways of delivering information as well as low level support services, equipment and adaptations⁵. It envisages i) the development of a new generation of clinics (sometimes called PolyClinics) where different service providers can work together (e.g. sheltered housing schemes or community centres), ii) greater recognition of the importance of neighbourhoods as a locus for healthy lifestyles, and iii) supporting people to remain in their own homes and iv) planning for the health and social care implications of new housing developments.

Engagement and Choice

- 3.6 One of the key shifts in recent years has been that older people, too often seen as the grateful recipients of service. They now have a clearer understanding of their rights and entitlements and an expectation that these

¹ DH (2001) *The Health and Social Care Act*. SO : London

² DH (2003) *Tackling Health Inequalities : A Programme for Action*. SO : London.

³ DH (2004) *Choosing Health : Making Healthier Choices Easier*. SO : London.

⁴ DH (2006) *Our Health, Our Care, Our Say*. SO : London.

⁵ DH (2007) *Whole Systems LTC Demonstrator Sites*.

will be met. Linked with this is the growing acceptance, underpinned by equalities and human rights legislation that individuals rights to service should not be compromised by age, or physical or mental disability.

- 3.7 Improved access to information - primarily through the internet - enables people to compare and contrast the services on offer much more easily. In all sectors, in the GP Surgery or in the housing office, people are looking for a much more bespoke service and to be offered a number of choices and to be able to make an assessment about the quality of service on offer.
- 3.8 People can only exercise choice if there is a wider range of providers available to them. For this reason (and the belief that competition between providers is the key to driving up quality) there have been a number of initiatives to encourage choice such as Choose and Book⁶ and Direct Payments⁷. There is also a recognition that those people who, for whatever reason, find it difficult to exercise choice will need to have access to advice.

Localisation

- 3.9 Choice, improved medical outcomes and new financial arrangements (Payment by Results) place increased emphasis on solutions that enable people receive care at home or to return home from a medical facility as soon as possible. *Our Health, Our Care, Our Say* (DH, 2006) proposes a 5% shift from hospital to community settings over the next ten years. This means that housing, housing adaptation and community based support services have a key role as part of the care pathway.
- 3.10 The public have indicated an increasing desire to receive care at home or closer to home in community settings. New providers and the flexibility to develop new patterns of provision (working with current and potential users) provide an opportunity to deliver quality public services. There will be a need to develop new facilities that enable the co-location of services. Good quality housing - be that Lifetime Homes, specialist provision such as extra-care housing or well designed general needs housing - will be key to the effective implementation of preventative strategies and to allow people to design their own care pathway and exercise real choice over the type of service they want and where they want to receive it.
- 3.11 In recent years there has been an increasing understanding that the housing provides the necessary underpinning for engagement in wider civil society and particularly as a route through to employment, to increased income and the kinds of choices that enhance someone's sense of well-being. Across Government, in the White Paper *Strong and Prosperous Communities*⁸, the *Commissioning Framework for Health and Well-being*⁹ and, the Hills Report, *Ends and Means: The Future Role of Social Housing in England*¹⁰ there is a requirement for health, housing and social care commissioners to work

⁶ Choose and Book Website : www.chooseandbook.nhs.uk

⁷ DH (2007) Independence, choice and risk : A Guide to Decision-Making. SO : London.

⁸ DCLG (2006) The Local Government White Paper : Strong and Prosperous Communities. SO : London.

⁹ DH (2007) Commissioning Framework for Health and Well-Being. SO : London.

¹⁰ DH (2007) Ends and Means : Future of Social Housing in England. SO : London.

together to improve the health of people who are in employment but also to help people to improve their well-being through employment.

- 3.12 The Local Government and Public Involvement in Health Bill¹¹ will require local authorities will produce a Joint Strategic Needs Assessment to inform commissioning decisions and investment. The assessment should describe future needs of the population over a 3 to 5 year period, be based on a robust analysis of need, indicate where there are inequalities, give voice to the expressed needs of local people and define achievable outcomes. The assessment will provide a firm foundation for agreeing the priorities within the Community Strategy and, via the Local Strategic Partnership, flow through to the joint objectives in the Local Area Agreement (LAAs). For further information on the implications of the LAAs and housing for older and vulnerable people, see forthcoming Housing LIN factsheet no. 22: 'Local Area Agreements :Maximising the Potential'.

