Now is the time for organisations, individuals, commissioners and government departments to look beyond traditional sector boundaries and make better use of public money in meeting people's needs.

Through this report and elsewhere, the National Housing Federation seeks to inspire collaboration between key sectors, and to find creative ways for the health and housing care and support needs of vulnerable people to be met.

Our website **www.housing.org.uk/careandsupport** provides further policy information for housing care and support providers

The National Housing Federation represents 1,200 not-for-profit, independent housing associations who together provide 2 million homes for around 5 million people in England.

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NATIONAL HOUSING FEDERATION

Health and housing: worlds apart?

Housing care and support solutions to health challenges

business for neighbourhoods

First published in 2010
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Printed by CPG

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Supported by the National Mental Health Development Unit

July 2010

Contents

Foreword

This report is published at a pivotal time for public services, as a ground-shifting overhaul of public spending priorities takes place across government departments. Now, more than ever, is the time for organisations, individuals, commissioners and government departments to look beyond traditional sector boundaries and make better use of public money and meet people's needs.

There are many areas of mutual interest and shared objectives for the worlds of housing and health. These are already being explored in innovative ways, often with fantastic results, in different areas of the country. And there are more opportunities for both in getting this right.

For the housing care and support sector, this means potential new ways of cutting across different spheres to deliver personalised, flexible services.

For the health sector, these opportunities can mean improved prevention of ill health and promotion of public health, both of which are key priorities for the new Government. The preventative services offered by the housing care and support world can mean that people are less likely to need acute health services, or are enabled to return home from hospital sooner. There are considerable cost benefits to the health sector in the services delivered by housing associations, with an estimated £315m[1] being saved from NHS budgets from investment in housing care and support services.

While re-evaluating the entirety of public spending, the Government has made clear its commitment to ensuring the most vulnerable people in society are not disadvantaged. More consistent engagement and cross-delivery between health and housing care and support is a practical way of doing this. For vulnerable people, older people, people with mental health problems and other marginalised groups, services are provided more effectively and efficiently when commissioning takes place in a way which is not constrained by traditional boundaries.

Housing associations are well placed to form a key part of a big society vision. The National Housing Federation's membership includes over 700 housing associations, who provide care and support services for some of the most vulnerable people in society, including many people who have no contact with mainstream services.

This report describes the health landscape for the housing care and support sector and highlights key points of interaction. For health bodies, there is insight into what housing care and support can achieve. Through this report and elsewhere, the Federation seeks to inspire collaboration between key sectors, and to find creative ways for the health and housing care and support needs of individuals to be met.

David Orr

Chief executive
National Housing Federation

1 CLG: *Research into the financial benefits of the Supporting People programme*, 2009

1: Introduction

Since 1997, spending on the NHS in England has tripled from £35bn in 1997/98 to £102bn in 2009/2010[2]. The coalition Government has undertaken to maintain levels of funding to the NHS in real terms over the next five years from 2010 to 2015. However, it is important to place this undertaking in context. Real increases in funding of up to 2% per year for the NHS, much lower than those experienced in recent years, might cover the implications of demographic change but not the increased costs of new technologies and pharmaceuticals[3]. This means that the NHS will have to focus on managing demand for healthcare by:

- improving health
- by reducing demand for high cost forms of care – particularly institutional forms of provision.

Housing and housing related support can improve health and reduce demand for health and social care services, enabling the full benefits of other services to be realised[4]. Certainly, housing associations have considerable experience of working to improve the health and safety of the homes they manage, to deliver health promotion initiatives and to provide services commissioned by Primary Care Trusts (PCTs) and local authorities. As health budgets come under pressure, there will be new opportunities to develop and provide services that:

- help people have a more mutual relationship with the NHS and to make good choices about their own health
- reduce demand for health and social care services
- develop new ways of providing services.

However, a distinction needs to be made between those situations where improvements in health provide a case for increased government investment in housing, and those situations where there is a case for health commissioners to invest health resources in housing and housing related services. If housing associations are to attract increased investment from the health sector, they will need to develop a case for how they can improve people's quality of life and reduce costs in health and social care.

This report explores a wide range of issues of relevance to both housing and health, and focuses on an examination of services for people who experience problems with their mental health, as this is an area where housing associations can achieve maximum impact. However, the principles outlined in this paper will have wider applicability, looking at:

- The changing environment and structures in the NHS
- The areas in which housing associations contribute to health and wellbeing
- The way in which housing associations can contribute to mental health and long term condition pathways
- Recommendations for how housing organisations can further engage with the health system.

2 House of Commons Health Select Committee (2010) *Public expenditure on health and personal social service 2009.*
3 Appleby J et al (2009) *How cold will it be? Prospects for NHS funding 2011 – 2017* Kings' Fund: London
4 Bolton J (2009) *The use of resources in adult social care*: A Guide for Local Authorities. DH: London.

2: Changing face of the NHS

Policy environment

The programme for Government published on the 21 May 2010[5] set out the coalition Government's plans for a wide range of policy areas, including for the NHS and for public health. A health White Paper was expected in July 2010 on the future structure of the NHS, and a White Paper in the Autumn of 2010 on public health. In its plans, the Government has already announced that it intends to set up an independent NHS Board to allocate resources and provide commissioning guidelines, and to increase democratic participation and accountability in the NHS. The Government confirmed its commitment to guarantee that health spending will increase in real terms in each year of the Parliament starting in 2010. However, it will look to reduce the number of health quangos and reduce the resources spent on administration by a third so that these resources can be diverted back to frontline care.

The work of the Department of Health (DH) is increasingly focused on public health and on preventing ill health. In fact, the Conservatives have previously indicated that they may rename the Department "the Department for Public Health". There are a number of themes that emerge through the content of *The programme for Government*. Whatever the detailed changes in policy that are developed over the next five years, it seems likely that there will be:

- A greater focus on clinical decision making with most commissioning devolved to GP consortia and any proposed changes requiring evidence of clinical support
- Greater choice and control for patients as people are supported to take more control of their own health, with services provided in or near people's homes
- An increased emphasis on public health and on preventing ill health
- New forms of accountability and engagement.

This section of the report looks at these themes in turn.

Clinical decision making

Primary care is seen by many as being at the heart of the UK health system, particularly as it takes on further public health and inequalities responsibilities going forward. It is expected that most health commissioning will be undertaken by consortia of GPs who will commission care on behalf of patients, with a view to strengthening their role as the patient's expert guide through the health system. An environment will be created where doctors and nurses need to be able to use their professional judgment about what is right for patients and this will be supported by giving frontline staff more control of their working environment.

GP consortia may choose to develop their own commissioning capacity, or purchase it from other consortia. What is clear is that any significant changes to healthcare will need evidence of the support of GPs.

These consortia will be charged with ensuring that the NHS works better by extending best practice on improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and where possible, enabling community access to care and treatments. There will be a greater focus on helping older people live at home for longer through solutions such as home adaptations and community support programmes. There is also a clear government pledge to prioritise investment in dementia research.

5 www.programmeforgovernment.hmg.gov.uk

Choice and control

We are witnessing an end to GP catchment areas, with everyone having the right to choose to register with the GP they want, without being restricted by where they live. Twenty four hour urgent care services will be available in every area of England, including GP out-of-hours services, to ensure that every patient has access to a local GP. The Government hopes to make care more accessible by introducing a single number for every kind of urgent care, and by using technology to improve ease of communication between patients and their doctors.

There have been some considerable successes in the NHS in recent years, including the reduction in waiting times and the availability of health screening, which have been driven by additional funding as well as in part by targets. However, many of these targets have now become obsolete and the coalition Government is set to move away from the large number of targets that measured process. Instead, the Government intends to measure success through health outcomes, including for cancer, stroke, and reducing hospital infection rates. In some areas, this direction of travel is already established, and further details of how this will be taken forward are expected to become available in 2010.

The Government intends to make more information on outcomes easily available to the public by publishing data about the performance of healthcare providers online. Increasingly, people will be put in charge of decisions about their care, including control of their health records.

The Government has committed itself to delivering continuous improvement in the quality of services to patients, and to achieving this through much greater involvement of independent and voluntary providers in service provision. This will be supported by giving every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices.

Accountability and engagement

The Government believes that too many reforms in the NHS have been centrally decided, and it proposes to make provision for direct elections of local individuals onto the boards of PCTs. The remainder of the board would be appointed by the relevant local authority or authorities, and PCT chief executives will be appointed by the Secretary of State on the advice of the new independent NHS board. These moves will shift the balance between locally accountable individuals and technical expertise.

PCTs will be given new responsibilities for improving local public health and will be encouraged to work alongside the local authority and other local organisations. They will commission services, which help meet their objectives, but which are better carried out at a wider lever, rather than directly by GPs. There may be potential for this to include services outside of the existing health sphere.

In addition, where a local authority does not agree with a proposed closure of health services in its area, for example, an accident and emergency (A&E) department, it will have the right to take its concerns to health organisations, and to refer the case to the Independent Reconfiguration Panel, which advises the Secretary of State for Health.

The Comprehensive Spending Review (CSR), taking place in Autumn 2010, will set out cross-governmental spending priorities for the following three years and will outline in detail the Government's deficit reduction programme. This will take precedence over the plans outlined in the coalition's programme for government, including those measures described here.

Operating environment

Given the condition of public finances, any enhancement in quality of service will need to be delivered with fewer resources. The challenge facing the NHS requires a transformation in the way healthcare services are delivered and, particularly the need for health to work with adult social care to prevent demand for institutional services. The increased investment of the past ten years should provide some of the necessary capacity to manage changes in the way services are commissioned and delivered.

Certainly, the downturn provides an impetus within the system to ensure that there is consistent implementation of existing best practice, early adoption of innovation, consistent implementation of known productivity improvements, and a more mutual relationship with consumers to help them to make good choices about their own health.

To achieve this, the NHS has adopted an approach to implementing quality innovation, productivity and prevention, known as QIPP. QIPP is embedded through a process of seeking out best practice and world-class performance. Only by capitalising on these examples of good practice, such as those provided by housing related support providers, can the NHS hope to achieve the necessary savings while continuing to deliver improvements in service quality. More information about QIPP is outlined in Figure 1.

Figure 1: QIPP

QIPP

QIPP is an approach that supports the NHS in delivering its quality and efficiency commitments through a greater focus on quality, innovation, productivity and prevention (QIPP). This allows the NHS to drive up quality while improving productivity. This is a challenge which means harnessing and spreading innovation and new ideas. The key principles of the QIPP programme, set out in Inspiring Change in the NHS[1] are:

- Effective engagement with clinicians and other stakeholders through the adoption of the principles of co-production
- The challenge of established thinking and current practice
- The application of knowledge of national and international best practice
- A drive to transfer knowledge and share learning
- Clear and honest communication at all stages of change
- A focus on performance measurement and benefits realisation
- The application of robust programme management and assurance frameworks.

This approach, echoed in *The programme for Government*, requires GP commissioners to focus on strategies based on 'predict and prevent' rather than 'diagnose and treat' with a matching shift in resources. The starting point here will be to ensure that risk is being profiled effectively within the population, and that those identified through this process are helped to make good choices about their health, given easy access to diagnostics and the most effective types of care. Early indications are that these predict and prevent approaches can result in a wholesale shift of resources across the healthcare system, improved quality of care and a reduction in healthcare costs[6] primarily by providing more care in the home and in the community rather than in a high cost hospital setting. Housing care and support services play a key role in delivering these sorts of preventative approaches.

