Walsall Housing Partnership

The Housing Association Impact on Health & Wellbeing

Introduction:

Walsall Housing Partnership (WHP) is a well-established mechanism bringing together the key housing associations that operate within the Walsall Borough. Just under a third of all households live in accommodation provided by a housing association and we also provide a vast range of care and support services that enable people to live independently whilst coping with health or social care issues. It is worth remembering that the member associations are not for profit organisations and the two largest have their roots in Walsall and exist for the benefit of the communities we serve.

Prior to 2012, WHP took a lead role within the prevention services strategy group and we were looking forward to having an even more positive impact on health & wellbeing as the responsibility for public heath moved back into the remit of the local authority. In autumn 2012, WHP established a health & wellbeing sub group to replace the feedback mechanism for the former prevention services group. The purpose of this paper is to provide a brief summary of the reasons we believe it is essential that the social housing movement is represented within the Health & Wellbeing Board for Walsall

1 – Early Diagnosis

We are in an ideal position to promote early diagnosis of symptoms that have the potential to develop into major issues that will adversely impact on the resources of our health care structure within Walsall. We represent the landlord for c60,000 residents and have regular and routine contact with these families – of which approximately 70% live in the super output areas of multi-deprivation in the borough. In addition to this we provide support services for over 5,000 people who already have specific vulnerabilities so that they can maintain independence within their own homes.

Many of our employees are already trained in safeguarding issues and we have the scope to build on this giving us the ability to help identify early warning signs and connect people to the appropriate health care while a wider range of cost effective treatments is available.

2 – Early Intervention

Our members already provide preventative interventions and therapies that help people cope with illness at a more manageable stage thus preventing a significant proportion of people going on to suffer a more acute form of the illness costing considerably more to treat. One example of this is the support services we provide to people recovering from mental and stress related illness. We also promote a range of wellbeing services within the community that help to build up the overall resilience within a community to provide low level support or low cost distraction activities.

3 – The Home as a Hub for Services

The importance of safe, warm and affordable homes as the basis for healthy lifestyles cannot be ignored and there is a huge amount of statistical evidence available to support this claim. It is also well established that most people would choose the home as the best place to receive treatment and support where hospital treatment is not essential. We believe that our representation on the

Health & Wellbeing Board will enable an expansion of cost effective home treatments and will enable us to factor in health care options in the homes we build or modify. Families are the fundamental structures that support positive growth, development and wellbeing in society and families can only function effectively when a warm safe and stable home is available within a safe area where people choose to live.

4 – Affordable warmth & Tackling Poverty

It is no coincidence that the link between poverty and poor health is so strong and as social housing providers we play a major role in alleviating the effects of poverty and enabling people to access affordable warmth. If we take just one example, Housing programmes could deliver vast improvements in the UKs poor record for excessive winter deaths. *The number of fuel poor households dramatically increased between 2004 and 2010 from 1.2 million to 4.6 million. With rising fuel prices since that point the situation is now undoubtedly much worse. The Marmot review (2010) found evidence of the impacts of fuel poverty on mortality, morbidity and other social impacts – and countries which have more energy efficient housing have lower excess winter deaths*. It therefore follows that members of the Walsall Housing Partnership have a significant role if we are to improve the mortality rate related to lack of affordable warmth.

We are also aware that residents within our more deprived areas have a poorer diet and less healthy lifestyle than those in the more affluent parts of the borough. Our work with residents in these areas focusses on all aspects of their life journey whether from “welfare to work” or from “poor health to wellbeing”

5 – Community Connections & Resource

The main housing associations in Walsall have a genuine commitment to resident engagement and community empowerment putting considerable resource into the development of communities and helping to build a more compassionate society. This aspect of our work in Walsall will complement the role of the Health & Wellbeing Board in making our poorest communities more resilient, self-sufficient and sustainable. There is a well-established link between poor health and low self-esteem and we have a range of local interventions with a proven track record in raising the sense of self-worth for our clients by encouraging them to volunteer and contribute to the communities that ultimately support them. We should not overlook the fact that we represent the employers of c 3000 people within the Walsall Borough and we operate healthy work places and can be a positive influence on their wellbeing.

6 – Co-ordinating hospital discharge

We are aware that health care resources are often tied down unnecessarily because it is not easy to make suitable discharge arrangements for patients who need to convalesce in a home environment. We believe our members can work with the Health & Wellbeing Board on this to provide some innovative partnership solutions

Conclusion

WHP has a great deal to offer through membership of the Health & Wellbeing Board and it makes sense that we should be involved at this strategic level. This summary has been deliberately curtailed to 2 sides of A4 but other more detailed information has been forwarded along with the relevant references and supporting evidence

Mike Hew
Chair of the Health & Wellbeing sub group, Walsall Housing Partnership

Housing and Health

By Professor Christopher Handy OBE

Introduction

There are clear links between health, housing and social care. The homeless live much shorter lives as do those people living in poorer quality accommodation and areas of deprivation. Life expectancy and the quality of life in later years are both drastically affected by Marmot's social gradient (2010), with people from poorer backgrounds often doing worse. A decent home is fundamental to a healthy and a good life.

Good health flows from good housing. It's not the whole of the story, but it is an important part of the story of better health. A connection between the two issues has been fully recognised since Victorian times, with the conditions in the slums of the time generating poor health outcomes being extensively documented. Damp and insanitary housing makes people ill. The Housing Acts and Building Acts have all been passed to address this fundamental understanding. "Those who live in better housing conditions have better health in terms of morbidity (both physical and mental health) and also in terms of mortality," according to Dorling *et al* (2000, p.191). It is estimated that poor housing costs the NHS some £2.5bn a year with around 4.8m of the population experiencing a "category one hazard" that could affect health such as cold, damp, mould, noise or inadequate space (Institute of Housing, 2012). Homeless people have more serious physical and mental health problems and shorter life expectancy than the rest of the population. Overcrowding has a significant impact on the health of the occupants. There is a strong correlation between neighbour nuisance, dangerous unsafe neighbourhoods and poor mental health. And housing which is difficult or expensive to heat has an impact on excess winter deaths totals during periods of low temperatures. It is estimated that some 40,000 deaths per year would be preventable, if homes had adequate heating (Institute of Housing 2012).