4.0 HEALTH AND SOCIAL CARE ARCHITECTURE

- 4.1 Bringing investment in health in the UK up to European levels as a proportion of GDP has been a key government objective in recent years. Certainly, in terms of presentation, this was to be spent improving the infrastructure, improving pay for staff and contractors (and hence improving recruitment and retention) and reducing waiting times. *Commissioning a Patient-Led NHS*¹² sought a strengthening in commissioning, the devolution of purchasing consortia of primary care professionals and competition from new providers entering the health and social care market (especially from the private sector).
- 4.2 At the same time there was a less public but just as significant change in the way that money moves around the NHS. *Reforming NHS Financial Flows: Introducing Payment by Result*¹³s (DH 2002) set up incentives for NHS hospitals to compete for business and indicated how money would follow the patient as they exercised choice. Under PbR hospitals are paid only if an operation or treatment is carried out. It will be paid a fixed price (tariff) for every treatment it undertakes and it will be allowed to keep any surpluses it generates. This means that hospitals will want to retain existing patients and attract new ones. At the same time PCTs will want to work with General Practices to improve care, manage demand and reduce the risk of costly hospital admissions.
- 4.3 This section of this paper looks at how the architecture of the NHS has changed to respond to this agenda. Figure 1 sets out the structure of the NHS in England. It then looks at the how the roles of these organisations have changed and how they will be working with their social care counterparts. In the following section it looks at how these new structures affect the market for housing organisations.

¹¹ DCLG (2007) The Local Government and Public Involvement in Health Bill. SO : London.

¹² DH (2005) Commissioning A Patient-Led NHS. SO : London.

¹³ DH (2002) Reforming NHS Financial Flows : Introducing Payment by Results. SO : London.

Commissioning

- 4.4 There are now 10 Strategic Health Authorities covering England. They are responsible for developing strategy and ensuring that local NHS organisations are performing well. As the key link between Department of Health and the NHS locally they ensure that national priorities are reflected in local plans and that PCTs and local NHS Trusts are performing well. They also have a key role to play in ensuring that there is a sufficient supply of well-trained staff available to meet local health and social care needs.
- 4.5 Strategic Health Authorities work together with local government to ensure that there are both cross-governmental and cross-sectoral approaches to tackling the wider determinants of health and health inequalities. They will provide input to regional strategies and to Local Strategic Partnerships. They will monitor health and disease trends and advise on methods for improving health and reducing health inequality and strategies for working up-stream to improve health. For further information see "The Role of Public Health in Supporting the Development of Integrated Services" (CSIP, 2007).
- 4.6 Since 2002 PCTs have been in control of 80% of the NHS budget and have had responsibility for identifying local health needs, commissioning the right services to meet these needs and where, it represents value for money, providing services. Key to making a success of this has been the engagement and involvement of local people, a continual search for improvement and innovation and seamless delivery of service - particularly across health and social care.
- 4.7 "Commissioning a Patient Led NHS" gave voice to the concern that PCT's had not been as effective as they might have been at commissioning. This signalled a further period of change as the number of PCTs reduced from 303 to 152. PCTs were asked to accelerate their move out of direct provision, they were required to demonstrate that they were commissioning services from the private sector and support the development of Practice Based Commissioning.
- 4.8 So, PCTs will increasingly devolve decisions about the commissioning of services to groups of primary care practices. These Practice Based Commissioning consortia will have the resources, the necessary direct contact with patients and the freedom to redesign services and form new relationships to best meet patient need. PCTs will, through PbC, provides incentives to practices to provide services closer to where people live - and particularly to control demand for hospital services.