6 System transformation in the NHS: QIPP the Tribal Approach, 2010.

Commissioners of healthcare services will be encouraged to improve the quality of decision making and be more focused on outcomes rather than process targets. This commissioning will require commissioners to improve the quality of their decision making through engagement with local people and local clinicians, thereby ensuring local support for any proposed investment or disinvestment decisions. GP commissioners will want to be sure that they are commissioning the best treatments and interventions from the best providers at the best price.

There have been a number of policy statements in recent years that have set out how healthcare will become personalised and fairer, will include the most effective treatments within a safe system, and will help people to stay healthy[7]. In addition, Putting People First[8] requires local authorities to transform their adult social care systems through a focus on personalisation, which gives people more choice over services and control over decision making to individual service users. Key elements of this are:

- Universal services, available to everyone
- Early intervention and prevention
- Social capital and
- Choice, control for individuals, with personalised services.

Putting People First is expected to continue until March 2011.

Our health, our care, our say[9] proposed a 5% shift in expenditure from hospital to community settings over the next ten years and most PCTs do have ambitious plans to take activity out of the acute sector. This means that housing, housing adaptations, and community-based support services have a key role as part of a care pathway that will increasingly be delivered from within local primary and community care networks.

Giving people much more choice and control over their lives goes well beyond simply giving personal budgets to people who are eligible for social care funding. It is intended to hand over control for the type of service, the way it is delivered, and control over decision making, to individual service users[10]. In healthcare, this means ensuring that people have wider choice in how their needs are met and are able to access universal services such as transport, leisure and education, housing, health and opportunities for employment, regardless of age or disability[11].

If demand is to be effectively managed then the NHS will need to establish a more mutual relationship between the patient and the NHS, with us all taking more responsibility for our own health, and doing more for ourselves and for each other. In this environment, the NHS will need to provide support for people wanting to make good choices about their health and wellbeing. If they do need a period of care or need support with managing a long term condition, this will, even more than now, take place in a primary or community care setting. In this context, a visit to hospital will become an even rarer event than it is now. This theme is explored in the Marmot Review[12].

The DH commissioned Professor Sir Michael Marmot to undertake a review of the social determinants of health and what could be done to reduce persistent health inequalities in England. The final report of the review, *Fair society, healthy lives* was published in early 2010 and proposes a strategy for reducing health inequalities. The review highlighted six policy objectives required to reduce inequalities. These included two objectives highly relevant to the provision of housing and related support: to create and develop healthy and sustainable places and communities; and to strengthen the role and impact of ill health prevention. The strategic review also concluded that the objectives will not be achieved without effective local delivery systems, that focus on health equality and bring together action by central and local government, the NHS, the third and private sectors and community groups.

7 DH (2008) *High quality care for all – the report of the next stage review.* SO: London.
8 DH (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care.* SO: London.
9 DH (2006) *Our health, our care, our say*
10 *Putting people first - a shared vision & commitment to the transformation of adult social care* DH December 2007
11 Personalisation briefing for commissioners, Social Care Institute for Excellence, June 2009
12 Marmot, Sir M (2010) *Fair society, healthy lives: a strategic review of health inequalities in England post-2010.*

In mental health, New Horizons[13] emphasised the importance of prevention, patient empowerment and quality services. It brought together key areas of policy increasingly addressing the mental health of communities as a whole and extending the progress to date to all age groups and those who might be marginalised such as ex-offenders[14]. New Horizons encourages commissioners to be creative in the development and design of services, to base services around models of recovery, and to seek to promote mental health and well-being in a broader public health context. It challenged both providers and commissioners to work across different settings to deliver services that don't just focus on secondary care but also primary care and the role of the voluntary sector.

It should be noted that the policies described here are of the previous Labour Government and the coalition Government will establish its own agenda for mental health. Time will tell the exact policy and strategy that will be adopted but early indications are that the direction of travel will be similar and that changes are more likely to be felt in how policy is implemented.

Changing environment for commissioners and providers of healthcare

In order to deliver its required outcomes, the Government has announced its intention to carry out a major restructuring of the NHS. Diagrams showing the current position and the likely changes are set out in Figures 3 and 4. There are currently ten Strategic Health Authorities (SHAs) in England with responsibility for developing strategy and ensuring that local NHS organisations are performing well. As the key link between DH and the NHS locally, they ensure that national priorities are reflected in local plans, for example, with programmes for improving cancer services. SHAs work together with local government to ensure that there are both cross-governmental and cross-sector approaches to tackling the wider determinants of health and health inequality. They map disease trends, provide risk-profiling data and advise on high impact changes necessary to improve health and reduce health inequality. The Government has signalled its intention to establish an independent NHS Board for England, and there will then be a smaller number of regional offices.

There are currently 152 PCTs in England, five of which are Care Trusts. They are in control of 80% of the NHS budget and have responsibility, often jointly with their local authority colleagues, for identifying local health needs, prioritising areas for investment and disinvestment, commissioning the right services to meet local needs and monitoring performance. PCTs have been moving out of direct provision and either setting up their community services as:

- Independent organisations such as a Community Foundation Trust or a social enterprise
- Merged with an acute provider
- Integrated with adult social care or children's services
- Put their community providers at arm's length to ensure that there is an appropriate separation between their commissioning function and their provider function.

Care Trusts are organisations that work in both health and social care. They carry out a range of services, including social care, mental health services and primary care services. Care Trusts are set up when the NHS and local authorities agree to work together, usually when it is felt that a closer relationship between health and social care is needed or would benefit local care services. There are also a small number of Public Service Trusts (PSTs) which bring all the activities of the local authority together with that of the PCT.

13 DH (2009) New Horizons

14 NMHDU (2009) *Briefing No 2: housing aspects of PSA16 mental health*, June 2009.

Hospitals in the NHS are managed by NHS Trusts, which are sometimes called Acute Trusts. These trusts employ the bulk of NHS staff, such as consultants, doctors, nurses, radiographers, porters, and cleaners, who are needed to provide safe care in a quality environment. Most people are admitted to hospital following a presentation at A&E, as a result of a blue-light admission in an ambulance, or following a referral from their GP.

A growing number of hospitals have become Foundation Trusts, and many more will become so in the future. 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 healthcare to core NHS principles and are regulated by Monitor, the regulator for NHS Foundation Trusts.

There are 73 Mental Health Trusts in England. They provide health and social care services for people with mental health problems. Mental health services can be provided through primary care centres, other primary care services or in more specialist care settings. This might include counselling and other psychological therapies, community and family support or general health screening. More specialist care is normally provided by mental health trusts. Services range from psychological therapy to very specialist medical and training services for people with serious mental health problems. Mental Health Partnership NHS Trusts, of which there are currently seven in England, provide substance misuse, learning disability or eating disorder services.

Looking forward, most healthcare commissioning will be devolved by the NHS Board to GP-led commissioning consortia. These will have the resources, the necessary direct contact with patients and the freedom to redesign services and form new relationships to best meet patient needs. The Government has signalled its desire to bring services closer to where people live, and particularly to control demand for hospital services by providing a broader range of services at a community level. This will see the further development of GP-run urgent care centres as a front end to A&E, long term condition management and demand management programmes in addition to a range of preventative interventions.

At a community level, services will be offered, that traditionally, were only provided in hospital by primary social care professionals. The Government will not seek to dictate to local areas how such community services should be delivered. However, GP-led health centres are likely to bring together primary care professionals, including GPs, dentists, and pharmacists, together with diagnostic facilities and a range of services that might include rheumatology, counselling and integrated health services such as massage. Sometimes called polysystems, these are likely to be networks of primary and community services including parts of housing and leisure services from private, public and voluntary sector providers. Figure 2 shows a diagram from NHS Redbridge that gives some indication of the relationships within such a network with patients very much at the centre.

Figure 2: The Redbridge polysystem model[15]

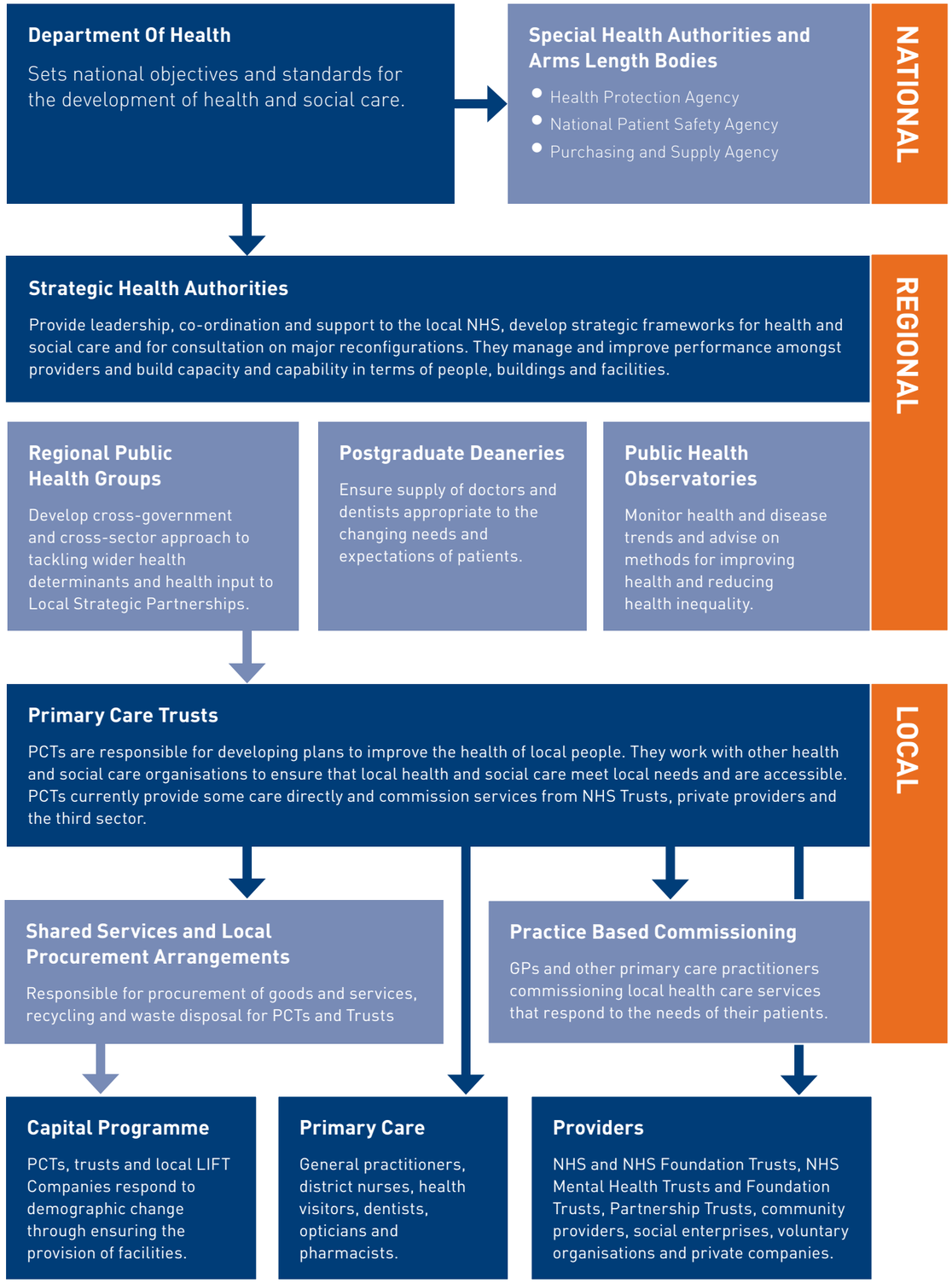
There are likely to be fewer PCTs. They will be responsible for those elements of commissioning that it makes sense to deliver across a bigger area. PCT boards will have a mixture of local authority appointees and members directly elected by the public. There are also proposals to make PCTs responsible for public health, with 4% of the total NHS budget being allocated for this purpose.