If we take one particular issue by way of illustration, excess winter deaths, we can see how fuel poverty which affects every stage of the life course has a major impact. Housing programmes could deliver vast improvements in the poor record in the UK in this area. The number of fuel poor households dramatically increased between 2004 and 2010 from 1.2 million to 4.6 million (Buggins *et al.*, 2012). With rising fuel prices since that point the situation is now undoubtedly much worse. The Marmot review (2010) found evidence of the impacts of fuel poverty on mortality, morbidity and other social impacts – and countries which have more energy efficient housing have lower excess winter deaths. Warmth is a key issue, as a wide range of physiological and psychological conditions are exacerbated by low and high temperatures. Sandwell, for example, in the West Midlands has the highest rate of excess winter deaths in Europe and this is put down to the relationship with poverty and fuel costs in winter months (Buggins *et al.*, 2012). We have known since 1985 that fuel poverty is a contributing factor in a number of cold, and poor housing,

related health conditions (WHO, 1987). One study found that every £1 spent on reducing fuel poverty saved the NHS 42 pence (Liddell, 2008, p.2).

Some existing health conditions can be seriously affected by cold while others can be caused by prolonged exposure to it. Sustained low indoor temperatures can make respiratory disorders worse and there is an increased tendency to suffer colds, flu, bronchitis and pneumonia. Cold makes condensation and mould growth more likely, an environment which exacerbates allergies and asthma. Low temperatures also affect the circulation. Below 12°C blood tends to thicken, increasing blood pressure, in turn leading to an increased risk of heart attack and stroke as the heart works harder to pump blood around the body. The chronically sick, disabled and those with lower mobility levels are particularly at risk from hypothermia.

A cold snap, even in a mild winter can sharply increase health emergencies:

> *"After two days there is a sudden rise in heart attacks, by up to a third; after five days there is a big rise in the number of strokes; and twelve days into a cold spell there is a rise in respiratory illnesses"* (Energy Action Scotland, n.d.).

There are various government initiatives to address insulation and heating standards (for example 'eco', 'retro fit' and 'green deal'). Investing in these in order to improve energy efficiency is crucial at this time of both welfare benefit reform and rising fuel costs to ensure better health outcomes for poorer groups in society.

Decent Homes Paradox

But there is another less obvious problem which affects the health of poorer groups in society, clustering around a set of factors to do with behaviour, life chances and opportunity. On the face of it for such factors there is not a direct relationship with the quality of housing. But there may well be a strong "tenure" correlation. 'Social Housing' (housing which is directed towards those people whose earnings are below the average and in the main provided by local authorities and housing associations) is a useful case study in this respect. Across the UK this type of housing effectively houses poorer groups in society who generally have poorer life and health outcomes, supporting Marmot's (2010) social gradient argument. There is, though, a paradox possibly linked to these social factors. The quality of this housing is generally very good and pretty well all of it has been subjected to the "decent homes" standard which has led to the improvement of much of social housing over the last decade. So physical conditions are good compared to other tenure forms, with good maintenance standards and repair response times being reported by almost the entire sector in individual published key performance indicators. Energy efficiency tends to be high, especially for properties which have been built in recent years, Taske *et al*, of behalf of NICE, in 2005 explained this paradox well: "poor housing conditions often coexist with other forms of deprivation (unemployment, poor education, ill health, social isolation etc.), making it difficult to isolate, modify and

assess the overall health impact of housing conditions" (p.1). So housing although vital, is not enough on its own; other factors are at play.

The paradox is then, despite high physical standards, health inequalities persist for people living in this type of tenure. Purely tackling physical standards (although it makes an excellent start) does not in itself remove the other deprivation factors which coexist. Some further light has been thrown on this paradox in a recent study by the King's Fund. David Buck and Francesca Frosini (2012) have examined the clustering of unhealthy behaviours - smoking, excessive alcohol use, poor diet and low levels of physical activity – and concluded where these cluster together then health inequalities for such people will widen and create increasing pressure on the NHS. The prevalence of these unhealthy behaviours is greater for people in lower socio-economic groups: "the poorest and those with least education" need the most help with the reduction of their unhealthy behaviours say Buck and Frosini (p.1).

Social Housing and Deprivation

Social housing tenants live in some of the most deprived neighbourhoods in the country. It is estimated that of the four million social housing properties in England more than half are in the top 20 per cent most deprived neighbourhoods (Greenhalgh and Moss, 2009). As far back as 1995 it was established that tenants living in local authority housing experienced the worst health outcomes (Filakti and Fox, 1995). Those people living in owner occupied housing have significantly better health on all health measures according to a study on tenure and care ownership carried out by Sally Macintyre *et al* in 2000. The key issues identified in the study were the quality of housing and the quality of the environment. But the study also identified higher levels of self-esteem, mastery, confidence and life satisfaction.

Feinstein *et al*, for the Smith Institute in 2008, claimed a "very strong relationship between residence in social housing and multiple forms of disadvantage and deprivation" (p.9). For a cohort of people born in 1970, this study found that those in social housing had odds of having experienced a lot of time "not in employment, education or training" around 11 times higher than those for the rest of the cohort. They were also nine times more likely to be in workless households, be without degree-level qualifications and be single parents. They were twice as likely to suffer "depression, mental health problems, low self-efficacy and of being dissatisfied with life" (p.9). In response, the report identified a "need for adequate support and services… and the need for joined-up policy interventions" (p.9). The report rather depressingly concluded that:

> *"Some of the outcomes for those in social housing are hard to explain away as the result of selection factors. They may be due to the life experiences of those in social housing, including high concentrations of enduring and persistent poverty, high demands on the most active for social care for elders, children and the ill and disabled, problems of debt, anxiety, depression and broader mental health problems, social and economic disengagement and disenfranchisement, weak labour market attachment, stigma and*

discrimination, low levels of occupational stability, poverty trap issues, poor schooling, and changing family structures and relationship breakdown." (p.10)

This brief review suggests that social housing tenants are amongst the most deprived groups in society and live in the poorer areas. From a health inequalities perspective:

> *"In many disease areas, such as heart disease, there are also distinct social gradients in the prevalence and incidence of disease, with people more deprived populations experiencing more disease and multiple diseases… if anything, these health inequalities are likely to worsen rather than improve over the next 20 years."* (Imison, 2012, p.5)

What, then, can be done to address and tackle these difficulties? This is a challenging issue for the NHS, since demand for services continues to grow year on year and is placing ever greater financial strain on the system. The primary driver is an ageing population, with baby boomers (the post ward bulge in the population) beginning to work their way through demographic and demand projections (ONS, 2012). Interventions are therefore needed in order to stem the tide of increasing demand for services.