Providing – Primary Care

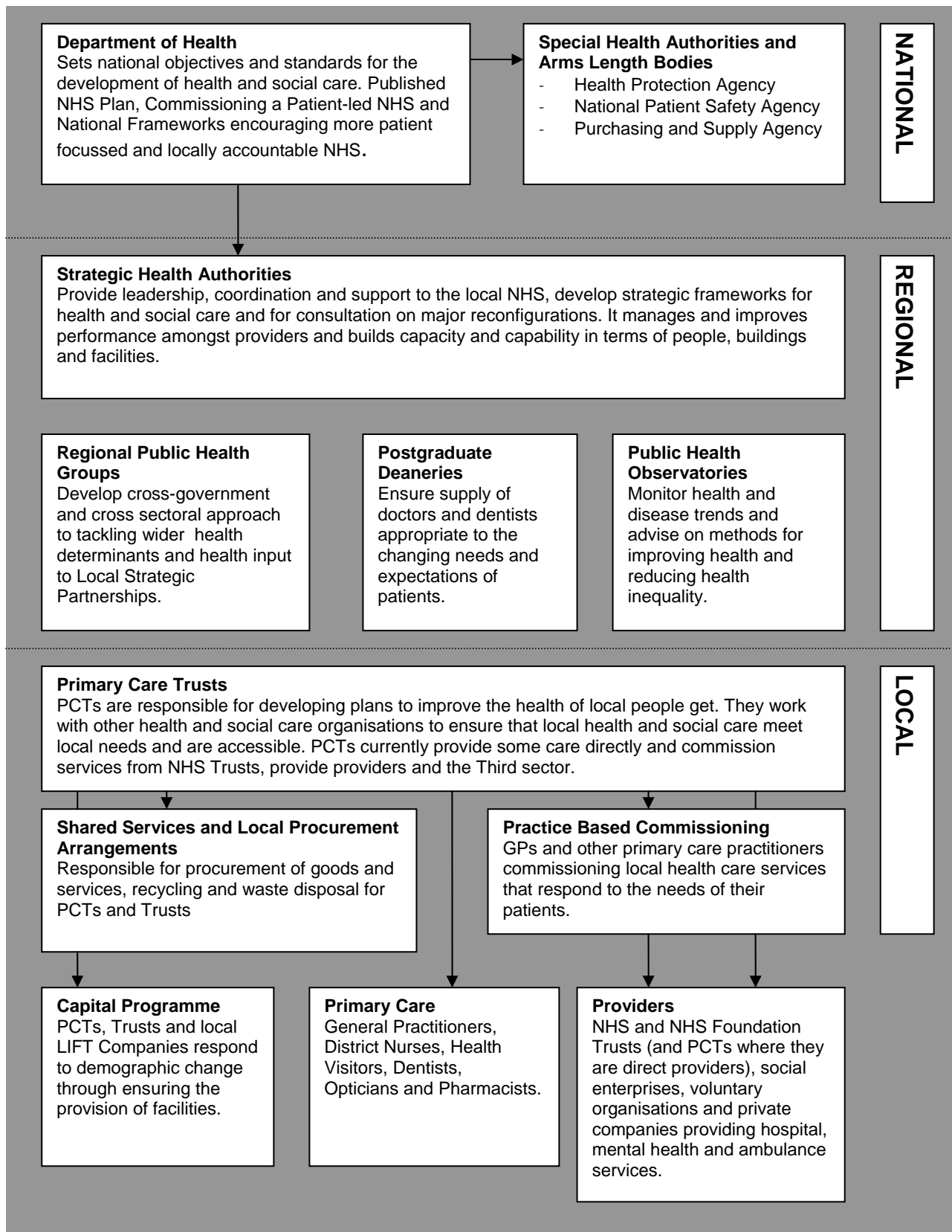
- 4.9 PCTs will move to put their provider services (e.g. health visitors, district nurses etc) as free standing services. These will be likely to be i) integrated with adult social care or children's services, ii) as part of a Community Foundation Trust or iii) as part of a social enterprise. PCTs, Practice Based Commissioners and Trusts will form joint ventures and set up local procurement arrangements and shared service arrangements to ensure that they achieve economies of scale in relation to support services. At the front-line it is to be expected that they will look to form new relationships to create services that contribute to neighbourhood sustainability.