Given the reconfiguration of the service described above, there are likely to be two key drivers affecting the provider landscape in which housing associations operate. The first is that there will be more GP-led services and more integrated models of care at a local level. There will be opportunities for other organisations, including housing associations, to provide services. Some housing associations provide services such as advice services, counselling, health trainer programmes, smoking cessation schemes, exercise programmes and screening programmes. As all providers look to improve quality at reduced cost, there will be more opportunities to provide housing-based services that deliver better outcomes for patients and avoid more expensive institutional forms of provision.

The other major driver for change is personalisation. This is likely to see a demand for more service-user driven services and more responsive local services. Both of which are likely to have a significant impact on the provider landscape as users have a real say in what is provided coupled with the economic power to back it up. For example, this could be a community mental health service or a clinic run as a joint venture with a pharmacy company to bring services onto a local estate.

15 www.redbridge.nhs.uk/files/documents/2111_rich-picture.gif

Figure 3: Structure of the NHS in England in April 2010[16]



16 Adapted from Cave B and Molyneux P (2004), Healthy sustainable communities a spatial planning checklist

Figure 4: Possible structure of the NHS in England: 2010 onwards

3: Housing's contribution to health

Cost benefits to health

Without good quality housing to perform the basic function of keeping people safe, warm and dry, some of the most common health conditions would be exacerbated[17]. Poor housing conditions increase the risk of severe ill health or disability by up to 25% during childhood and early adulthood[18]. The Housing Health and Safety Rating system has taken a robust approach to the mitigation of risk and has enabled housing organisations to contribute to health and well being. Many have been successful in attracting investment from PCTs as part of local strategies to reduce falls, excess winter deaths and hence hospital visits[19].

Housing associations have also contributed to health and wellbeing by running programmes that help their tenants and other local residents to adopt healthier lifestyles and improve access to healthcare services. Given that the people who they house include people who experience some form of inequality or vulnerability, this is important as a way of reducing health inequality. This is something which has been recognised within local health improvement programmes, in plans to improve access to services and through specialist services to promote autonomy and independence amongst those who experience inequality or people from marginalised groups.

As well as contributing to the built environment, housing associations provide a range of care and support services and healthy living initiatives that have a direct impact on the health needs of a number of different client groups. These include, for example:

- Providing supported housing and services for older people, to help them with their care needs and day-to-day living support to help them live more independently, including provision of alarm systems, adaptations to their home and social and neighbourhood activities
- Specialist accommodation and support to help people with mental health needs to stabilise their lives, recover, maintain a tenancy and live more independently
- Working with homeless individuals with complex and multiple needs
- Providing refuge and support for victims of domestic violence
- Supporting people to access other public services, training or employment
- Direct health advice and support through community health workers and healthy living initiatives.

As public investment reduces there will be new opportunities to develop solutions based on housing care and support for people who rely heavily on health and social care services. Personalisation and a need to support people to make good choices about their health, will create new opportunities for new providers and new forms of service. There are a number of ways in which housing associations do this.

17 House proud: Health. Inside Housing 22.01.10

18 Shelter (2009)

19 Davidson, M (2007) *Estimating the Costs to Society of Poor Housing*. ENHR: Rotterdam.

As well as contributing to achieving health objectives, housing related support also contributes to ensuring cost effectiveness and good value for money. Through the wide range of housing, care and support services that housing associations provide, real cost benefits are seen to other sectors.

The CapGemini study of the benefits of the Supporting People (SP) funding programme estimated that £1.6bn in housing-related support services generated savings of £3.41bn to the public purse, including to health and social care, by avoiding more costly acute services[20].

The Federation's work with the DH's Care Services Efficiency Delivery team (CSED) demonstrates that investment in preventative support through housing associations leads to better outcomes for the users of the service, their families, and savings to the tax payer, through, for example, the avoidance of hospital admissions and reduced numbers of looked-after children. The services analysed often cost less and delivered better outcomes than the most likely alternative if housing-related support was not available. They also enabled people to exercise greater independence, choice and control over their lives.

Willow Housing and Care: Hospital Discharge

As a specialist provider of homes, sheltered housing and services for older people Willow Housing and Care became aware that a number of new tenants were coming from hospital, where it seemed they had remained too long because their own home was not suitable to return to. Working closely with SP commissioners, Willow Housing and Care decided to provide a support service to older people in hospital, who were ready to leave but could not return home. The scheme focuses on prevention, diverts people away from residential care placements, saves social services delayed discharge fines and helps free hospital beds.

The service receives referrals from the hospital and GPs. Their support worker works with the patient and their family in hospital for two to three weeks, helping them make choices about returning home or alternative accommodation such as sheltered or extra care. If they wish to return home, Willow Housing and Care arranges for any aids and adaptations, cleaning, and and homecare required. It then provides on-going support for up to six months.

The DH's evaluation of the service has shown that for a £40k investment, the service has saved £400k in health and social care expenditure through reducing admissions to residential care and re-admissions to hospital. Service users have shown a high satisfaction with the service, an increasing number of older people have returned to live independently after hospital with a better quality of life and greater control over where they live.

This report argues throughout that to deliver truly preventative services that will reduce health inequalities, there needs to be a more joined-up approach across housing, health and care services, from assessment of need, commissioning and procurement and working in partnership to deliver the services. It is also important to be clear that more focus on prevention and early intervention in this way, saves money in the long run and ensures better outcomes.

20 CapGemini, *Research into the financial benefits of the Supporting People programme*, CLG, 2008

Promoting health and wellbeing

Housing associations have considerable experience of working with a range of commissioners, purchasers and providers, including other community based organisations. Where this experience is applied to the health and social care market it can 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 to promote health and promote access to healthcare.

Housing associations: creating sustainable neighbourhoods

Housing associations are well placed to provide the core services at the hub of a local community. They can also use their development skills to ensure that there are accessible services for those who experience the worst inequalities. These skills will be key as health and social care, as the NHS in particular, attempts to develop more responsive services and ensure that there is a choice of provision available. Along with accident prevention, neighbourhood management and crime prevention initiatives, they will be keen to ensure that the neighbourhood becomes a more dynamic and responsive unit and develops the resilience to respond positively to people living there. The case study below from Impact Housing Association is an example of how links are being made between different parts of the local community through their engagement in an enjoyable, and health-promoting activity.

Impact Housing Association: On Your Bike

Impact Housing Association has 3,000 properties and is the largest provider of supported housing and accommodation for people who experience homelessness, those who have experienced domestic violence, young people at risk and those with care and support needs in Cumbria.

On Your Bike (OYB) has used cycling as a way of encouraging social inclusion for the most hard-to-reach. In 2009, 517 residents took part in one or more cycling taster sessions, which also included cycle mechanics and some red and black mountain bike rides in the Lake District for younger residents. The scheme is perceived to have increased health by promoting exercise with residents and independence as residents are given a bicycle to use at home between OYB cycling sessions and trips.

People who experience homelessness and who have drug or alcohol issues and people with an experience of domestic violence have been the main users of the scheme. The scheme has been a useful way of building links between the residents of supported housing schemes and owner occupiers in the area as all residents in a given area are encouraged to participate. By ensuring that this programme is based on an activity that everyone can enjoy – and which promotes health – Impact Housing Association is contributing to local health and wellbeing and to community cohesion.

Housing associations: designing homes for healthy living

Housing associations have been at the forefront of promoting accessibility for disabled people on the one hand and those who experience mobility problems as a result of frailty on older age, temporary injury or being in early years on the other. They have done this through designated wheelchair housing or through principles such as Lifetime Homes. There have been a number of projects where housing associations have sought to reduce fuel poverty through ensuring that homes are well insulated, well ventilated and have good levels of natural light. By reducing fuel poverty, they also reduce demand for healthcare services and hence, such schemes have been funded by local PCTs. There has also been significant investment in schemes to reduce falls or prevent accidents with a view to preventing emergency admissions. The example below was delivered by Old Ford Housing Association and funded through a regeneration partnership.

Old Ford Housing Association: Accident Prevention[1]

Because 1,500 falls a year in the UK result in death and more result in hospital admission prior to a return home, Old Ford Housing Association (OFHA) secured £102,000 of local regeneration money to identify and implement strategies to reduce household accidents amongst older people and children under five. Tower Hamlets PCT and OFHA came together to develop a project that could both reduce accidents and identify ways in which accident prevention measures could be delivered through mainstream activity.

OFHA installed equipment where there was an evidence base to support the intervention. These were stair-gates, outlet covers, cupboard latches and poison stickers; the housing association installed fire alarms with ionisation sensor lithium batteries and a pause button, and grab-rails and non-slipping surfaces in kitchens and bathrooms. These were known to be effective and most likely to be working after an 18 month period. The project was recognised as a success by all partners and had a good response from residents.

Housing associations: promoting independence

Housing is an essential partner in the provision of support and care. Many housing-based models are less intrusive and less expensive than their institutional alternatives, and can help people to live independently for longer. 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 participating in pooled budget arrangements. This helps to foster close working relationships between providers, referral agencies and others across health and social care. As institutional forms change, housing providers will want to maintain the relationships necessary to ensure that housing and housing related support are included in commissioning arrangements. The example given below is a partnership between Elgar Housing Association and the Extra Care Charitable Trust and it highlights one of the models available to promote greater independence[21].

Elgar Housing Association: The Rose Garden, Hereford

This extra care housing development is located on the site of a former local authority nursery close to Hereford city centre. It comprises 91 self-contained one and two-bedroom flats centred around a range of social and leisure facilities, designed to support independence and wellbeing for older people.

The scheme is a partnership between Herefordshire Council, Hereford Primary Care Trust, Elgar Housing Association and The Extra Care Charitable Trust. It aims to promote a way of life that gives choice and opportunity for all those who live there, with planned on-site facilities to include a restaurant and bar, fitness gym, wellbeing centre, library, shop, computer suite, hair and beauty salon, greenhouse, art and craft studio and woodwork room. Activities are organised by the residents with the support of a village activity co-ordinator.

The quality of provision at Rose Garden matches private sector provision for this type of scheme while providing access to extra care for people who would not otherwise have been able to afford it, and in so doing freed up affordable housing units in the county. One of the perceived benefits of this sort of provision is that it can provide a setting in which the needs of older people with dementia, and the increasing numbers of people with learning disabilities who would require such care, are addressed. Local health and social care commissioners believe that extra care provision is a good setting in which to provide such care and delivers better quality of life than more institutional forms of provision.