The Need for Partnership

Buck and Frosini (2012, p.1) are clear that what is needed are "holistic approaches to policy and practice which, if adopted, will address lifestyles that encompass multiple unhealthy behaviours." Even the Smith Institute report recommended a partnership approach linking housing policy with other elements of social and public policy including education, health, work and welfare on a multi-agency basis.

It is clear that the wider determinants of health therefore have an important role to play:

> "Our health is determined by a complex interaction between our individual characteristics, our lifestyle and the physical, social and economic environment." (Imison, 2012, p.3)

Rising education attainment, improved working and living conditions, and greater access to green space all have a positive impact on population health (but because these advances are not accruing in the most deprived communities, health inequality gaps are rising – see Marmot, 2010). A partnership approach addressing these wider determinants of health would seem to be essential. With the restructuring of health care in England and with public health teams in particular joining local authorities there is a significant opportunity which should not be missed.

The new NHS architecture also brings opportunities and challenges. A paper written by Elisabeth Buggins, Bal Kaur and Chris Handy (2012) for the Housing Learning and Improvement Network, *Shaping the concrete before it sets: building effective*

health and housing partnerships, explores the opportunity that this unique moment in time brings to forge a joint agenda and joint working. The authors argue that forging strong relationships between Health and Well Being Boards and local housing agencies is vital in tackling housing-related health inequalities, as already mentioned above. It is equally important that leaders within housing organisations recognise the important role they can play in designing and managing housing and communities in ways which encourage healthy outcomes: designing space which assists in community interaction, constructive play for children and young people and providing and accessing the sports activities of other healthy venues, perhaps by providing appropriate space or by forging partnerships with other organisations. The proximity and positioning of amenities could equally ‘nudge’ healthy behaviours whether physical or through the encouragement of social interaction for young and old alike.

Directors of Public Health (DPH’s) - the independent advocate for the health of the people in their area - are moving back into local authorities with the changes in the Health and Social Care Act 2012 and will be able to assist Health and Well-being Boards to rethink service provision. This could provide a point of contact for service providers and give DPH’s a greater opportunity to influence decisions which affect the wider determinants of health such as social care, housing, education and the environment. Through their leadership role in the development of the annual Joint Strategic Needs Assessment and the local Health and Wellbeing Strategy they will be in a prime position to drive the prioritisation of issues such as housing, health and social care. They have a strategic population overview with access to detailed demographic and epidemiological intelligence and a vital role in the three domains of public health: health improvement; protection; and in assessing the quality of health and social care. They are skilled in interpreting such intelligence to help decision-makers understand health profiles and the likely impact of health and social interventions. When finances are tight, this aids the targeting of investment to those communities where the benefit may be greatest.

The purpose of the NHS is enshrined in the NHS Constitution (NHS, 2013):

> “*[The NHS] is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.”*

It is a noble purpose. Delivering that promise while accommodating current financial challenges necessitates thinking increasingly differently about service models and care pathways. Any contribution housing providers can make through tighter engagement with health and social care providers for those people with disabilities, mental illness or the infirmities of old age will be welcome. The most useful contact points are the GP lead for a specific patient group within the local Clinical Commissioning Group, the service manager within community health services or the relevant director in the local hospital. The acronym most current in the NHS is QIPP – quality, innovation, productivity and prevention. This is the framework being used to assess progress against the 2011-2015 £20 billion savings target. Framing proposals to demonstrate success in any of these four domains, whilst also cutting costs, is very likely to engage the interest of senior NHS leaders.

Conclusions: The Governance and Leadership Challenge

Having a good quality home is essential to good health. But on its own it is not enough. The right kind of support is also required so that vulnerable people can live independent lives, and this can rarely be provided by one organisation working alone. Issues within poorer neighbourhoods have to be tackled in a coherent way so that the complex interaction of deprivation factors can be addressed through the collaboration of agencies. Marmot's solution of proportionate universalism (a greater focus on areas and issues having the greatest importance and impact) is surely a way forward as long as agencies work together. Over time, a better alignment of decision making and investment must surely have deeper, broader and more cost effective impact. Inter-agency and multi-professional working through the use of health impact assessment may be a key and practical way forward to better understand measures which can address health inequalities in individual homes and within neighbourhoods. This is a significant cross-organisational governance challenge, but one that we should not let slip.

There are good examples of some of this joint governance happening. Health For Living, a joint venture set up in the West Midlands, is a collaboration between four local organisations firmly committed to providing effective, efficient and high quality health and social care services to local people. These organisations are Accord Housing Group, Black Country Housing, Kaleidoscope Plus and Murray Hall. This initiative, which got going just over a year ago, initially involved commissioners to co-produce and co-design services and still has a close association with Sandwell and West Birmingham CCG. The partnership already delivers a high level programme of support to children through a number of children's centres in partnership with Family Action and also health, confidence and well-being services. It demonstrates on the ground the way in which agencies can work with the new NHS framework to deliver services in a different way.

The opportunities to increase impact are there and the evidence is growing (Porteus, 2011). The structural changes currently underway may support more cohesive thinking within local areas. However, it is too easy to watch and wait to see how new systems bed in and then to find that they have created new constraints to making the right things happen. We must respond to this key governance challenge now. As Buggins, Kaur and Handy argue (2012, p.7):

> *"Fortune favours the brave. It is time for leaders from all sectors to seize the space, to craft a clear vision, to harness courage and to collaborate across organisational and professional boundaries to shape the concrete before emerging system specifications set."*

References

Buck, D. and Frosini, F. (2012) *Clustering of unhealthy behaviours: implications for policy and practice*. London, King's Fund

Buggins, E., Kaur, B. and Handy, C. (2102) S*haping the concrete before it sets: building effective health and housing partnerships*. Housing Learning and Improvement Network (available online www.housinglin.org.uk)

Dorling, D., Shaw, M. and Brimblecombe, N. (2000) Housing, wealth and community health: exploring the role of migration, in H. Graham (ed.) *Understanding health inequalities*. Buckingham, Open University Press, 186-199

Energy Action Scotland (n.d.) *Fuel poverty and health: the impact of cold temperatures on health.* Available online via http://www.eas.org.uk/page.php?id=2305 (accessed 21/06/2013)

Feinstein, L., Lupton, R., Hammond, C., Mujtaba, T., Salter, E. and Sorhaindo, A. (2008) *The public value of social housing: a longitudinal analysis of the relationship between housing and life chances*. London, The Smith Institute

Filakti, H. and Fox, J. (1995) Differences in mortality by housing tenure and by car access from the OPCS Longitudinal Study, *Populations Trends*, 81, 27-30

Greenhalgh, S. and Moss, J. (2009) *Principles for social housing reform*. London, Localis

Imison, C. (2012) *Future trends*. London, King's Fund

Institute of Housing (2012) *Health and housing*, September/October.

