An Integrated approach to delivering Personalisation ... or a Personalised approach to delivering Integration?

When I was asked to speak at a Sector-led Improvement Conference on the subject of 'An integrated approach to delivering personalisation', housing colleagues suggested to me that I might want to base this on the notion of a 'three-legged stool' supporting personalisation – the three legs being Health care, Social Care and Housing.

I considered this, but came to the conclusion that a purely technical integration of these three will not deliver a health and social care service that is truly personalised. Neither is personalisation the only legitmate goal of health and social care transformation.

In this paper, which is based on the presentation I made that day, I make the converse case for 'A personalised approach to integration' based on the notion of an 'eight-legged stool'.

It makes an appeal for housing to be considered alongside social care and is intended to be read by health, care and housing professionals. It encourages professionals to find solutions in the community sector and proposes a framework through which it might be possible to develop a common vision for reform.

Written for the Housing Learning & Improvement Network by
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Introduction

Everyone agrees that 'better integration' in health and wellbeing services is essential if we as a nation are to stand a chance of matching services to individuals requirements and making an impact on the inequalities in health exposed by Marmot[1] in an age of austerity. But not everyone agrees on precisely what needs to be 'integrated'.

One 'health' perspective is that the health service needs to be better integrated within itself – better connections between primary and secondary care, specialist and generalist health services.[2] Another view held by the health minister Jeremy Hunt and underpinned by the Health and Social Care Act, is that health and social care (the NHS and local authorities) must be better joined up.[3] While others believe the integration must be much more broadly based and 'preventative', including a range of other local authority services such as housing, public health and community services.[4]

The three-legged stool ... health, care and housing

One picture of the desired integration, favoured by housing professionals, is of a 'three-legged stool' – the three legs being Health care, Social Care and Housing.

This is because housing professionals know that 'housing' is part of the solution (as well as part of the problem) when it comes to health and wellbeing, but this is not routinely recognised among health and care professionals. Specifically, housing professionals are aware of five things[5]:

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[1] Fair Society Healthy Lives (The Marmot Review), 2010:
www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[2] For example, a recent report by Rightcare called The Accountable Lead Provider suggests that key lead providers of community health services that have significant 'integrative power' are best placed to create integrated and accountable programmes of care within the health sector.

[3] Jeremy Hunt keynote speech, Kings Fund Annual Conference, 28 Nov 12
www.kingsfund.org.uk/audio-video/jeremy-hunt-making-quality-care-important-quality-treatment

[4] Steve Field, Deputy Medical Director of the new NHS Commissioning Board Director and Chair of NHS Future Forum, www.insidehousing.co.uk/care/nhs-and-housing-should-work-closer-together/6525919.article

[5] A small selection of a significant and growing evidence base that supports points (i) and (iii) is presented in boxes A and B

(i)   the relatively poor health outcomes of people living in poor housing in poor neighbourhoods – a key social determinant of health identified by Marmot

(ii) the growing importance of 'the home' as a place of treatment, rehabilitation and care as the population ages and management of long-term conditions becomes a way of life for many

(iii) the potential for relatively inexpensive improvements and adaptations to housing to reduce illness and injury, support reablement and save the health service significant sums of money

(iv) the potential for 'low-level' housing-based support, which is highly valued by disabled and older households to maintain independent living at home

(v)   the opportunity for housing providers to expand their business into the fields of public health and social care, both for their own residents and others in the local community.

As a housing specialist, I can see the difficulties that health and care professionals might have in understanding how to engage 'housing'. Here are just a few of them:

- unlike in health and social care service delivery, there is no 'outcomes framework' for housing. There is broad agreement to the objective of 'providing good quality, affordable housing', but after that the housing sector is quite diverse in terms of organisations' aspirations which makes it difficult for others to see what the sector is aiming for

- there is a patchwork of housing providers that together house around 18% of the population – councils, ALMOs[6], housing associations – each of which has a different geography, specialism and ambition

- 66% of people live in their own homes and almost 17% in the private rented sector – these sectors have no organisation undertaking active management or regulatory roles and therefore no obvious point of connection for health and care services

- the strategic role that local authorities have relating to housing is much less directive than the 'commissioning' roles in health and care, and is separate from what existed under Supporting People commissioning arrangements.

While I am less well-versed in the difficulties associated with health and social care, and it is indeed risky to point out perceived problems in another's profession, I am conscious of a number of factors that could be impeding better integration with housing. These include:

- the continuing clinically-led nature of the health service creating difficulties in moving from a medical to a social model of health and wellbeing or taking into account wider environmental factors

- political, professional and organisational barriers to diverting budgets from acute to preventative measures

- distrust of the evidence base demonstrating that targeted spend on housing-related services can result in significant cost savings for acute health services.

In addition to these, differences in understanding each others' priorities, preoccupations, potential, systems, organisations and language, not to mention the 'what's in it for me' factor, can all get in the way of service integration. Even as we try to deal with these barriers, it will be very easy for them to prevail and to prevent the invention of a properly integrated and personalised system of health care management.