21 Evans S, Vallelly S (2007) *Best practice in promoting social well-being in extra care housing: a literature review.* Joseph Rowntree Foundation: York.

Housing associations: promoting healthy choices

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. The coalition Government has said that it will investigate more ways of improving access to preventative healthcare in disadvantaged areas. Housing associations can increase opportunities for healthy choices and mutual aid, for example, through setting up food co-ops, through action for safe parks and streets so that people can exercise safely, or through the provision of neighbourhood services, carbon reduction, and initiatives such as green gyms. They can also help people to do more to look after their own health, understand the risks they are taking with their health and to make the changes they want to their lifestyles. To support them in this, a number of health trainer schemes have been established, such as the example below which is run by Amber Valley Housing Limited. In this example employment opportunities are created for local people as well.

Amber Valley Housing Limited: Health Trainers

The successful Health Trainer Programme, run by Amber Valley Housing Limited in partnership with Derbyshire County Primary Care Trust was introduced in September 2008. Nine Amber Valley Housing Neighbourhood Support Co-ordinators (working at sheltered housing schemes) were initially trained as Level 2 Health Champions to provide support and put residents in touch with more specialist health agencies. Subsequently, one full-time and one part-time Level 3 Health Trainers were employed to take on referrals and give specialist advice.

The service offers tailored advice, motivation and practical support to residents wanting to lead a healthier lifestyle. The programme forms part of the local public health agenda and is designed to prevent cardio-vascular disease and falls by encouraging people to take more exercise, adopt a healthier a diet and give up smoking. Residents are provided with information and the opportunity to join chair-based exercise classes, use weights through Otago, and have their progress monitored over a year. Falls clinics reduce the risk of falls; thereby reducing admissions to hospital. The Be Active and WaistWise programmes combine exercise with dietary advice to support weight management.

The Health Trainers work with Amber Valley Housing and another neighbouring housing provider. All have undergone training and accreditation from the Royal Institute of Public Health to offer this enhanced service

Housing associations: responding to what clients want

There is a shift away from traditional risk-based assessments of need, to one that is more responsive to people's aspirations. People are increasingly interested in flexible, personal services, rather than a one size fits all approach. A specific area of change lies in differing demands and expectations when it comes to independence. As service users demand greater independence, and purchasers back them in this, there are challenges and opportunities for service provider organisations in responding to these demands, and in absorbing the associated risks. This same shift is also taking place in the health sector, with people looking to be in the driving seat for their own health, care and support.

The example given below shows how Look Ahead Housing and Care has developed a core and flexi model of personalised support services. This ensures that the service is more responsive to what people want. Given the pressure on public finances, it is important that services achieve a high level of satisfaction for service users and are delivering what they really believe will make a difference to them.

Look Ahead Housing and Care: Coventry Road pilot

The Coventry Road service in Tower Hamlets is a high–needs, mental health accommodation-based service that has self-contained flats for 20 clients. Clients have a range of complex needs including ongoing substance misuse, gambling addictions and forensic histories. There is a staff team of ten support workers, one manager and one deputy manager jointly funded by Supporting People and the PCT.

The purpose of the pilot, being run jointly by Look Ahead Housing and Care and London Borough of Tower Hamlets, is to trial a core and flexi model of personalised support services. The core refers to a fixed range of services required by all clients in order to run an accommodation-based service, while the flexi refers to individual support and a cash budget that enables the service to be more tailored to the needs, wishes and interests of the customer.

The pilot aims to:

- **i)** Develop a personalised model that increases choice and control for Coventry Road clients while also enabling staff to deliver safe and effective rehabilitation and recovery service
- **ii)** Develop a personalised model that is cost effective and sustainable
- **iii)** Create a body of learning that will assist other services to adopt personalisation and will inform commissioning approaches.

Housing associations: preventing admissions

Housing associations have a good track record of delivering services that are designed to promote health and wellbeing, to prevent falls, prevent accidents and promote independence through the provision of technology, equipment or adaptation. PCTs have shown the greatest appetite to commission those which are explicitly designed to prevent hospital admission. In some areas, housing associations have been commissioned to deliver services that promote independence and re-ablement but this is not common practice everywhere. As the NHS seeks to develop a more mutual relationship with patients and wants them to make good choices about their own health, such services have a clear role to play for the health service, provided that the benefits can be realised and demonstrated effectively. The example given below is from St Helens where the PCT has funded early intervention to prevent over-representation on acute mental health services of people who experience disadvantage in some form.

Helena Partnerships : Community Wellbeing Officer

The Community Health and Wellbeing post has been funded by Halton and St Helens PCT to focus in areas of greatest deprivation and will support the implementation of the local mental health promotion strategy. The post is designed to undertake preventative work and to work upstream in order to deliver improvements in public health. Given that the biggest determinant of poor mental health is poverty and deprivation, it is hoped that investing in a range of preventative services for mental health will go some way to protecting vulnerable communities from the damaging effects of inequality and deprivation.

The two year project focuses on the areas of greatest deprivation and supports the implementation of the local mental health promotion strategy by working in partnership with the public health delivery team and the leads for adult mental health promotion, suicide prevention and child and adolescent mental health promotion. The work focuses largely on enhancing the preventative services for mental health in the community and on helping people to make healthy choices about their own mental health by making advice and information more accessible.

This has shown not only that self-reported mental health has improved but also that people are less likely to staircase into acute services. Mental health is less likely to be cited as a reason for low take up of training and employment opportunities.

Housing associations: enabling faster discharge

Housing associations provide rapid home adaptation services, telecare, floating support and step-down services which enable faster discharge from an acute or institutional environment. Home Improvement Agencies (HIAs) have been critical in helping to ensure that people who have been admitted to hospital can have any necessary changes made to their home, either temporary or permanent, in a timescale that enables a more speedy return home and which supports independent living and the sense of security that someone with a long term condition might need. The example below is of a step-down scheme from a psychiatric hospital in Co. Durham that shows the benefits that were identified by the Care Services Efficiency Delivery unit (CSED) to the wider health and social care system of such a scheme.

Three Rivers Housing Association: St Stephen's Close supported living step-down following discharge from a psychiatric hospital

Wear Valley DC, Durham County Council, Three Rivers Housing Association and the Richmond Fellowship have developed a supported living service to help people step down from psychiatric hospital to independent living. The service has eight self-contained flats built around a communal space. Entry to the premises are controlled 24 hours a day so that new clients feel safe and each client has a key to their own flat and is responsible for their own bills. Of the eight flats, five are block purchased by the PCT as a step-down facility to enable prompt discharges from psychiatric hospitals into the community.

The provision of four weeks of floating support to clients immediately after they move on provides vital continuity of support during transition. This helps to reduce the revolving door scenario where people relapse during stressful changes in circumstances and need more intensive support again.

In 2007-08 the running costs for St Stephen's Close were £277,000 or on average £34,625 pa or £665 for each of its eight clients per week. Around £109 of this is paid for by rent from the clients or by housing benefits. This gives a net cost of £556 per client week. This equates to a saving of 39% or around £22,000 per client per year across the wider health and social care system.

Housing associations: strengthening asset management

Housing organisations are experts in 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 for the development and management of local health and social care facilities.

As more agencies seek to explore the 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 providing a hub for local older people as with extra care housing. Housing associations are involved in the provision of accessible homes and adaptations, fuel poverty initiatives, community assets, building health centres, neighbourhood services and effective asset management.

One of the issues that most affects public satisfaction with the NHS, is access to services. In the example below, Leicester Housing Association has provided a community asset and improved access to primary care services by bringing them closer to where people live.

Leicester Housing Association and Leicester City West PCT

Residents of the Braunstone Estate in Leicester have for many years experienced the worst health record of any neighbourhood within Leicester. A major contributing factor to that was poor housing, along with low levels of unemployment and low income.

As well as contributing to better health standards by transforming local housing, Leicester Housing Association developed one of the country's first one-stop shops for health and social care, in Braunstone. The new £6.3m Health and Social Care Centre is a partnership between Leicester Housing Association, Leicester City West Primary Care Trust, Braunstone Community Association and Leicester City Council. It comprises a cafe, GPs' surgeries, community nurses, physiotherapy, dentists, chemists, opticians, mental health advisors, family planning services, child behaviour advice and drug and alcohol counsellors, all under one roof.

The project has been welcomed by local people as way of making a real difference to health deprivation on the estate. The PCT has recognised the importance of the project to improving access to healthcare and healthy living programmes.

Health commissioners may want to see an expansion of these kinds of initiatives as they seek to cope in an environment of less growth in their sector. They will be interested in ways that services can be run in community settings, ways in which more mutual support can be engendered, ways of preventing admission or lengthy stays in institutional settings and ways of making maximum use of assets. Some of these will be commissioned directly, some will be commissioned through Supply2Health[22] and some of this activity will come through joint ventures with existing providers. What is clear that there will be opportunities to find new ways of doing things provided that these offer more for less.

22 www.supply2health.nhs.uk

Housing as part of care pathways

Care pathways were developed 20 years ago and are used widely in many areas of healthcare across the world. There is an extensive evidence base for their effectiveness in improving the care provided to patients. Care pathways aim to improve the continuity and co-ordination of care across different disciplines and sectors. Care pathways can be viewed as algorithms that offer, in a flow chart format, the decisions to be made and the care to be provided for a people with a given condition. Care pathways have four main components:

- A timeline
- The categories of care with preferred interventions
- Short, intermediate and long term outcome criteria
- A record of any permitted deviations and variations.

Housing organisations can reduce the possible uptake of health and social care services through the work they do to prevent accidents 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 played a key role in minimising delayed transfers of care. GP commissioners will be interested in packages of service targeted at people with long-term conditions, and which reduce the need for hospital admission.

Housing associations have been at the forefront of providing housingbased solutions to the needs of older people. Extra care housing, housing based services for people with dementia, and neighbourhood wardens are all services championed by housing associations, and some PCTs have invested in these services. There is scope to provide targeted prevention services, especially for people with dementia, to reduce admissions and promote home care for those in need of support.

This list is not intended to be comprehensive. However, it is designed to indicate the likely direction of travel. If the NHS is to respond effectively to the challenge of delivering improved quality and productivity by looking for innovation, in line with QIPP, then commissioners will need to support people to develop the necessary capabilities to do more for themselves, to invest in those initiatives proven to prevent the need for care, to transfer care from the acute sector to the community setting and to look at how this can work more effectively.

Housing associations will need to show evidence of how investing health resources in housing and housing related support services will either buy more care or will prevent expenditure on expensive procedures. They may be able to attract business by demonstrating how they can help redesign a pathway and re-profile the use of resources with a Mental Health Trust, an established community provider or a well-functioning GP provider organisation. This is most likely to happen through one of two routes. The first is where a partnership is formed with providers within an existing pathway. These providers could be a Mental Health Trust or a group of GP providers. The second is where a pathway is being redesigned and housing associations can partner to be part of that process.

Organisations may be willing to buy into an approach that improves care and reduces expenditure on expensive interventions. They are likely to be more open to sharing any savings as they tend to operate on the basis of ring-fenced budgets. However, there will need to be a clear evidence base which demonstrates the effectiveness of proposed interventions, so that these are measurable, marketable and tradeable.