Liddell, C. (2008) *The impact of fuel poverty on children*. London, Save the Children/University of Ulster

Marmot, M. (2010) *Fair society, healthy lives*. London, the Marmot Review

Macintyre, S., Ellaway, A., Keanrs, A. and Hiscock, R. (2000) *Housing tenure and car ownership: why do they predict health and longevity*. ESRC Research Findings 7

NHS (2013) *The NHS constitution*. London, Department of Health

Office for National Statistics (2012) *Age breakdown of England population by national population projections (2012 and 2032).* London, ONS

Porteus, J. (2011) *Housing prevention and early intervention at work: summary of the evidence base.* Housing Learning and Improvement Network (Viewpoint 21)

Taske, N., Taylor, L., Mulvihill, c. and Doyle, N. (2005) *Housing and public health: a review of reviews of interventions for improving health*. London, National Institute of Health and Clinical Excellence

World Health Organisation (1987) *The Health Impact of Low Indoor Temperatures*

NATIONAL HOUSING FEDERATION

Providing an alternative pathway

The value of integrating housing, care and support

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Midland Heart
Papworth Trust
Scope
Yarrow

The National Housing Federation runs **iN business for neighbourhoods** in partnership with members to promote the neighbourhood work of housing associations.

Introduction

"A well-funded, fully integrated system of care, support, health, housing and other services is essential, not just to provide high quality support for individuals, carers and families, but also to provide good value to the exchequer and the tax payer."

Health Select Committee 2012 [1]

Housing is a central part of an effective care system. This report, aimed at local commissioners of health and social care, tells the real stories of five people who receive integrated care, housing and support. Each service shows local authorities, housing providers, GPs and acute trusts working together to provide an alternative care pathway which reduces the demand an individual has for other services, as well as improving their quality of life.

Specialist housing and housing-related support help people to live independently in the community, reducing the need for care and preventing poor health. Timely home adaptations and reablement services get people home from hospital quickly and prevent hospital readmissions, helping them to recover their independence after illness.

Housing features heavily in the recent white paper, *Caring for our Future*[2], as part of an integrated health and social care system, which prioritises preventative care and speeds recovery to independence. Joint working between housing, health and social care can:

- **avoid or delay a move to residential care**
- **reduce admittance to hospital and avoid readmission**
- **reduce the demand for assessment and treatment centres**
- **prevent the need for domiciliary care**
- **prevent health emergencies and reduce demands on A&E**
- **prevent mental health deterioration and overall deterioration in health and wellbeing.**

These case studies, which provide practical examples of bringing together housing, health and care, deliver savings of between £2,946 and £17,992 a year compared to less integrated pathways. One service saved a total of £241,670 to local health and social care budgets. At a time when local authorities have to cut spending while continuing to meet the needs created by changing demographics, it is imperative that we integrate as a way of improving outcomes while achieving efficiencies.

For the people who use these services, they do more than just provide good value for money. People get the care and support they need to live an active life - getting back into work, having friends and family to visit or simply going for a walk in the local park.

[1] Health Select Committee Report on Social Care, Fourteenth Report of Session 2012, Volume 1, 2012
www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/1583.pdf
[2] Caring for our future: reforming care and support, HM Government, 2012

Anna

Anna, aged 30, has autistic spectrum disorder and a learning disability. She does not use words to communicate. After a year in an assessment and treatment hospital, Anna is now happily living in her own home, developed by Dolphin Square Foundation and managed by Yarrow in London, with round the clock support from a small well-trained team.

Anna had been detained under the Mental Health Act and transferred from a care home to an assessment and treatment hospital far from her family. This was a result of changes to her medication which negatively affected her behaviour and which put her safety and those living with her at risk.

One year on and Anna now lives in her own home with round the clock support from a small well-trained team. This includes two sleep-in staff at night to manage risk and prevent injury because of the risks she can sometimes pose to herself and others. All staff working with Anna are trained to use a positive approach to behaviour management[3], which recognises the triggers that may lead to challenging behaviour.

'Over the moon' is how Anna's sister describes how she feels about her new home and service. She had been deeply concerned about Anna's stay for over a year in an assessment and treatment centre. Since moving to her new home in Queens Park, Anna is enjoying better physical and mental health, and is happier and more independent.

As a result, Anna's incidences of challenging behaviour are reducing. She burns up energy running in the local park, accompanied by support staff, who must be fit to keep up. Local shopkeepers value her custom and she has become part of the community. Anna has also become independent enough to manage at night with staff she can wake if she has a problem instead of waking staff. This is obviously better for Anna and represents an annual saving of approximately £50,000.[4]

[3] Staff working with Anna are trained to use PROACT-SCIPr-UK®::www.proact-scipr-uk.com/index.html
[4] This is Yarrow's estimate of the cost of providing sleep-in night staff as opposed to waking night staff

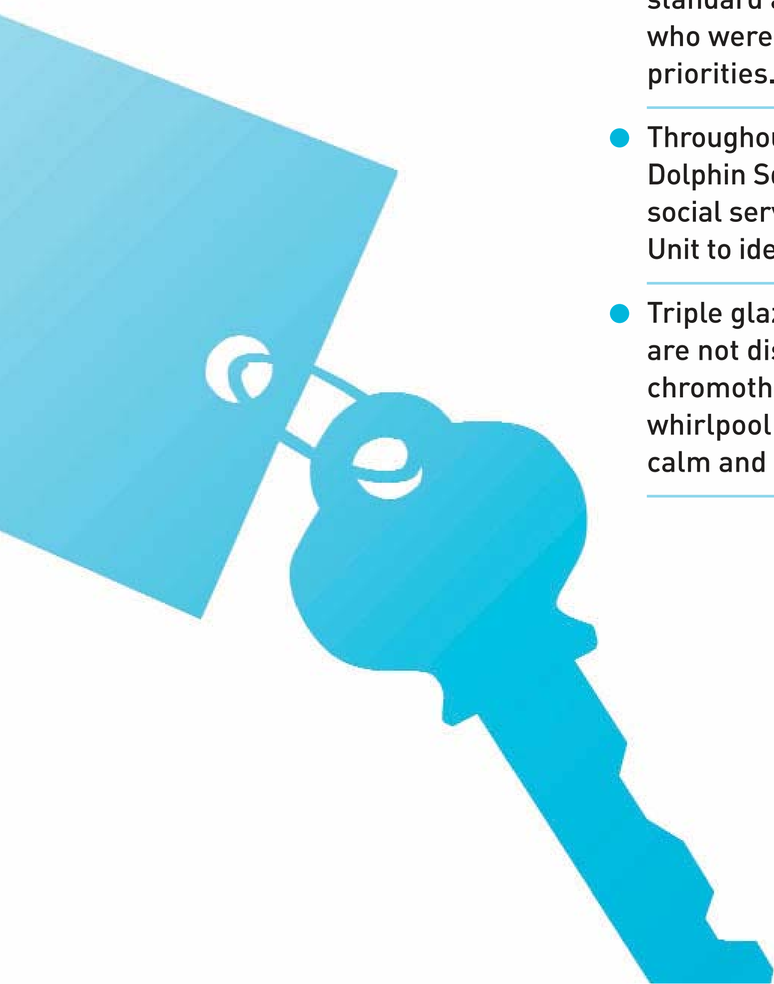
Since moving to her new home in Queens Park, Anna is enjoying better physical and mental health, and is happier and more independent.

