



Breaking through Bureaucracy

Involving the Citizen

Empowering Front Line Staff

Unleashing Change

A Report for Community Housing Cymru Group

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Executive Summary

This study was commissioned to identify opportunities for the community housing sector to support health outcomes, particularly in meeting the needs of our 'ageing society'. In line with Welsh Government policy, we were particularly interested in opportunities which result in integration of services around citizen needs, enabling both prevention of crises and earlier intervention when problems do arise – and which held the promise of better value for public money too.

The first step was to baseline current provision in Wales. In doing so, we identified a broad pattern of RSL (registered social landlord) activity in health-related services:

1. Traditional housing associations, whose mission remains general purpose housing provision, which usually include some sheltered housing;
2. Traditional housing associations which have taken advantage of Extra Care funding, and therefore include a small number of Extra Care units alongside general and sheltered stock;
3. A smaller number of housing associations which have made the strategic decision to become care providers and which are increasingly focusing on Extra Care and nursing care.

Alongside RSLs, Care & Repair agencies deliver a range of services which have a direct bearing on the health of older people and thus their service needs.

Next, we sought out quantified evidence of the value of housing-provided health services. Very little hard data is available in Wales, but what data *is* available – for example on adaptations and the Supporting People programme – is positive. Widening our perspective, we found strong evidence of the value of preventative services, which is broadly supported by the qualitative evidence too. While this evidence is not provider-specific, it affords sufficient encouragement for opportunities for closer joint working between the Welsh NHS and the Welsh community housing sector to be explored.

Through a series of interviews and a focus group, involving a total of more than 30 people from the health and housing sectors, we developed an understanding of the barriers to closer health and housing collaboration and five key practical opportunities that might be realised. All the opportunities offer the potential of supporting better outcomes for citizens, potentially at reduced cost to the public purse, across the whole of Wales. Each relates to prevention/delay of admission to hospital or effective discharge:

1. **Early discharge support in Extra Care schemes and nursing homes;**
2. **Expansion of not-for-profit nursing care;**
3. **Increasing the level of care available in sheltered housing and Extra Care schemes;**
4. **Ongoing support to enable older people to live more independently & healthier at home; and**
5. **Mutualised continuing care villages.**

To enable these opportunities – plus the specific opportunities in 6.7 - to be realised, we propose eight ideas for action at the policy level. Given the barriers most often cited in our interviews, we suggest that three ideas for action in particular are tabled at the Ministerial Summit in July:

1. **Giving a strategic signal that collaboration between health and housing is an expected part of the NHS reform agenda;**
2. **A short series of facilitated 'opportunity conferences' at which the opportunities set out in this report can be jointly considered at regional level;**
3. **Clarity on the application of procurement and state aid regulations to housing associations.**



This report is a means to an end: it is intended to stimulate constructive discussion and action towards closer operational partnerships across the health and housing sectors in Wales. We look forward to it playing that role.

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Director, Kafka Brigade UK
May 2011

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1 Context & purpose of this study

1.1 Context

Housing Associations and Care & Repair agencies in Wales, through Community Housing Cymru (CHC) and in partnership with Care and Repair Cymru (CRC), are keen to explore opportunities to support better health outcomes in Wales. Firstly, they see good, safe housing as a key enabler to a wide range of positive life outcomes. Secondly, they believe housing associations and Care & Repair agencies as well positioned to provide additional health-related services to their communities.

At the same time, the Welsh Assembly Government, through strategic reviews of social care and health provision and through the wider work of the Efficiency and Innovation Board has indicated its willingness to consider new models of service delivery. There is also an interest in growing social enterprise and mutual organisations in Wales, which has not yet fully translated from strategic intention to practical action.

Today, in response to the needs of their communities, housing associations in Wales offer a wide range of “non-traditional” services, from child care to dementia care to preventative / public health programmes. Little of this work receives mainstream funding. Similarly, Care & Repair agencies are increasing the range of preventative services and services that help older people return from a medical care setting back to their home. Both perceive opportunities to increase joint working in the community through their facilities so that people can achieve better health outcomes, closer to home.

1.2 Aim & research questions

Community Housing Cymru and Care & Repair Cymru have jointly commissioned this short study to identify further opportunities for the community housing sector to support health outcomes. As well as identifying possible new services for housing to support, the study will explore policy barriers and enablers.

The specific research questions established at the beginning of this study were:

1. What is the current picture in Wales?
 - What types of ‘health’ services are currently provided in Wales by RSLs and Care & Repair? Where are they?
 - What evidence is available on the public value of ‘health’ services provided by RSLs and Care & Repair?
 - Better outcomes?
 - Cost efficiency (resource cost to public services)?
2. What further ‘health’ services are provided by RSLs / Care & Repair agencies / other third sector organisations elsewhere in the UK?
 - What ‘health’ services are provided?
 - What evidence is easily available on the public value achieved by the involvement of the new provider?
3. What therefore are the main opportunities to extend delivery of ‘health’ services by RSLs and Care & Repair in Wales?
 - By scaling geographically?
 - By introducing new models?
4. What might be done at the policy level to help this to happen?
 - What are the key concerns / perceived risks?