Housing based services and housing related support have grown up in an environment where discreet funding and commissioning is the norm, under SP and the funding which preceded it. Now, following the removal of the ringfence from SP, there is all the more reason for these services to be integrated across and to look at how floating support works with the range of hospital and community based roles, for example.

4: Mental health commissioning

This report has sought to outline the broad health landscape from the perspective of housing care and support, considering a wide range of client groups. Mental health commissioning offers an example of where these two sectors meet and how housing care and support can be part of a care pathway. It is this example which is explored in more depth below.

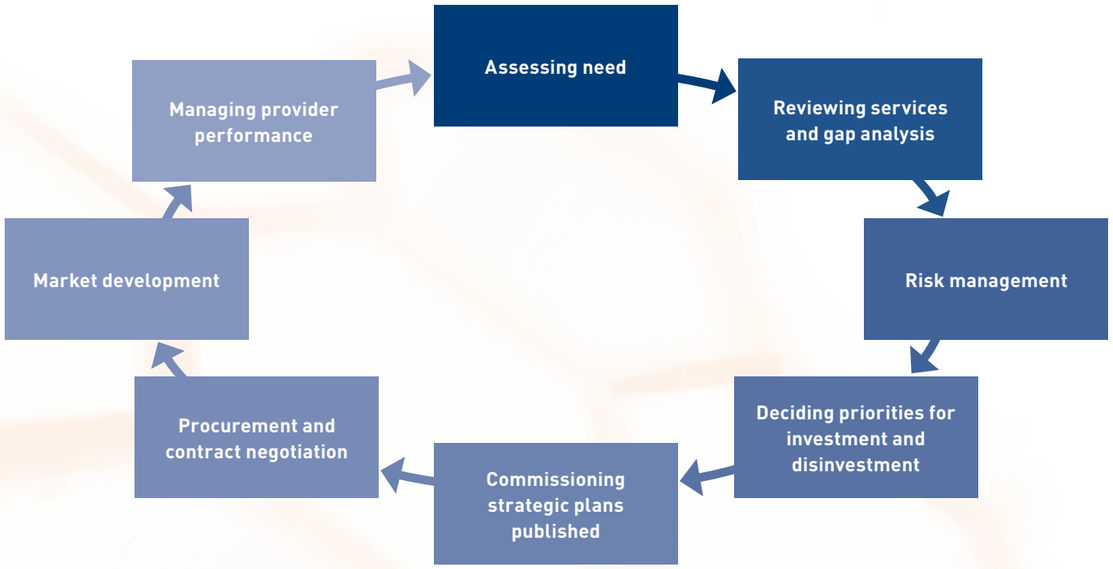
Commissioning is 'the cycle of assessing the needs of people in an area, designing and then securing appropriate service[23].' Mental health commissioning is a joint activity for health and social care that brings together differing organisational cultures and presents particular challenges for commissioners. This includes the extent to which each copes with the need to embrace different targets and priorities that can create boundaries to effective commissioning[24].

To achieve the best possible outcomes, there is a recognition that organisations need to co-operate and jointly commission services. Commissioning is a continual process that takes place across the year and this involves a number of processes including:

- A Joint Strategic Needs Assessment (JSNA) to identify the level of need and forecast future levels of need across the local area
- The agreement of priorities for investment and disinvestment
- The procurement of a particular service through co-production market testing or tendering
- The monitoring of performance.
- There are opportunities for providers of housing care and support to engage in this cycle.

This can be presented as a cycle that takes place through the financial year. This will be different in each commissioning area but the principles will be consistent. There have been a number of representations of the commissioning cycle. The one set out in Figure 5 is adapted from the one set out in the *Mental health world-class commissioning – a guide for mental health professionals* produced by Commissioning Support for London (CSL) and the National Mental Health Development Unit (NMHDU)[25].

Figure 5: illustration of commissioning cycle



23 Cabinet Office (2006) *Partnership in Public Services*, p.4

24 Appleton S (2009) *The Commissioning Friend for Mental Health Services*. NMHDU : London.

25 NMHDU/CSL (2009) *Mental health world class commissioning: a quick guide for mental health professionals*.

Mental health commissioning is not as well developed as acute commissioning and there are significant local variations in the way it is delivered. Arguably, mental health commissioning has not been as well resourced and has not always managed to establish the same level of authority over the provider market as in other areas of commissioning. There are, essentially, three main types of commissioning[D]. These are:

- Top down commissioner-led commissioning
- Bottom up provider-dominated commissioning
- Genuine collaboration between providers and commissioners.

Provider-driven commissioning is the most prevalent when it comes to mental health services. This is often characterised by one large mental health provider informing the commissioner of what is needed in their block contract. Much more effective is collaborative commissioning where there is genuine collaboration between providers and commissioners with active engagement of service users and carers and a willingness to explore innovation and joint ventures with a broader range of providers. This will change even more as personal budgets become more common and service users are more active in shaping the market. Given that most of those charged with commissioning mental health services tend to come with experience of being a practitioner, this model plays to their strengths.

Mental health pathways

Mental health care pathways are subject to a high degree of local variation. There has been a tendency, across the range of different mental health needs, to see mental health as one pathway from prevention through to end of life. For the purpose of this report we propose to look at these areas:

- Acute mental health
- Forensic
- Personality disorder
- Dementia.

These areas are explored in more detail in this chapter. The relationship between health, and housing care and support for learning disability care pathways does not easily lend itself to this analysis, as the funding and direction for learning disability services tends to come from local authorities rather than from the health sector. Therefore, this area may be better explored elsewhere.

Within each of the identified areas we will look at:

- The key elements of the care pathway
- The possible contribution of housing and housing related support services to the pathway
- A series of proposals for how to put the case and access this market, through case study examples.

Acute mental health

The acute care pathway lays out the journey that people make from initial referral to discharge from acute services. An integrated acute care pathway refers to integrated working arrangements between services and agencies so that hospital and community elements of the acute care service work together to support the client in the achievement of their goals. Figure 6 outlines key elements in an acute mental health care pathway, and is a good example of what an early intervention approach includes.

Common mental illness includes depression, anxiety, and obsessive compulsive disorders and is usually treated with a combination of counselling and medication. This may include a referral to secondary care if someone does not respond to treatment. However, there is an increasing recognition that hospital is not necessarily the best setting for care and patients can end up with poorer quality of life with long periods on medication. The development of Improving Access to Psychological Therapies (IAPT) and intermediate care models has brought secondary care staff (such as psychologists and psychiatrists) into primary care services. This is designed to deliver better outcomes and avoid people being referred to secondary care.

Severe and enduring mental illness includes psychotic diseases such as schizophrenia and bipolar disorder. Traditionally these have been treated with medication in a secondary care setting. When the patient is stable they are likely to see a psychiatrist for a review every six months or so. Increasingly, reviews are provided in primary care with a referral back to secondary care if needed.

Figure 6: The acute mental health care pathway

Common mental illness	
Access	• Primary care • Emergency admission if a crisis (s136 or via A&E)
Primary care	• Primary care psychological services/Improving Access to Psychological Therapies (IAPT) • Investment in primary care is to increase access for clients who are without services and who are in secondary care • For those who do not respond to primary care treatment, or whose needs are too acute, they will be referred on to secondary care • Possible shift of early intervention in psychosis services into primary care
Community care	• Specialist psychology • Community Mental Health Team • Possible support via other team such as Crisis Resolution (admission avoidance). • Medication support – psychiatrist prescribes and team will support • Social care advice and support, including housing and benefits
Inpatient care	• Acute wards in hospital (if needed either voluntarily or under section)
Rehabilitation	• Rehabilitation wards and community care • A range from full recovery to needing high level of support in the community and hospital admissions • Employment, training, housing support
Recovery/ end of life	• Will usually stay in community • Many people recover fully and can manage their illness themselves. They will go back to primary care and complete discharge • Some will need ongoing support but we are trying to move this back to primary care where possible.

Regardless of the type of mental illness, it is important that people are only admitted to hospital when necessary, with access to alternatives that may prevent admission. If admission is needed, it is important that people should remain in hospital no longer than is necessary and be supported to make the transition back home[26].

A recent survey by the Healthcare Commission found that more needs to be done to improve support to people in a crisis in the community, and to enable people to move out of acute facilities with proper support available in the community. Crisis accommodation, providing places for people in the short term, was only available in 39% of areas. Given the role intended for Crisis Resolution Home Treatment (CRHT) teams to provide intensive support to people during a mental health crisis in community settings, the survey showed that CRHT teams acted as gatekeepers in only 61% of the 39,223 admissions to acute wards, varying between trusts from 9% to 100% of admissions.

Equally important is the prevention of delayed discharge and ensuring the appropriate use of costly acute admission beds in the locality. New Horizons stresses the need for value for money and improved outcomes through efficient discharge planning within the acute care pathway, thereby reducing the length of stay and overall bed days that patients stay in hospital. Specialist housing officers or housing link workers have played a key role in preventing admissions, facilitating discharge and being part of planning an effective transfer of care. Floating support and support time and recovery workers have an important role to play with preventing re-admission to hospital and tenancy sustainment. The example below outlines an early intervention service.

Housing associations can contribute to this pathway in several ways. There are a number of services that are run by associations to offer psychological therapies in partnership with another agency, or to offer early intervention services, especially for people who are new to the mental health system.

The other area where housing associations make a contribution is in providing step-down accommodation from acute care or providing accommodation for people who are effectively managing their own health. While these services are often directly commissioned by PCTs from housing associations, they may also be offered in partnership with mental health trusts.

26 Healthcare Commission (2008) *Pathways to Recovery*. HCC: London.

Midland Heart Housing Group: Early Intervention Service, Solihull

The Early Intervention Service (EIS) is delivered in partnership with Birmingham and Solihull Mental Health NHS Trust (BSMHT). The purpose of the service is to promote recovery, social inclusion and quality of life for young people between the ages of 14 and 30 with mental health problems, and who are experiencing their first episode of psychosis. The service objectives are to ensure that all people who use the service have:

- Access to accommodation appropriate to their needs and choices
- Support and advice to enable individuals to sustain their accommodation
- Choice in defining the level of support required in accessing community resources
- Individual needs and aspirations in accordance with their culture
- Access to staff
- Participation in service reviews.

Many psychiatric disorders, particularly the severe mental health problems, begin or have their origins in adolescence. BSMHT recognised the need to provide more integrated services for young people with complex mental health problems and their carers. In developing the EIS, it recognised that such problems are the cause of disturbed developmental trajectories and that this is often accompanied by social deprivation.

Therefore, the service aims for a community assertive outreach model. By working in partnership with Midland Heart, the strengths of the two organisations is combined to provide staffing aimed at meeting clinical and social inclusion roles. Staff from the housing association work under direct supervision of the senior clinical practitioner within the EIS. The staff already had considerable experience of working with young people with mental health problems and had already developed the expertise in working in different age appropriate settings and the necessary knowledge of the services available across the city.

Midland Heart has its own training organisation, has experience of managing and supporting staff in these services and existing relationships with a wide range of statutory and voluntary organisations in different sectors.