Integrated services

- Close partnership working between three main agencies – Westminster Social Services, Kingswood NHS Assessment and Treatment Unit and Yarrow – meant that there was a shared awareness of Anna's very complex needs and a joint willingness to seek solutions.
- Specialist partnerships, which are able to think beyond the traditional boundaries of services to search for and find innovative and often less expensive solutions when none appear to be available, are essential. Yarrow worked closely with Anna's family, NHS psychologists, psychiatrists, speech and language therapists and occupational therapists.

The central role of housing

- Anna's home is one of five houses refurbished to a very high standard and commissioned to meet the specific needs of adults who were Westminster Council's highest health and social care priorities.
- Throughout the planning process, Yarrow Housing and the Dolphin Square Foundation frequently met with Westminster social services and Kingswood NHS Assessment and Treatment Unit to identify ways of improving the living environment for Anna.
- Triple glazing and sound proofed walls ensure that neighbours are not disturbed by Anna's vocalisations or loud music. A chromotherapy bath, which provides a body massage with a whirlpool with coloured jets, was fitted to help Anna relax, be calm and have fun.



Contribution to health, social care and public health outcomes

The scheme delivers a positive impact across all three outcome frameworks. In particular, the scheme delivers strongly against:

- **NHS Outcomes Framework 2.3.i** Reduced unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- **Adult Social Care Outcomes Framework 1G** Increased proportion of adults with a learning disability who live in their own home
- **Public Health Outcomes Framework 1.6** Increased number of people with a disability in settled accommodation.

Service impact

Westminster City Council commissions both the care and support for Anna, jointly funding the package with Supporting People funding and NHS continuing care funding. The current weekly cost for Anna is £3,154[5]; this excludes the cost of transitional support, which will taper off as she settles in.

It has prevented Anna remaining in an assessment and treatment centre

If Anna had not moved to her new home, she is highly likely to have remained in an assessment and treatment service, which would not have benefited her overall wellbeing. Not only are the fees for this type of service £3,500 per week[6], but the review of Winterbourne View highlighted the importance of reducing long-term stays in assessment and treatment centres.[7]

It has prevented the need for high levels of social care

Anna would have needed higher levels of social care, with additional staff, if she were living with others, as her behaviour could put their safety at risk. If Anna had to share with other people, there is a greater possibility of increased incidences of safeguarding alerts.

It has prevented health emergencies

The prevalence of health emergencies would be higher if Anna had remained in an assessment and treatment centre, as Anna found it difficult to live in a shared living environment. Anna's present clinical team have known her for years and are only a quarter of a mile from where she now lives. Yarrow drew up a health action plan for Anna, which is monitored by Yarrow staff and clinicians, who know her well.

After the initial service to support Anna's transition to her new home tapers off, this services shows an annual saving to health and social care budgets of £17,992, as compared with Winterborne View.

[5] This figure does not include Anna's weekly housing costs of £290.
[6] This cost is based on the widely reported costs of a weekly stay at the assessment and treatment service, Winterbourne View.
[7] Review of Compliance: Castlebeck Care (Teesdale) Ltd, Care Quality Commission, 2011

Grace

Grace, aged 74, has dementia and until recently was neglecting her health and having difficulty managing at home on her own. Moving to an Accord Housing extra care scheme has meant that she can continue to have a home of her own, with access to care and support when she needs it.

Although Grace has a dementia diagnosis, she is able to retain her independence in her own self-contained flat.

Grace had been living in her home for many years, but increasingly she had been finding it difficult to cope. Grace was having difficulty managing her personal care and her diet was very poor. She was very isolated with no family to provide support and regular contact, and had become anxious about leaving the house.

A social worker from the local authority ensured that Grace's care needs were reviewed and agreement reached that even with a care package, remaining at her current home was not the best option for her. She was referred to Moxley Court extra care scheme by a joint housing and social care allocation panel.

Although Grace has a dementia diagnosis, she is able to retain her independence in her own self-contained flat, rented on an assured tenancy, with both care and support staff available around the clock. Additionally, Grace has use of a range of communal facilities at Moxley Court such as the dining room and lounge, garden, hairdressing salon and an assisted bathing facility.

Grace says that she is much happier at Moxley Court. Grace is able to continue enjoying her life, which in turn maximises her ability to remain independent. Staff have helped Grace integrate well into the life of the scheme and mix with other residents there.

Integrated services

- An extra care scheme allows someone's home to be 'care-ready' in that the service is able to adapt quickly to individual requirements as someone's care needs change.
- Grace's personal care is supported by staff who have developed a relationship with her. This has helped to improve her self-esteem and sense of self-worth. The care and housing-related support team liaise with health professionals such as her GP, occupational therapists and physiotherapists to ensure that Grace has good access to these services.

The central role of housing

- Although Grace needs a high level of care at Moxley Court, Accord staff work with her to maximise her independence, providing flexible assistance with all aspects of daily living, such as support with shopping and meal preparation. The accommodation is accessibly designed and residents have the option of an emergency alarm system. This is the benefit of providing dementia care in an extra care housing context.
- Both the housing management, the care and the support services are provided by the same organisation at Moxley Court. The continuity of staffing ensures that meaningful relationships with Grace and a sense of trust have been built over time.