- 4.10 Hospitals in the NHS are managed by NHS Trusts (sometimes called acute Trusts). These Trusts employ the bulk of NHS staff (such as consultants, doctors, nurses, radiographers, porters, cleaners) who are needed to provide safe care in a quality environment. Most people arrive at hospital either as a result of a 'blue light' admission via ambulance or by referral from their GP.
- 4.11 A small but growing number of hospitals are applying for Foundation Trust status. NHS Foundation Trusts are autonomous organisations, free from central Government control, that can decide for themselves how best to improve services and are allowed to retain any surpluses that they generate. They are accountable to their local community through their membership and the Board of Governors. However, it is important to remember that they are still part of the NHS family, provide health care to core NHS principles and are regulated by Monitor (the independent regulator for NHS Foundation Trusts).
- 4.12 Polyclinics are one-stop centres which will offer a range of healthcare services traditionally only provided in hospital as well as access to GP and other health and social care professionals. The clinics will bring together primary care professionals (GP's , dentists, pharmacists) together with diagnostic facilities (x-ray, phlebotomy etc) and a range of services that might include rheumatology on the one hand and a debt counselling service on the other.

Providing – Social Care

- 4.13 The main change in social care has been the separation of adult social care and childrens' services. This has brought a greater alignment between childrens' social services and education on the one hand and between adult social care, housing and environmental health on the other. This has the potential to encourage joint ventures between adult social care and housing commissioners such as Extra Care Housing providing an opportunity for the care to staircase up and down as the resident's needs change and for a range of services to be provided both for residents and other older people in the neighbourhood. There have also been initiatives such as the POPPs (Partnership for Older People Projects) designed to sustain work on prevention to improve outcomes for older people.
- 4.14 Care Trusts are set up to provide integrated health and social care. By combining both NHS responsibilities and local authority responsibilities under a single management, Care Trusts can improve continuity of care and simplify administration. Thus far there have been very few Care Trusts established with many PCTs and Adult Social Care choosing to continue with or further develop Section 31 agreements or joint commissioning arrangements.

Figure 1 : The Structure of the NHS in England



5.0 THE CHANGING MARKET: A ROLE FOR HOUSING?

5.1 Housing organisations have considerable experience of working with a range of commissioners, purchasers and providers – including community based organisations. If this experience was applied to the health and social care market it could have considerable benefits. In this section we will explore where future market opportunities lie for housing providers in relation to housing quality, housing related support services and housing skills.

5.2 The health and social care market - together with the supported housing market - is a complex, and fast changing one. With the pressure to deliver more plurality of provision on the one hand and increasing devolution of commissioning on the other this will have to change. As the rate at which investment in health and social care increases slows down there will be new opportunities to i) develop housing based solutions to those who make a heavy call on health and social care services, and ii) to develop new providers with the business skills to withstand change.

Housing organisations as part of a sustainable neighbourhood

5.3 Housing organisations, and organisations providing support services in particular, are well placed to provide the core services at the 'hub' of a local community. These skills will be key as health and social care, and the NHS in particular, attempt to develop and stimulate the market so that there is more choice in the system. As other services and powers are devolved, and as anchor, or hub, organisations grow and develop, the neighbourhood itself has the potential to become a more dynamic and responsive unit. For further information see "Healthy Sustainable Neighbourhoods" (NHS Confederation / CSIP, 2005).

Housing organisations as part of the care pathway

5.4 Housing organisations can reduce the possible uptake of health and social care services -for example projects on accident prevention and affordable warmth or by providing more accessible homes or adaptations. Housing can become a formalised part of the care pathway. By providing rapid home adaptation services, floating support and step-down services housing organisations have minimised delayed transfers of care. Practice Based Commissioners and PCTs will be interested in packages of service targeted at people with long-term conditions and which reduce the need for hospital admission.

Housing organisations promote health and well-being

5.5 Housing organisations have played a key role in providing facilities and seed-corn funding for a range of social businesses and in sharing that expertise within a local setting. Housing organisations can increase opportunities for healthy choices, for example through setting up food co-ops or through action for safe parks and streets so that people can exercise safely. (For an example, see the Housing LIN Case Study No. 27 Dee Park Active Retirement Club – Age Concern Berkshire).

Housing organisations promoting independence

- 5.6 Housing is an essential partner in the provision of support and care. Many of the housing based models are less intrusive and less expensive than their institutional alternatives. Providers of housing for older people and people with a range of care and support needs have been very successful at forging partnerships outside the sector and participate in pooled budget arrangements and close working relationships between providers, referral agencies and others within health and social care. As institutional forms change so housing providers will need to maintain the relationships necessary to ensure that commissioning intentions and joint commissioning arrangements include models of housing and housing related support services.