This service helps young people to manage their mental health and helps to ensure that they do not experience additional social disadvantage as a result of experiencing psychotic episodes. They are less likely to experience an acute admission and the disruption that flows from this.

Forensic services

Forensic services are for anyone who commits a crime but is found to have done so due to mental illness. Forensic services refer to those that provide the care of mentally-disordered offenders, who have been in contact with the criminal justice system and who have been transferred to secure hospitals. There are two main levels of security in forensic services hospitals to which both offenders charged with an offence and prisoners can be transferred: high secure and medium secure. There is also a low secure level, but very few offenders are transferred there directly from prisons or the courts. Rather, the vast majority of people transferred from prison or the courts initially enter high or medium secure facilities.

All high secure beds are provided by the NHS. Currently, there are three NHS providers (Ashworth, Broadmoor and Rampton Hospitals), with around 800 high secure beds in total. Medium secure beds are provided by both the NHS and the independent sector, with the latter providing around 35% of the medium secure capacity. They are designed for patients detained under the Mental Health Act 1983 who pose a serious danger to the public. For people who commit a minor crime, the pathway is similar to that for people with serious mental illnesses. For people who have committed a serious offence, step down is a gradual process, working through layers of security. Specialist and high-support hostels are the last step before a return to the community. The NHS provides continuing care treatment in hospital settings for people who are too dangerous for the community.

Low secure beds are provided by the NHS and the independent sector for patients detained under the Mental Health Act 1983 who pose a significant danger to themselves or others. Normally, people will move down through to low secure after a period of time spent in medium secure. They may also be used for voluntary patients. However, there are no definitive rules on what does or does not constitute low secure treatment and some services are indistinguishable from services for recovering mentally ill people in care homes[27].

The example below shows a different approach to risk has led to a successful community based service. This scheme has been commissioned from a housing association by both local authority and mental health commissioners with a view to delivering a better set of outcomes for the individual at a lower cost to the health service. The main economic benefit comes from the reduction in the use of out-of-borough placements. Such placements can cost between £2,500 and £3,000 per week compared to a cost of £1,000 to £1,500 per week for a community based service.

27 Laing and Buisson (2006) *Mental health and specialist care services UK market report 2006*

London Cyrenians Housing: Cedar House

Cedar House is a high support service for men with a forensic history who may also present with challenging and complex needs. Run by London Cyrenians Housing, the name Cedar stands for Choice, Employment, Development, Aspirations and Recovery. The service is located in a large 10-bedroom property in Kensington and Chelsea.

Cedar House provides a multi-skilled 24-hour high support service that manages high risk behaviours by providing individually tailored support with a focus on the recovery model and maintains an emphasis on education and skills training. Staff provide support based on the psychosocial rehabilitation model, promoting the concept of recovery, incorporating Wellness Recovery Action Plan (WRAP) to help service users move on to less supported accommodation. Through professional one-to-one and group support, Cedar House will help to support service users to receive the services they need in the community to promote independence.

Key to the scheme is a focus on social inclusion. To facilitate this, London Cyrenians Housing worked closely with the All Saints Road Residents Association to ensure that the aims of the scheme were understood by local people and that they could play their role as a facilitator for change. Training was provided to the residents association to ensure that it understood the experiences of the people who would be living in the scheme and how the association could support their integration into the local community. There is representation from the residents association on the project steering group and residents of Cedar House are members of the residents association. The active support of the Cabinet Member for Housing and Adult Social Care from the Royal Borough of Kensington and Chelsea was also critical in obtaining political support for the scheme.

The main outcome so far has been the demonstration that the scheme has successfully managed the risk of placing people with challenging or complex needs in the community. Clinicians have recognised that clinical risk can be managed in a community setting and that health commissioners can manage any concerns that the local community has. For the residents they have the benefits of better integration into the community and greater independence. For the system as a whole it is a good example of achieving more for less.

Personality disorder

People can present with personality disorder on its own, or with other mental health problems. It has many manifestations from making it difficult for people to get over recurrent depression, through to antisocial Personality Disorder which may include violence and be apparently incorrigible destructive behaviour. It does not have its own pathway, but is characterised by people who may be stuck in the system and who use a lot of different services. People with this diagnosis may well have an ongoing depression and find it difficult to use traditional community-based services. However, they are unlikely to qualify for secondary care and so bounce around between primary and secondary care.

Several commissioning consortia have developed psychological intermediate care programmes which improve access to psychiatry in primary care as a way of resolving this. Figure 7 below summarises functions of service provision at each tier and describes the services which need to be developed at national, regional and local levels, using different service models and approaches.

Figure 7: Personality Disorder Pathway[28]

Service Tier	Functions	Services required at National, Regional and Local levels
Tier 6	To ensure appropriate treatment within required levels of security for those patients with severe personality disorder (PD) who present the highest risk to others. To provide assessment, formulation, treatment and management with co-ordinated access to highly specialist facilities in NHS and National Offender Management Service (NOMS)	• Dangerous people with severe personality disorder (DSPD) units • High Secure PD prison units • PD services within high secure hospitals
Tier 5	To ensure appropriate treatment within required levels of security for those patients with severe PD who present a high risk to others and/or self. To provide assessment, formulation, treatment, management and rehabilitation within a structured pathway that ensures appropriate step down from highly specialist provision. Support to Multi Agency Public Protection Arrangements (MAPPAs). Longer term maintenance/monitoring.	• Medium secure PD services • Step down rehabilitation services for patients with forensic risk • Prison Therapeutic Communities (TCs) • Lower-level prison step-down • Joint health and Criminal Justice System pathways and management system for high harm PD patients • Supported community residential provision for patients with forensic risk • PD community risk and case management services • Generic Medium Secure Unit (MSU), both inpatient and community treatment packages • Generic MSU Community Forensic Team

28 Adapted from Personality Disorder Framework produced by the London Specialised Commissioning Group

Service Tier	Functions	Services required at National, Regional and Local levels
Tier 4	To ensure appropriate specialist intensive treatment for those patients with severe PD who have high harm to self risk and/or limited/improved risk to others who cannot be managed in Tier 3; or who may need to be treated on a 24-hour basis and away from home. To provide assessment, formulation, treatment and management & co-ordinated access to specialist facilities.	• Range of services for diverse population groups with severe and complex PD • Appropriate outreach and follow-up
Tier 3	To ensure appropriate treatment for patients with moderate to severe PD who do not pose significant risk to others. To provide assessment, formulation and treatment.	• Intensive treatment on a day service basis. A range of other supportive interventions including crisis support • Intensive community and prison-based programmes for offenders
Tier 2	To ensure appropriate treatment for those with moderate to severe PD who do not pose significant risk to others. To provide assessment, formulation and treatment.	• PD specific treatment packages in outpatient settings • Treatment packages on outpatient basis for individuals and families and those with drug and alcohol problems • Crisis support • Mainstream mental health and drug and alcohol services providing appropriate support to people with PD • Community and prison-based treatment and management for offenders
Tier 1	To ensure responsive community networks To ensure early identification, referral on and management of PD through primary care agencies. Socially inclusive access to general services for people with PD	• Appropriate housing, employment and education services to support full recovery • All local primary care agencies providing PD awareness services • Service user and carer networks for support

There are a number of schemes provided by housing associations for people with personality disorders. Their main contribution is to provide accommodation for people with the right level of staffing and appropriate design to manage the risks effectively. They may also provide housing with support services for people who cannot be housed or who cannot cope with mainstream housing. This is demonstrated by the high rates of personality disorder among people who experience homelessness[29]. The example below gives an example of how housing associations are contributing to this area of business.

St Mungo's: Lifeworks

The Lifeworks programme offers individual psychotherapy (up to 25 sessions) to chronically excluded adults and is flexible and effective in working in a variety of settings and with a variety of voluntary and statutory sector partners. These range from a frontline homelessness hostel to a medium secure unit in a psychiatric hospital to a substance use aftercare service. There is strong evidence for a link between complex needs (such as personality disorder), complex trauma and homelessness. Of Lifeworks' clients, 52% lost a primary carer in their early childhood, over half were abused as children and most have histories of chronic trauma. Since, 43% have been in prison, 70% – 80% have mental health problems, two-thirds use three or more substances and all have either been in a psychiatric hospital or a hostel.

The objective of Lifeworks is to enable the client to manage their feelings and think things through better, and thereby to facilitate their ability to change the destructive patterns that keep them in chronic exclusion. The project achieves an engagement rate of 70%, excellent when considering the complexity of need and a figure comparably favourable to take up of talking treatments from the general public. Those using the service experience a greater degree of recovery (across a broad spectrum of areas as measured by Outcome Star comparison study) than those using standard support services alone. The bulk of the project's work has been evidenced to 'trigger' change in individuals who may be described as pre-/contemplative in relation to the cycle of change model and facilitate them to the stages of action. This is reflected in real changes to people's access of education, training and employment opportunities and their housing move on. The service is equally effective in providing significant benefit for those who have engaged in (substance use) treatment but where that treatment has not addressed the core issues that led to problematic use or where there is risk of relapse as the clients search to develop new identities and coping strategies and move away from those of drug user or victim of abuse.

It costs around £500pw to support someone in a frontline hostel. Lifeworks costs £1,500 per client should they use 25 sessions. If people are ready to move on just a few weeks earlier, there is already a cost saving. Other cost benefits are through reduced (re) hospitalisations, including those discharged from the secure unit. The current Cabinet Office programme which supports the project ends in September 2010.

29 St Mungo's (2009). *Down and out? The final report of St Mungo's Call 4 Evidence: mental health and street homelessness*. London: St Mungo's.

Dementia

Dementia is the umbrella term for a range of conditions, the most common of which being Alzheimers disease, and all of which reduce the capacity of the person to cope with looking after themselves. The number of people with dementia in the UK is upwards of 700,000 at present, and the numbers are set to increase with an ageing population. Dementia already costs the health service more than cancer, heart disease and stroke put together, and the cost of institutional care is a very large part of that. Just delaying the date of institutionalisation can reduce these costs immensely.

Up to 80% of people with dementia live in the community, and many never go into care. People with dementia can manage to live independently with support if they are diagnosed early and enabled to access all the community support they need. Instead of presenting with dementia at a time of crisis, and feeling unprepared for the terminal illness that they are living with, the person can maintain and even build on the social and support networks that will keep them independent for longer, and prepare for the future and avoid crises.

These preparations include personal health measures, design and technology adaptations for the home, legal preparation for handing over executive and financial functions to trusted friends or relatives, and conscious planning to maximise the quality of life for the time that is left to them. One example of the pathway is set out by the Dementia Services Guide in Figure 8.