Contribution to health, social care and public health outcomes

The scheme delivers a positive impact across all three outcome frameworks, in particular:

- **NHS Outcomes Framework 2.6ii** Effective post-diagnosis care in sustaining independence and improving quality of life
- **Adult Social Care Outcomes Framework 2A** Reduced admissions to residential and nursing care homes
- **Public Health Outcomes Framework 4.16** Dementia and its impacts (placeholder).

If Grace had been left in her flat alone, it is likely she would have deteriorated further and been less able to live a normal life in the community.

Service impact

The services at Moxley Court are commissioned and funded under a block contract by Walsall Council social services department. By April 2013, all residents will use Individual Budgets. Based on the current level of services, Accord Housing anticipates that Grace's Individual Budget will be £305 per week to purchase care services.

It has delayed a move to residential care

Dementia costs the UK £23bn a year, with accommodation in care homes accounting for 41% of that cost.[8] Grace's behaviour at the time of her referral would have meant that she would most likely have been moved to a residential care home. Elderly mentally ill placements for a person with dementia average between £500 and £600 per week in a residential setting, almost £300 more than the cost of extra care.[9]

It has reduced admittance to hospital

The nature of extra care means that Grace's care providers are able to be responsive rather than reactive. If Grace had been left in her flat alone, it is likely she would have deteriorated further and been less able to live a normal life in the community. Ensuring Grace is in the most appropriate housing, with the care and support she needs, has prevented hospital admissions which may have occurred if she was left in her own flat.

The Alzheimer's Society reports that one quarter of hospital beds at any one time are occupied by people aged 65 and over with dementia and that this cohort will stay in longer than expected and their dementia-related symptoms will worsen. Residence in extra care housing is associated with a lower likelihood of admittance to hospital for an overnight stay and a lower incidence of falls compared to a matched sample living in the community.[10] The overall costs to local authorities and the NHS of each fall is £1,882.[11]

Living at Moxley Court extra care scheme currently presents a potential saving to social care budgets of £17,222 per year.

[8] Financial cost of dementia, Alzheimer's Society, 2009
[9] This is based on the average costs of residential care in the Walsall area for EMI placements.
[10] Establishing the Extra in Extra Care, International Longevity Centre UK, 2011
[11] Unit Costs of Health and Social Care, the Personal Social Services Research Unit, 2011. This figure is the cost of a typical rehabilitation episode following a fall.

Andy

Andy aged 32, was diagnosed with schizoaffective disorder and bipolar affective disorder at the age of 18 and has a long history of acute in-patient admissions and safeguarding concerns owing to his particular vulnerabilities. Look Ahead's rehabilitation service has supported him to move to independent living within 18 months, which is less than half the time and less than half the weekly cost of the average traditional alternative.

Following an acute six-month long in-patient admission, it had initially been intended that Andy move to a residential care placement. Instead he was referred to Look Ahead's rehabilitation service via the Tower Hamlets Community Rehabilitation and Recovery Service in London.

The rehabilitation service provides intensive support for up to 11 individuals in fully self-contained accommodation and is staffed 24 hours a day. Residents almost exclusively come from residential care (often out-of-borough) and long-term in-patient stays prior to moving in. At the heart of the service is an aim to support these individuals to move to greater independence.

The support Andy initially received focused largely on basic life-skills, diet management and health concerns. Within six months Andy felt able to reduce his psychiatric medication and start voluntary work with Oxfam. He chose to use his personal allocation of funds to purchase an exercise bike and exercise sessions. Andy had developed a personal interest in crosswords and set up and ran a successful 'crossword club' with other residents of the service.

Approximately a year after moving to the rehabilitation service, Andy successfully applied to do a nursing diploma at City University. He also started voluntary work serving refreshments at Tower Hamlets Centre for Mental Health. After only 18 months at the scheme, Andy successfully moved nearby to his own permanent flat, where he has been supported by Look Ahead's floating mental health service. In the near future, as Andy becomes increasingly independent, the service plans to discharge him.

After only 18 months at the scheme, Andy successfully moved nearby to his own permanent flat. In the near future, as Andy becomes increasingly independent, the service plans to discharge him.

Integrated services

- The service is funded by NHS Tower Hamlets Clinical Commissioning Group and was originally commissioned as part of the partnership commissioning strategy between East London and City NHS and London Borough of Tower Hamlets following the closure of an in-patient rehabilitation ward. Look Ahead's rehabilitation service has the primary aim of reducing the need for long-term in-patient stays.
- Embedded within the service is a sub-contract (25% of total) with the East London NHS Foundation Trust (ELFT) allowing close joint working and clinical input provided by the multi-disciplinary Tower Hamlets Community Rehabilitation and Recovery Team.
- The joint approach enabled by the contracting arrangements ensures an integral link between the social care outcomes delivered by Look Ahead and the clinical and health outcomes achieved by ELFT. This has delivered significant improvements in health and wellbeing outcomes, avoiding both a residential care placement and any subsequent additional high support setting.
- The Tower Hamlets Community Rehabilitation and Recovery Service also chairs a panel with housing department colleagues, which manages access to a local priority quota for choice-based lettings. This meant that as Andy's skills and confidence improved, the availability of suitable move-on accommodation could be assured.

The central role of housing

- The demonstrable successes of this service result from the embedded joint working, which ensures clear performance management, whilst efficiently recognising the particular skills Look Ahead and ELFT have to offer. Combining the clinical expertise of the trust with Look Ahead's experience of supporting individuals with complex mental health needs in a variety of supported housing settings has delivered real results for both individual customers and the borough.
- This model has recognised the distinct yet complimentary skills, expertise and experience both organisations can bring to supporting individuals to move towards greater independence. It still ensures clear accountability through a structured primary and sub-contractor arrangement and a clear focus on customer outcomes as part of the performance management of this contract.
- The service developed by Look Ahead has a personalised approach focusing on recovery and positive risk management, with customer-reported outcomes integral to its performance measurement. The service also delivers a range of broader social care outcomes including community and service engagement, employment, education, developing relationships and external networks, engagement with health conditions and management of presenting risks.