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[6] Arms Length Management Organisation – council-owned housing managed through a separate Board at 'arms-length' from the council

The eight-legged stool approach to personalisation and integration

Having pointed out some intractable difficulties in attempting to orchestrate a technical integration, I suggest that there is a different course of action. This can be boiled down into three essential steps.

The **first step** is to recognise that there are many more elements to draw from than just health, care and housing.

Public Health has a distinct role, and its migration to local authorities is already helping to bridge the divide in some places. Some health and social care practitioners are starting to recognise the potential role that housing and also 'support' (in the wake of Supporting People) can play in 'early intervention and prevention' strategies. Looking more broadly still, there is now significant buy-in to asset-based approaches that draw on assets within the community rather than always looking to organisations to deliver services. Most local authorities now undertake a Joint Strategic *Asset* Assessment as well as the JSNA and many are looking at what community-based support might offer through a programme of asset-based community development (ABCD).

Folding these into the mix, what started as a figurative three-legged stool is now starting to look much more like an eight-legged stool supporting a shift to personalisation.

Each leg of the stool has a legitimacy based in legislation, policy or financial imperatives.

Leg of stool	Legislation, policy, financial imperative
Personalisation (choice and control, prevention, social capital, universal services)	Putting People First
	Think Local Act Personal
Health & Public Health	Health and Social Care Act
	National Public Health Strategy and outcomes framework
	CCG Commissioning Outcomes Framework
Social Care	Health and Social Care Act
	Caring for our future – White Paper
	Draft Care and Support Bill
Housing	Localism Bill
	Laying the Foundations: Housing Strategy for England
	Caring for our future – White Paper
	Draft Care and Support Bill
	Growth and Infrastructure Bill
Support	Un-ring-fencing of Supporting People
	Draft Care and Support Bill
Community-based support	Coproduction – health programmes
	Social Value Act
	Right to challenge, bid etc
Asset Based Community Development	Localism
Prevention	Spending Review
	NHS Efficiency Savings

The **second step** is to create a conceptual framework that the relevant professions from the eight legs – led in part by participants of Health and Wellbeing Boards – can buy into and adopt as their overarching guide that will drive transformation of commissioning practice. Having a common goal is fundamental and I would question whether integration is indeed possible without it.
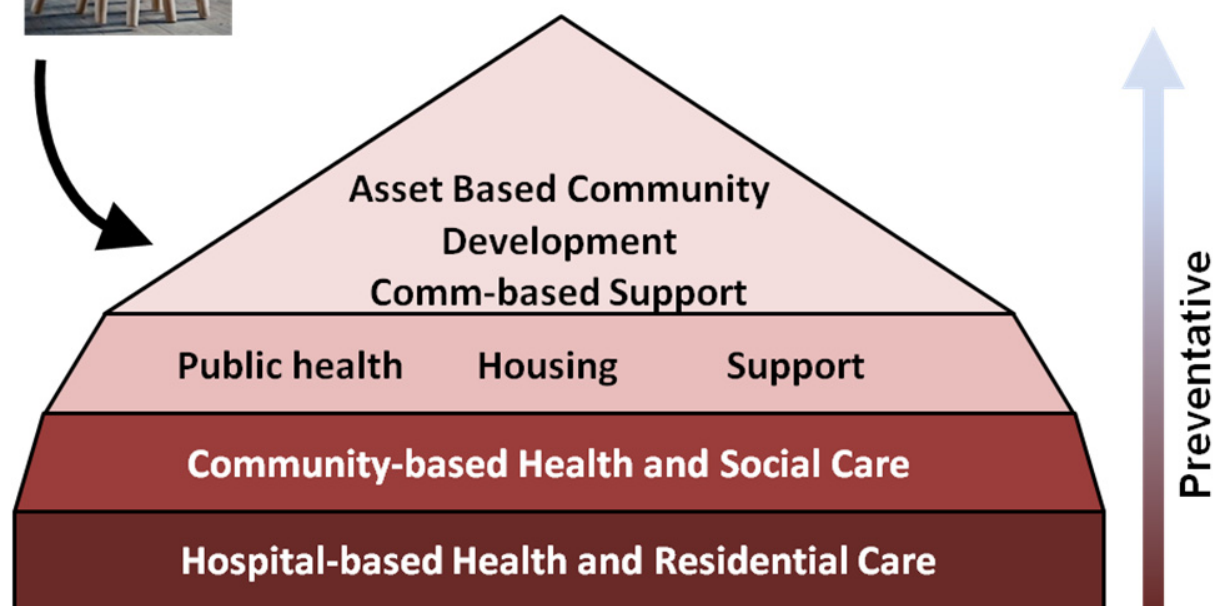
In the light of the need to make NHS efficiency savings of £20bn, it would not be unreasonable to expect NHS professionals and all the functions of local authorities to look for ways of helping people to improve their wellbeing that (i) serve people better and (ii) are less expensive. This is not a pipe dream; better, cheaper solutions do exist in the statutory, community, charity and social enterprise sectors. Liverpool's Healthy Homes Programme refers vulnerable people to some of them. The programme costs the PCT around £1m per year and is projected to save £55m over a 10 year period. Other solutions are being found in 'early intervention and prevention' programmes. They are not necessarily best described as 'services' since they are often lighter touch, less interventionist and less formal than traditional services.