Figure 8: Joint commissioning of services within a defined care pathway to enable people to live well with dementia[30]

Dementia Care Pathway

Raising awareness dementia

01 Public information campaign
02 Memory services

Early diagnosis and support

03 Information for people with dementia and carers
04 Continuity of support for people with dementia and carers
05 Peer support for people with dementia and carers

Living well with and understanding

06 Improved community personal support
07 Implementing carers' strategy
08 Improved care in general hospitals
09 Improved intermediate care for dementia
010 Housing including telecare
011 Improved care home care
012 Improved end-of-life care

Making the change

013 Workforce competencies, development and training
014 Joint local commissioning strategy and World Class Commissioning
015 Performance monitoring and evaluation including inspection
016 Research
017 Effective national and regional support for implementation of the strategy

30 www.healthcareforlondon.nhs.uk/assets/Mentalhealth/HealthcareforLondon_Dementia-services-guide.pdf

The following interventions alone can dramatically reduce the demand for health and social services:

- General awareness of the signs that can be presented to the doctor
- Early and accurate diagnosis to allow for medication and social interventions to keep the person well
- Carer support that acknowledges the needs of the carer as well as the condition of the person with dementia. This could be someone to help in the house, rather than a day centre for the person with dementia to go to
- Basic knowledge of dementia for all health, housing and social care staff so that they can maximise the capacity of the person with dementia, rather than inadvertently increase their impairment
- Best use of design and technology in the home to increase independence and safety
- Hospital avoidance through flexible and responsive community based care
- Crisis intervention that assumes the person will remain in or return to their own home and is designed around that aim.

Housing based solutions to dementia care have been developed around architectural features and sensitive housing management. Architecture and design features minimise the effect of the impairments that are suffered by a person with dementia. Features that make it simpler for someone to remain in their own home are bright lights, obvious functions for each room and pieces of domestic apparatus, reduced clutter, labelling and the minimising of noise pollution.

Sensitive housing management includes training staff in how to communicate with people who are cognitively impaired, knowledge of assistive technology that is inexpensive and freely available for those clients, and how to help people retain memory through the use of communications passports. In some circumstances, there will be a valuable role for a specialist dementia housing worker, who can work across a range of residences and focus on areas of crisis or during periods of transition such as the point of diagnosis or when there is a threat of having to move into care, or at the end of life, when the person may wish to die at home. There is an equally important role for specific housing solutions for people with dementia such as specialist dementia extra care schemes, which help the person with dementia to live independently for longer. The example below outlines a housing-based dementia service.

Shore Green (part of Irwell Valley Housing Association): Manchester

Shore Green is an extra care housing scheme with 10 units (six one-bedroom flats and four two-bedroom flats) developed by Irwell Valley Housing Association in collaboration with Manchester City Council. It offers a specialist care service for older people with dementia and other memory loss conditions. It has a communal lounge, kitchen and garden and it enables tenants to continue a level of independent living in an environment where support is available when it is required. Tenants have assured leases, pay rent (personally or funded by housing benefit), pay their own utility bills and are encouraged to live as independently as possible.

The scheme was carefully designed and contains features which assist clients with day-to-day living, for example, through:

- Gas monitors that cut off the gas supply if a cooker is left on
- Door sensors that alert the night care worker if a tenant has opened a door
- Colour coding and personalisation (shelves/cubby holes with personal items) at the entrances to each flat to help each tenant identify their door
- Glass fronted kitchen units so tenants can see which cupboards items are kept in
- A single secure entrance and exit to ensure the safety of residents both in stopping unwanted visitors coming in and by reducing the risk of tenants wandering
- A visitor sleepover facility so friends and family can visit the tenants. This facilitates continued contact and has reunited people on occasions after contact had been lost.

One driver for the development of extra care housing for dementia was to reduce future demand for nursing placements. This was because Manchester (in common with many areas) has an ageing population and has projected that increased levels of dementia would lead to increased demand for nursing home placements.

Shore Green gives people with dementia more choice and control over their lives and the support they receive with more than 50% of its high-need clients to live independently until the end of their life. It appears to reduce demand for NHS services from people with severe dementia. Incident records show that in the last 12 months collectively, the 11 tenants have attended A&E services five times and have only been admitted to hospital on nine occasions (one person accounted for three of these). Given the high needs of this group, this is a very low level of activity.

The Care Services Efficiency Delivery unit (CSED) concluded that the service at Shore Green is good value for money even though care costs at Shore Green are £7k pa higher than alternative residential or nursing costs. They argued that better outcomes were being achieved at a marginal extra cost. Additionally, this cost comparison is before any savings related to A&E, hospital, ambulance or police (in relation to less incidents of wandering) are taken into account. CSED, therefore, believes that it is reasonable to conclude that the Shore Green model would provide people with dementia with a better quality of support and cost the wider health and social care system less than traditional nursing and residential support options.

5: Facing the future

There is an opportunity to treat the current squeeze in public finances as a catalyst for considering radically different ways of meeting the needs of those who live in housing association stock or who receive services from them. The Wanless Report envisaged a time when improvements in productivity, public health and a reduction in high risk behaviours would begin to control the proportion of GDP[31] spent on health and social care, although the 2007 update found that productivity in the NHS and progress on population health measures was not as had originally been hoped[32]. The recession presents a real opportunity to engage with local people, politicians and providers about delivering solutions that were previously unthinkable[33].

We are all going to have to do more for ourselves and we are all going to have to do more for each other. This has implications for all services, including housing and related support, because attitudes to risk will have to change and new expectations brokered as to where and how people will live and receive their care and support, as the numbers of people who are living with long-term conditions or some form of vulnerability increase and expectations of the state reduce.

Given the variations in health commissioning and the different patterns of service from locality to locality there is no one size fits all solution to people's needs that will work or be appropriate. Nonetheless, in the discussions that have been held as part the development of this report and through the development of the case study examples, it is clear that providers of housing and housing related support will want to consider a number of issues. These are set out under the headings used in Section 4.

Creating sustainable neighbourhoods

There are a number of factors that contribute to the ability of a neighbourhood to respond positively to change and to care for those that live within it[34]. These include the quality of the services that are available, how accessible they are and the environment in which they are delivered. The London Cyrenians case study above shows the importance of helping the local residents association to understand the needs of their new residents. Whether it is to understand the needs of new residents, grandparents with dementia or people with a forensic history, then there is a role for housing associations to support people to foster mutual understanding of each others' needs.

This could also apply to supporting all staff who have contact with residents to have an appreciation of the needs of people with mental health issues or long-term conditions such as dementia – possibly jointly with adult social care or NHS community providers. Such skills are going to be critical as part of building social cohesion as well as an increasingly personalised market[35].

31 Wanless D (2002) *Securing our future health: taking a long term view*. HM Treasury: London

32 Wanless D et al (2007) *Our future health secured?* A Review of NHS Funding and Performance. Kings Fund : London.

33 Webber J (2009) *Commissioning in a Cold Climate*. NHS Confederation : London.

34 Appleton N and Molyneux P (2007) *Connecting housing to the health and social care agenda: a person-centred approach*. Housing LIN: London.

35 University of Birmingham (2009) *Evidence for transforming community services: services for long term conditions*.

Designing homes for healthy living

Housing associations will continue to innovate in terms of designing homes that are sustainable, attractive, easy to use and cost effective to run. In terms of healthy housing, there is a need to ensure that there is good natural light, good ventilation to improve air quality and reduce mould, non-toxic materials, and good insulation to improve warmth and reduce noise together with affordable heating sources[36]. The biggest impact on health will come from working amongst those who are at risk of respiratory disease or other forms of frailty[37]. A one degree lowering in living room temperature is associated with a rise of 1.3mmHg blood pressure increasing the risk of heart attack, an increased risk of falls and, if dampness ensues, respiratory disease[38]. All tenants and residents will inevitably benefit from accessibly-built housing, which is easier to adapt if the resident becomes ill, disabled or frail with age[39].

Home modification in the absence of other interventions may be effective for people with a history of falls. However, it is most likely to be effective when integrated into a multi-faceted intervention programme that also focuses on education, exercise, hydration and nutrition[40]. Despite the importance of installing grab rails, lighting stairwells and avoiding hard surfaces, this alone will not reduce falls[41]. Housing associations could provide cupboard locks, poison labels and pan guards when refurbishing homes. Assistive technology has been observed to increase choice, improve quality of life, reduce pressure on carers and maintain independence. There is a need to build further evidence to support this[42], such as the Whole Systems Demonstrators research work being done by the DH looking at how technology can help people manage their own health[43].

Providers of designated housing for older people will want to be sure that they have adopted best practice in design. The Stirling Standard developed by the Dementia Services Development Centre suggests consideration is given to installing, gas monitors that cut off the gas supply if a cooker is left on, advice on colour coding, non-reflective glass-fronted kitchen units so tenants can see which cupboards items are kept in, bright lights, obvious functions for each piece of domestic apparatus, reduced clutter, labelling and the minimising of noise pollution. Consideration may also be given to parking and charging points for mobility buggies.

36 www.who.int/hia/evidence/whohia092/en/index.html

37 Commissioning housing support for health and wellbeing: Communities and Local Government with Care Services Improvement Partnership

38 www.heartforum.org.uk/publications_NHFreports_FuelpovertyToolkit.aspx

39 www.lifetimehomes.org.uk

40 DH (2009) *Falls and fractures: Effective Introductions in health and social care*. SO: London.

41 Gilliespie LD et al (2009) *Interventions for preventing falls in older people living in the community*. Cochrane Review Issue 4.

42 Beech R and Roberts D (2008) SCIE *Research Briefing 28: assistive technology and older people*.

43 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100946

Promoting independence

80% of care services is delivered in a primary or community setting. This excludes the care that is delivered in the home by family members. Going into hospital remains a rare event for most of us. However, traditionally, this has been less the case for people with mental health problems. So, the challenge is to further develop models of self-care and home care.

There has been a move in recent years to transfer care out of the acute sector and into a community setting. However, there are a number of considerations when transferring care and support to a community setting:

- Clinicians feel responsible for transfers of care, for safety, and for the wider community. Housing care and support staff need to be able to confidently discuss clinical matters and build trust that risks can be managed effectively in a community setting. There is a financial disincentive for a clinician and the institutional provider to agree to the transfer care to a housing association wishing to provide the service in the community.
- Commissioners have to be prepared to negotiate contracts in a way that allows for flexibility when it comes to transferring care to a community setting. Otherwise it is institutional service providers who take decisions on whether someone is ready to move to community care, even though there is a financial disincentive for them to agree to transfer care.

Individuals and organisations working close to the community, with experience of effective community based services, are potentially more likely to believe that it is possible to provide a service in a community setting. Clinicians in a high or medium secure facility are much less likely to be confident that a transfer of care to a community setting is safe and appropriate. These clinicians need to see that a patient with the same clinical diagnosis and the same degree of social isolation is experiencing better outcomes in the community and that they are operating successfully and safely within the neighbourhood where they live.

Promoting healthy choices

We discussed earlier that PCTs will want to move from strategies that are based on diagnose and treat to prevent and predict. The coalition Government has announced that PCTs will have responsibility for public health, and they will have 4% of the NHS budget. They will be tasked with encouraging a shift from population-based medical care to a more consumer-based approach to behaviour change. Such interventions will need to very targeted and evidence-based. Given who they house, housing association will still be in a position to offer evidence based interventions such as health trainers programmes, cook and taste projects and exercise programmes[44].

As we saw with the Impact Housing Association's case study it is important if people are to make healthy choices that they have fun. If they are enjoying themselves, they are much more likely to maintain the healthy activity. This is underlined in the Fun Theory projects where people were encouraged to adopt positive behaviours through the adoption of interventions that were fun and rewarding. In one example, a staircase next to an escalator was turned into a walking piano to see if more people would use the stairs by making it fun to do. This resulted in 66% more people using the stairs when they would previously have used the escalator[45]. This moves the emphasis from predict and prevent to engage and inspire.