Service impact

The total cost of the 18-month placement was £78,156.[12]

It stopped Andy entering a long period of residential care

Based on Look Ahead's experience of previous service admissions, if Andy had moved to residential care as initially planned, it is estimated that he would have stayed there 4.5 years at an average cost of £953 per week[13] representing a saving of £144,846.[14]

It stopped Andy remaining too long in a high support accommodation setting

Following an extended stay in residential care, it is most likely that residents are discharged into a high support accommodation setting, as it is deemed most appropriate for their levels of skill and confidence. Based on averages, Andy has been moved to a housing association tenancy approximately six years sooner than he might otherwise have done. This represents another saving of £54,600 based on Look Ahead's average costs of providing high level support and the average length of stay that invariably follows a residential care placement.[15]

It prevented hospital admissions

Since accessing the rehabilitation service, Andy has not required any hospital admissions, despite a history of repeated admissions prior to that point. To date, each individual supported by the rehabilitation service is characterised by repeated and/or lengthy hospital admissions prior to entering the service. This represents a further saving of £42,224, based on minimum admission expectations for similar cases.[16]

It is estimated that this service has made an overall saving of £241,670 by supporting Andy to transition from in-patient service through to an independent flat in just 18 months.

Contribution to health, social care and public health outcomes

The scheme delivers a positive impact across all three outcome frameworks, in particular:

- **Adult Social Care Outcomes Framework 2A** Reduced admissions to residential and nursing care homes
- **NHS Outcomes Framework 2.5** Improved employment of people with mental illness
- **Public Health Outcomes Framework 1.6** Increased number of people with mental illness and/or a disability in settled accommodation.

[12] This figure does not include housing costs.
[13] £953 is the actual average weekly cost the residential care placements based on the clients coming into the service.
[14] This overall cost is based on the average weekly residential care placement cost (£953) over a three year period. This cost has already subtracted the cost of the Look Ahead service for the 18 month placement.
[15] Following a residential care placement, clients require high level support for approximately three years.
[16] A hospital admission for someone with mental health problems is £232 per in-patient day according to Unit Costs of Health and Social Care, PSSRU, 2011. The figure of £42,224 is a conservative figure based on the experience of individuals entering the service. They had spent an average of 26 weeks in hospital in the 18 months prior to starting in the Look Ahead service.

Bruce

Bruce was the director of a successful flooring distribution company in Cambridge. A motorbike accident changed his life forever. Bruce's 18 year old son, James, was killed in the accident and Bruce was left tetraplegic. He needed multiple operations including the amputation of a leg. Through the support of Papworth Trust, he is now living independently in his own purpose-designed flat and uses an individual budget to purchase the few hours of care a day he needs.

Bruce was referred to Papworth Trust by the senior rehabilitation consultant at Addenbrooke's Hospital to take part in a vocational rehabilitation programme. Bruce describes arriving at Papworth as life changing. Previously he had assumed that disabled people had a reduced quality of life, but he saw how he could be independent and make his own choices about how he lived.

Bruce initially moved into a Papworth Trust residential care home with 24-hour care, however as his health improved he was able to move to a semi-independent living scheme, but still with lots of support. More recently Bruce has been able to move to live independently in his own two-bedroom flat in Huntingdon, close to shops and other amenities, and with his daughter and grandson able to stay. The specialist design of the flat is key to enabling Bruce to live independently, with his own front door, almost to pre-accident levels.

He got to choose how his home was furnished, for example preferring vinyl to carpet as it was easier to keep clean if he brings mud in on his wheel chair. The kitchen work surfaces and oven are at a height that he can use by himself. The kitchen sink, hob and the bathroom sink are all height adjustable. Light switches are at elbow height, heating controls are accessible to him and doorways are wider than normal to allow access for his wheelchair.

Papworth's insight and understanding of the importance of an adapted and accessible home sped up Bruce's recovery and helped him return to living independently. He learnt to drive again which he hadn't thought was a possibility. Having regained his confidence, Bruce's computer skills also meant he was able to get a job in the electronics industry.

Integrated services

- Bruce's home at Temple Place was developed by a joint venture between Papworth Trust, Huntingdonshire District Council and Cambridgeshire County Council, enabling the local authority to move more people out of residential care and into independent living.
- Papworth Trust has excellent links with local hospitals in Cambridgeshire, mainly because of their award-winning rehabilitation service. These links ensure that people who have had a life-changing injury have a clear understanding of the housing options available to them now and in the future.

The central role of housing

- Specialised support and an adapted home have greatly improved his independence and wellbeing. Living in inappropriate or inaccessible housing can greatly increase the need for and cost of social care and support.
- The key to Bruce's independence in his current home is the accessible design. The proactive planning to develop specialist housing has meant long-term benefits for both Bruce and the council.

Contribution to health, social care and public health outcomes

The scheme delivers a positive impact across all three outcome frameworks, in particular:

- **NHS Outcomes Framework 2** Enhanced quality of life for people with long-term conditions
- **Adult Social Care Outcomes Framework 1B** Increased proportion of people who use services who have control of their daily life.

The specialist design of the flat is key to enabling Bruce to live independently, with his own front door, almost to pre-accident levels.

Service impact

Bruce's current weekly care package is £550, which he receives as an individual budget. Housing benefit currently funds the rent and service charges of £123.65 and £51.45. The new size criteria brought in by the Welfare Reform Act could affect Bruce's ability to remain in his home. This case study highlights the importance of a continued local commitment to meeting rental costs for supported and specialist housing.

It has reduced the need for social care

Following Bruce's accident, his own home was effectively inaccessible to him; the only other option at that time was residential care. Whilst Bruce continues to receive an individual care budget, the design of Bruce's home has drastically reduced his health and care needs. The Cambridgeshire average cost for a residential care home placement for working age adults with a physical disability is £1,018 per week.[17]

It has prevented mental health deterioration

After the accident, Bruce felt that his life had in many ways ended. Following discharge from hospital, he quickly went downhill and was unable to walk or take care of himself. Bruce felt that his own home was like a prison and that he was a burden to his family. After three months, he attempted suicide. Simply enabling Bruce to live independently has helped combat this severe depression.

Bruce's current living and care arrangements represent an annual saving of social care costs of £15,230.80 per year, inclusive of housing costs. Bruce's mental health and wellbeing are greatly enhanced by his independence.

[17] This cost is based on the average price of residential care for people with a physical disability in Cambridgeshire: http://www.carehome.co.uk/carehome.cfm/searchazref/72715

Beryl

At 82, Beryl was diagnosed with stomach cancer and admitted to hospital. As a result of a major operation, she now has a permanent stoma bag. After only a month Beryl was successfully discharged from hospital to her own home with a reablement package from Leicester City Council and support from Midland Heart to help her regain her independence.