This would be reasonable on the condition that they could also continue to maintain access to more interventionist, more expensive and more directive services in instances where these are required.

Such a framework might be look something like this, in which every profession is constantly doing two things in everything they do: (i) asking the question 'How do we maximise the life opportunities for people?' and (ii) seeking ways of preventing the need for acute services.

The **third step** is to allow the framework to drive transformation decisions. The NHS, Public Health and Social Care Outcomes Frameworks go some of the way to supporting this, but they could go further. NHS commissioners could be required to spend a proportion of their budget procuring services from community-based organisations that employ asset-based principles, since this would encourage them to explore and understand what is available. And all professionals should be rewarded for behaviours that support the framework while being discouraged from 'business as usual' behaviours.

This is not personalisation for personalisation's sake or because a government programme is promoting it. It is because the only way to respond to the demographic time-bomb while facing a future of limited public funds without chronically reducing quality, is to recognise the potential for people to look after their own health and wellbeing, collectively as well as individually, and to entertain the idea that there might be wholly different (and less expensive) solutions that can help people to stay well.

Clearly, this is a huge simplification of what is a highly complex transformation. But some simple concepts are needed to bring minds together. Taking the necessary course of action requires professionals to be prepared to think beyond their professional boundaries and for organisations to be flexible, open to change and supportive of embedding radically new practices. Some organisations have already embarked on this journey, adopting personalised approaches such as Local Area Coordination.[7]

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[7] Local Area Coordination uses local government employed professionals to work directly to support people in their own communities, connecting with and developing organisations offering community-based support. It has been used to great effect in Western Australia for around 25 years. www.centreforwelfarereform.org/library/type/pdfs/local-area-coordination.html

You may or may not agree with my suggested approach. If you don't agree, then please use it as an "aunt sally" to think through the issues and come up with something better yourself. Because, in the words of Geoff Alltimes, Chief Executive at London Borough of Hammersmith & Fulham and NHS Hammersmith and Fulham, *"It is no longer acceptable, or affordable, to retain artificial barriers between public services or expect our residents to navigate the plethora of agencies that provide the services they need to make a difference to their lives"*.

Box A: Evidence linking poor housing and poor health – in Liverpool

- Poor housing causes ~500 deaths and ~5,000 illnesses requiring medical attention each year **(BRE)**

- 5,500 rented properties contain ~7,500 category 1 hazards **(2006 stock condition survey)**

- Accidents in the home cause 77 deaths pa **(2008 PCT)**

- 242 excess winter deaths pa **(2009 NHS profile)** and for each there are 8 emergency admissions **(DoH)**

- 7.5% of households lack central heating **(HCS 2010)**

Further evidence can be found in Housing Learning and Improvement Network report, *Housing, prevention and early intervention at work: a summary of the evidence base:*

www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Viewpoints/Viewpoint_21_Prevention_and_Early_Intervention.pdf

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Box B: Examples of cost-savings that can be made by investing small amounts in targeted housing interventions

- One hip replacement (£28,665) pays for 100 grab rails

- Rapid Response Adaptations save NHS £7.50 for every £1 spent – keeping/getting people out of hospital **(Care and Repair Cymru)**

- NHS spends £600million pa treating people because of poor housing **(hact report)**

- Over 10 years, £1 adapting 100,000 homes, could save the NHS £69.37 and £1 improving 100,000 cold homes, could save the NHS £34.19 **(CIH research)**

An evaluation undertaken by the BRE in January 2011 of the first year's operation of Liverpool's Healthy Homes Programme shows that for a total project cost of **£1.07m**, the total anticipated savings (over 10 years) will be **£55m**. Further useful evidence on initiatives such as this one and practical hints and tips on working across housing, health and social care can be found in the Department and Health/Department for Communities and Local Government endorsed Hospital2Home resource pack at:

www.housinglin.org.uk/hospital2home_pack/

About the author

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Note

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

About the Housing LIN

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

For further information about the Housing LIN's comprehensive list of online resources and shared learning and service improvement networking opportunities, including site visits and network meetings in your region, visit: www.housinglin.org.uk

The Housing LIN welcomes contributions on a range of issues pertinent to housing with care for older and vulnerable adults. If you have an example of how your organisation is closely aligned to a 'Living Lab' approach or' a subject that you feel we should cover, please contact us.

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