44 Ryburn B, Wells Y and Foreman P (2009) *Enabling independence: restorative approaches to home care provision for frail older adults*.

45 www.thefuntheory.com

Responding to what clients want

The Joint Strategic Needs Assessment (JSNA) is the process for assessing the health and wellbeing status of local populations, building on a range of sources of local information. Specifically it is a tool to identify inequalities in health and wellbeing, and use the views of local people to prioritise areas for improving outcomes for local populations in the future.

The JSNA remains the main way in which needs are assessed and commissioning priorities are made. It is extremely important that as many agencies as possible engage with the JSNA and do a reality check on it. It is also very important that those who may be numerically small in number but who experience a lot of inequality, are accurately represented in the document.

The JSNA must shape the commissioning to meet identified needs and achieve improved health and well-being for the population served over the medium to long term (five to 10 years). It should also inform the development of universal services that have an impact on the health and wellbeing of the local population, such as housing and transport. The guidance that established the JSNA clearly expects that it should inform the Local Area Agreement

The JSNA is intended to provide effective, local intelligence and a shared evidence base upon which all partners can make critical commissioning decisions. It is particularly valuable as a basis for partners to agree the targeting of resources aimed at achieving improvements in health and wellbeing and promoting positive lifestyle choices of people who often belong to interdependent groups and who use a wide range of public services.

Multi-agency commissioning, based on a shared understanding of local needs, is considered key to improving outcomes for vulnerable people, reducing health inequalities and to achieving increased value from public funds. The better use of the JSNA can help in achieving this. However, in practice, it appears that in most areas the linkages between the JSNA processes and the commissioners for vulnerable adults and housing is at a relatively early stage although some positive examples are now emerging.

Elsewhere, this report considers the need for us all to do more for ourselves. At the same time we will want to know that there is a good universal service available, even if it is less. There is a strong expectation that you can register with a GP, walk into a chemist and get free advice and walk in to primary care services in an emergency and receive care. In more extreme circumstances, this is escalated to a right to access A&E and, when necessary, to call an ambulance. There is an expectation of sexual health advice and free contraception, the right to maternity care, an expectation of a visit from a health visitor and free childhood immunisations and vaccinations. At the other end of the age range, we have an expectation that we will receive care for our chronic conditions, receive free nursing care if we need it and free palliative or end-of-life care.

At its best, personalisation brings a real sense of choice and empowerment, and enables people to take responsibility for their own health and for their own care.

Certainly, the public seems to welcome choice when it has enough information, when it is not significantly disadvantaging anyone else, when there is time to consider the options available and, of course, when the choices are good ones. This makes it clear that choice will only be welcomed if there is the time and capacity to provide the necessary information and support[46]. This is underlined by the Look Ahead example in Section 4 where there is a core offer but also an area that is more flexible.

46 Molyneux P (2009) *Universalism vs personalisation.* Housing, Care and Support: London

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. Increasingly, neighbourhood forums have become a place where people don't just seek information about local tradespeople but also exchange information about their experience of public services. The Government has promised to make more information available to help people compare the quality of healthcare services.

The downturn creates a renewed concern to reduce demand for institutional care. Personalisation will create new demands from service users for services that they want rather than what they need. This may mean that there will be a growth in new providers to respond to these demands. However, financial constraints will mean that these will need to be accompanied by more self-care and more preventative measures, and that personalisation may also be constrained in this way.

Preventing admissions

Moving forward, acute commissioning is likely to be done by teams employed by GP commissioners for this purpose. Local authorities are likely to play a greater role in the commissioning of community services and to want to see the greater use of local strategic mechanisms, however these are badged, moving forward. Meanwhile, primary care commissioners, either through practice-based commissioning or other mechanisms, will have increased responsibility for commissioning clinical services that prevent demand and design care pathways in a way that delivers care closer to home.

As part of the field work for this report, one group of GP commissioners said that there are instances where residents are directed by support workers straight to A&E services, rather than to the GPs, and that there can be unnecessary referrals to A&E, often by ambulance. Housing associations can make a big contribution to preventing admission and maintaining independence. As GPs take more responsibility for commissioning, they should be open to new ways of managing demand, provided that there is an accompanying shift of investment into the community. However, the lesson from the fieldwork is that much mental health commissioning is done in close collaboration with existing providers. Hence, the easiest way to enter the market in many areas will be with mental health trusts looking to do more for less, who may be open to a joint venture on a risk-sharing basis.

Enabling faster discharge

Housing associations will find willing collaborators in GP commissioners who are more used to managing risk in the community. Housing associations have a good track record in assuring acute clinicians that people can be managed successfully and with better quality of life in community based services.

Certainly, housing associations will continue to be crucial in delivering the vision that was set out in New Horizons and this, no matter how it is badged, is likely to remain the direction of travel. Mental Health Foundation Trusts may be willing partners in the development of step-down and other forms of accommodation on a risk share basis.

Strengthening asset management

GPs are being encouraged to work more co-operatively and will be forming commissioning groups. Many are already looking at ways of using their estate more creatively or exploring ways of establishing Community Interest Companies, which are companies that exist for community benefit where the assets and profits are dedicated to these purposes. This can act as a way of having the necessary estate to offer a broader range of services. HUDU (the Healthy Urban Development Unit) aims to improve communication between spatial planning and the health sector. It has developed a checklist to test the alignment of strategy, systems and structures within local health and social care economies[47]. Housing associations are in a position to offer expertise in developing such facilities and managing them on behalf of GP consortia. They could also bid to run community health centres jointly with GPs. They would need to have developed relationships with GP provider arms and commissioning consortia. Such opportunities are likely to be tendered out through Supply2Health.

47 www.healthyurbandevelopment.nhs.uk/documents/engagement_toolkit/HUDU_Health_and_Urban_Planning_Toolkit_Alignment_Checklist.pdf

6: Conclusion

In a situation where services are delivered through partnerships and networks of providers, the specific impact of one intervention can be hard to single out. Providers of housing and housing-related support are increasingly required to demonstrate tangible outcomes from what they do. This means that there is a need to make services measurable, tradeable and marketable.

This suggests that there is a need to do three things. The first is to ensure that the effectiveness of an intervention can be clearly demonstrated. There is considerable respect for the skills and expertise located within care and support organisations, but the impact of this needs to be measurable, and measured.

Secondly, there is a need to develop a local evidence base that is collectively owned by clinicians, politicians, residents groups and service users, which evidences measureable benefits to the health sector and elsewhere.

Thirdly, providers of housing and housing related support should continue to propose innovative ways of demonstrating positive outcomes that add to those already being proposed by commissioners.

Pathways are not the same from area to area, they can be very compartmentalised and also individualised. While taking a client-centred approach is a good thing, there is also a need to take a strategic approach to planning and adopting a consistent approach to managing risk. This can mean that adopting a community setting, as the appropriate place to deliver care often has to be negotiated on a case-by-case basis.

What is clear across the spectrum of outcomes and care pathways, is that there is huge potential for both the health sector and the housing care and support sector in working together across traditional boundaries.

There are considerable advantages to service users, to the public purse, and to meeting the shared objectives of prevention and tackling inequalities, of increased collaboration across health, housing care and support. This is a key moment for public services, and a time at which there are major challenges facing service providers and commissioners in both sectors.

There is much to celebrate in the innovative work being done to maximise opportunities which have a mutual benefit both for health and for housing care and support, as outlined in this report. By developing a strong evidence base, and working creatively at key points along the care pathway, local partners can support each other in the delivery of person-centred services which improve people's lives and improve efficiency.

Glossary

Acute services:

Acute care is the treatment of a patient for a brief but severe episode of illness usually in hospital.

Avoidable admission:

An admission to secondary care that could have been avoided. This is usually emergency or unplanned admission (possibly under Section) rather than an elective admission.

Care pathway:

Care Pathways are structured plans of care designed to support the implementation of clinical guidelines and protocols for the treatment of a patients with a specific condition over a given time period.

Community services:

Includes all care in the community provided by local authorities and health services. This includes intermediate care provision such as reablement, domiciliary care and community healthcare provision. It also includes some elements of preventative services.

CSED:

The Care Services Efficiency Delivery unit, which sits within the DH.

Early intervention:

Working proactively to identify people whose independence is at risk. Risk profiling and predictive models are essential for the effective implementation of early intervention services.

Elective Care:

Secondary care that has been planned and arranged in advance.

Integrated Care Pilots:

Integrated Care Pilots (ICP) are designed to look beyond the traditional boundaries between primary and secondary care to explore new, integrated models of care. Integration can refer to partnerships, systems and models as well as organisations, crossing boundaries across primary, community, secondary and social care.

Non-Elective Care:

Secondary care that has not been planned, for example, an A&E or as a result of a Section.

PCT:

Primary Care Trust. Responsible for the health of the population in the geographical area it covers and, using monies that have been devolved from the Department of Health, commissioning health services for the people of the area.

Prevention:

Prevention is action which is aimed at reducing the risk of poor health, helping people to do more self-care and reducing demand for healthcare.

Primary Care:

Primary care is the term for the health services that play a central role in the local community. It includes GPs, pharmacists, dentists and midwives. Primary care providers are usually the first point of contact for a patient. They also follow a patient throughout their care pathway.

Secondary care:

Acute hospital care.

Supporting People:

The funding programme which is allocated to local authorities as part of the area-based grant to provide housing related support to vulnerable people to enable them to live more independently.

Tariff:

A nationally defined set of costs that the NHS uses to cost secondary care costs on a case-by-case basis.

Third sector or civil society:

A range of organisations which have voluntarily chosen to respond to a defined set of needs and reinvest any financial surpluses to further their objectives. These terms are used to describe voluntary and community organisations, charities, social enterprises, co-operatives and mutuals.

Wellbeing:

A focus on maintaining independence and good physical, mental and social health and wellbeing. Interventions include providing access to good quality information and advice, supporting safer neighbourhoods and promoting health and active life styles.

A comprehensive guide to housing terms and phrases can be found in the National Housing Federation's *Housing jargon guide*[1].

1 Campbell Tickell and the National Housing Federation (2010) *Housing jargon* (7th edition)

Acknowledgements

The National Housing Federation would like to thank the following for their contribution to this report:

Professor June Andrews	Dementia Services Development Centre
Steve Appleton	Contact Consulting
Kevin Beirne	One Housing Group
James Berrington	Homes and Communities Agency
Mark Creelman	NHS Kensington and Chelsea
Andrew van Doorn	National Mental Health Development Unit
Jane Greenhalgh	Great Places Housing Group
Chris Hampson	Look Ahead Housing and Care
Chris Munday	Midland Heart
Jeremy Porteus	DH Care Networks, Putting People First Programme
Sally Scriminger	Foundation 66
Prof Richard Williams	University of Glamorgan

And the following organisations whose work features in this report:

Willow Housing and Care

Impact Housing Association

Old Ford Housing Association

Elgar Housing Association

Amber Valley Housing Limited

Look Ahead Housing and Care

Halton and St Helen's PCT

Three Rivers Housing Association

Leicester Housing Association

Leicester City West PCT

Midland Heart Housing Group

London Cyrenians Housing

St Mungo's

Irwell Valley Housing Association