Following Beryl's major operation, her Midland Heart housing support worker met with hospital staff and requested that the hospital social work team carried out a pre-discharge assessment of her personal care needs, engaging the reablement service run by Leicester City Council. Together, they were able to plan for her return home, ensuring that any practical adjustments to her home were ready such as the provision of a shower seat necessary for care staff to assist with her bathing.

Once Beryl had been discharged and was back at home, the housing support worker provided a point of liaison with the reablement team to focus on helping Beryl to return to living independently in her own home. Beryl had a second assessment to ascertain how well she was managing at home and how able she was to complete day-to-day tasks alone. As Beryl was managing well, it was agreed that the reablement service would end after six weeks.

However, Beryl still needed support to maintain her recovery and take further steps towards independence. Her housing support worker helped with welfare benefits, maintenance and housing issues, managing GP appointments, and arranging collection and delivery of prescriptions. Encouragement from the housing support worker to regain her independence and confidence has led her to be involved once again in her local community. Since returning home, Beryl's health and wellbeing has steadily improved.

Integrated services

- Effective joint working from hospital to community has ensured that Beryl is able to remain in her own home and maintain her independence. The reablement service has re-established Beryl in her own home. The on-going provision of low level weekly support has enabled her to remain there, quickly regaining her independence.
- Good communication between hospital and support staff have helped Beryl get back in her own home after only one month, and have prevented on-going health and social care services.

Effective joint working from hospital to community has ensured that Beryl is able to remain in her own home and maintain her independence.

The central role of housing

- The provision of home adaptations and a housing-related support worker has bridged the gaps between hospital, reablement and home. The prompting, signposting and assistance to access the services she needs, ensures Beryl continues to live independently in her own home.
- The housing-related support service has helped Beryl to obtain a Severn Trent Trust Fund to clear utility bill debts. Welfare benefits advice resulted in successful applications for attendance allowance and other benefits, boosting her income and ensuring that Beryl is able to be warm in her home.
- The housing support worker enabled Beryl to access primary care, including GP appointments and arranging collection and delivery of prescriptions. They also liaised closely with social services regarding access to services to assist mobility or personal care.

Contribution to health, social care and public health outcomes

The scheme delivers important outcomes across different services, in particular:

- **NHS Outcomes Framework 3.6.i** Increased proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- **Adult Social Care Outcomes Framework 2A** Reduced/delayed permanent admissions to residential care homes
- **Public Health Outcomes Framework 4.11** Reduced emergency readmissions 30 days of discharge from hospital.

Without the floating support service, Beryl has stated she would not be accessing services at all which over time would have resulted in an increased need for social care.

Service impact

The Leicester City Council reablement service run by Leicester City Council Adult Social Care is developed in partnership with NHS Leicester City. The Midland Heart floating support service commissioned by Leicester City Council Supporting People team is offered to any tenant living in the City of Leicester with low to medium support needs. The cost of the reablement episode was £2,088.[18] Beryl continues to receive one hour of housing related support per week at a weekly cost of £28.83.

It has ensured that Beryl has returned home as quickly as possible

If Beryl had not received a reablement package to support her return to her own home, she would have been discharged to a care home on a temporary basis prior to returning home. If discharged to a residential home for intermediate care, the cost would be between £2,614 per episode.[19] Without the floating support service, Beryl has stated she would not be accessing services at all, not wanting to be a bother to anyone, which over time would have resulted in an increased need for social care.

It has prevented readmission to hospital

The reablement service has ensured that Beryl's home was suitably adapted for her return, which allowed a speedy discharge and avoided the need for institutional care.

The support service has assisted her attendance at medical appointments with her GP and monitored the impact of her medication. This intervention has prevented readmission to hospital at a cost of £2,334.[20]

The reablement package and subsequent support currently save £1360.84 per year, avoiding poor longer-term outcomes such as on-going social care service use.[21]

[18] Unit Costs of Health and Social Care, PSSRU, 2011
[19] Unit Costs of Health and Social Care, PSSRU, 2011
[20] Unit Costs of Health and Social Care, PSSRU, 2011
[21] Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study), Social Policy Research Unit, University of York and PSSRU, University of Kent, 2010

Summary

The stories in this report have aimed to illustrate to local commissioners the real and meaningful outcomes of integrating care, housing and support. So how do we make this type of integration happen? Different local areas will develop different answers to this question, but there are a number of emerging common themes.

In the short-term

- Understand the routes people take through local services. Where can closer working with housing providers give better results? Meet with local housing providers to discuss how housing can prevent or directly address health and social care pressures.
- Identify what knowledge and intelligence you need to know, and plan for how to use housing to improve care outcomes and reduce demands on the NHS.
- Talk to local specialist housing and care projects, home improvement agencies, and other frontline services to understand where barriers exist and where outcomes are being limited by fragmented services. For example, are hospital and care staff working closely with housing support staff to deliver reablement services effectively, helping to discharge people home quickly and prevent readmissions?
- As reductions in spending are planned and implemented, local authorities, health and housing providers should openly discuss the implications on different elements of the health and care system, identifying alternative ways of meeting local needs in the area.

In the longer term:

- Include housing options and housing-based services in local market statements to ensure housing providers are recognised as local partners in providing accessible care services that help people maximise independence.
- The NHS, housing providers and local authorities should work together to understand where costs build up in different parts of the care and health system, and to recognise the value of safe and settled homes, housing-related support and home-based care services across primary and secondary care.
- Adult social services departments and housing departments should work together to establish and maintain a register of adapted housing as part of their oversight of the local care market. A clear, up-to-date understanding of specialist local housing stock will also help authorities manage and respond to the impact of the Welfare Reform Act on residents in specialist housing with care.
- The health and wellbeing boards should address both housing needs and the role of housing and related services in their Joint Strategic Needs Assessments and local clinical commissioning plans in meeting local priorities and improving health and wellbeing.
- Health and wellbeing boards, housing providers and local authorities should work together to identify the need for specialist and accessible housing, which could take the pressure off local hospitals and residential care homes. This should then feed through into local planning strategies and priorities.
- Information and advice services across housing, health and welfare must ensure that individuals in need of care are aware of housing options and housing-based services as part of the local care market.

If you would like to find out more about the work of housing associations offering care and support, please contact us on 020 7067 1000 or visit our website www.housing.org.uk

NATIONAL HOUSING FEDERATION

The National Housing Federation is the voice of affordable housing in England. We believe that everyone should have the home they need at a price they can afford. That's why we represent the work of housing associations and campaign for better housing.

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