Housing organisations value and understand customers

- 5.7 There is a shift away from traditional risk based assessments of need to one that is more responsive to peoples' aspirations. Consumers are increasingly intolerant of a one size fits all approach to public services. A specific area of change lies in the differing demands and expectations of independence. As service users demand greater independence, and purchasers back them in this, there are challenges for provider organisations in responding to these demands, and in absorbing the associated risks.

Housing organisations strengthen asset management

- 5.8 Housing organisations are experienced at managing facilities and in managing community assets for the long-term benefit of all. This is reflected in their increasing involvement in public / private partnerships such as LIFT (Local Initiative Finance Trust) for the development and management of local health and social care facilities. As more agencies seek to explore co-location of services at a local level there is a key role for agencies with expertise in development and facilities management to act as stewards of the public realm on behalf of a range of providers. This may be in relation to the provision of neighbourhood wardens or in terms of providing a hub for local older people as with Extra Care Housing. (e.g. Housing 21 Extra Care Scheme, Bainbridge, North Yorks).

6.0 ENGAGING WITH HEALTH AND SOCIAL CARE

- 6.1 Housing organisations play a full role in local partnerships and have a considerable contribution to make to health and social care developments. However, as structures change and job titles change It can be very difficult to keep pace and difficult to find those people within the health and social care system who are interested in working together.
- 6.2 Clearly maintaining a strategic contact programme with colleagues in social care will be important and useful and, it is a truism to say, that maintaining and sustaining relationships is key to successful partnership working. However, it is the language is more consistent and although it is subject to change and to fashion it changes at a slower pace. This argues for a different approach based on an understanding of the main agendas across health and social care and the language that needs to be used when advocating for

housing's contribution to policy.

6.3 Housing organisations' experience of working with health and social care is variable and very dependent on local circumstances. However there are a number of themes that are likely to endure for the foreseeable future. These are:

- All agencies are charged with a duty to engage the public in their decision-making processes. Those charged with this responsibility in each agency can share resources and ensure that residents, users and patients have access to information about consultations and ways of contributing to strategy development and service design;
- Housing organisations can contribute to Joint Strategic Needs Assessments, Statements of Community Involvement and compliance with Section 11 of the Health and Social Care Act as well as ensuring that new needs are identified and unmet needs addressed;
- Maintain relationships and form joint ventures, particularly with primary care businesses, to increase choice of provider and choice of service at a local level particularly for those who experience the worst inequalities;
- Develop new mechanisms for ensuring that people can stay in their own homes and work with those responsible for the care of people with long-term conditions to target packages of support, adaptation and home improvement to reduce demand for hospital care;
- Form relationships with commissioners in social care and health (and especially practice based commissioners) to identify and demonstrate ways in which housing based solutions can reduce the demand for service and improve quality of life;
- Develop ways between health, housing and social care - possibly through local area agreements - to test the resilience of neighbourhoods to respond to change and establish 'alarm' mechanisms for early identification of problems at a neighbourhood level;
- Use development and asset management skills to improve the quality of facilities through estates strategies, LIFT programmes and Section 106 agreements.

7.0 OTHER HOUSING LIN BRIEFINGS IN THIS SERIES

1. Department of Health's White Paper: Our health, our care, our say; a new direction for community services
2. Individual Budgets
3. Wanless Social Care review - Telecare and older people
4. Long Term Conditions and the Wider Policy Context
5. Disabled Persons (Independent Living) Bill
6. Learning Disability & Housing
7. Local Government White Paper: 'Strong and Prosperous Communities'
8. Disabled Facilities Grant: Department for Communities and Local Government consultation

- 9 Mental Capacity Act: An Introduction
10. Commissioning Framework for Health and Well-being
11. Prevention of Homelessness: the Role of Health and Social Care
12. Improving Access to Health and Social Care Services by People who are Homeless or Living in Temporary or Insecure Accommodation

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If you would like further to receive further briefings from the Housing LIN and/or information on our national/regional events and associated learning tools and resources, please email us at housing@csip.org.uk or write to Housing LIN, CSIP Networks, Department of Health, 3rd Floor, Wellington House, 133-155 Waterloo Road, London SE1 8UG or visit www.icn.csip.org.uk/housing.