- What key strategic / policy interventions might therefore be considered?
- What further research or evidence may be required?

1.3 Scope of this study

'Health and housing' is a large topic, and so to retain focus the following decisions were taken on scope:

Firstly, we acknowledge the health benefits of good quality housing. The importance of good housing is recognized in the Welsh Housing Quality Standard and, in research terms, an extensive literature is available. (For example, during the course of this study, Shelter Cymru and the BRE published 'The Cost of Poor Housing in Wales'). Similarly, many housing associations and Care and Repair agencies are active in health promotion too. Rather than repeat the evidence for this work, this study instead focuses on (further) opportunities for the housing sector to become involved in health/care service provision.

Secondly, while services for all parts of the population are relevant, steered by the project board, this study responds to a particular interest in understanding the opportunities to support 'our ageing society'.

Thirdly, during the course of this study, we have come to realize that both Care & Repair and RSLs are considered to be in the 'housing' sector; we use this short-hand occasionally in this report, but only when seeking to emphasize that such compartmentalization may need to be overcome.

Fourthly, social services partners are of course also a key partner in much of the work around health and care. Their crucial role is acknowledged; where this role is not set out explicitly in this report, that is only because we are interested in the less-well explored direct relationship between health and housing.

Lastly, this study draws on interviews and desk research to draw together a picture of current service provision and future opportunities. This is informed by secondary source research only (i.e., where information is publicly available, it has been included in this study). The risk of limited information being available on cost-benefits of alternative models of service provision were noted at the start.

1.4 Introduction to chapters

This report documents the findings of this short study as follows:

- Chapter 2: explains the concept of public value and its application to this work
- Chapter 3: presents a baseline of health-related services provided by RSLs and Care & Repair agencies in Wales
- Chapter 4: documents the findings of our desk research on the quantified evidence of value delivered by housing / third sector involvement in healthcare
- Chapter 5: summarises the key barriers to closer joint working between the sectors
- Chapter 6: sets out our view of main joint opportunities for health & housing to achieve greater public value (better outcomes and greater efficiency)
- Chapter 7: proposes some ideas for action at the policy level to help ensure these opportunities are explored and realized.

2 Research frame: creating public value

Public value is a concept first defined by Moore (1995) to capture the multi-faceted nature of what is valued in public service work. Moore defines 3 key questions, which managers can use as a rule of thumb test for their work:

- i. Is the purpose publicly valuable – i.e., will better outcomes be achieved?
- ii. Is it operationally feasible (considering all resources available)?
- iii. Is it politically and legally supported?

Only when all three can be fully answered can managers be confident that an idea, a plan or a strategy can be successfully translated into publicly valuable action. Public value, and Moore's 3 key questions above, afford a useful framework for this study.

2.1 So what is publicly valuable in health & housing?

To understand the sorts of activities, services and partnership models that might be considered publicly valuable around health and housing, we reviewed some key policy documents.

In **'Setting the Direction' (2010)**, the Welsh Government sets out the vision for the future of primary and community services in Wales. The strategy is primarily focused on integration of health and social care outside the hospital setting. It aims for services

"... focussed on the holistic needs of the citizen and delivered by the NHS, LAs and other partners working together. The approach will change from reactive crisis management to a pro-active, co-ordinated and preventative agenda, with a particular focus on high risk patient groups and those with increasing frailty. Such services will enable an increasing number of people to be managed effectively in their communities and localities, avoiding unnecessary and often debilitating hospital admissions".

The strategy goes on to establish some key facets of the future system, which includes organising services on a locality basis (of 30,000 – 50,000 people) and establishment of community resource teams to support this approach. The strategy specifically states that within this context:

"Co-ordinated care management systems for both physical and mental health will be developed to include:

- *Specific admission avoidance schemes;*
- *Supportive discharge schemes;*
- *Chronic condition case management;*
- *Enhance preparation for scheduled care;*
- *Enhanced medicines management;*
- *Advanced access to diagnostics;*
- *Active rehabilitation".*

The NHS Wales is just beginning the journey envisioned in 'Setting the Direction' now; much work is yet to be done on the detail of the above model and on the transition to it. Usefully, 'Setting the Direction' recommends that this work is done under the auspices of Local Service Boards to encourage wider partnership involvement.

In the **Welsh Labour Manifesto 2011**, the now-governing Labour party made the following relevant manifesto commitments:

- *"We will continue to rebalance services to provide more care in the community setting, closer to patients' homes" (p.41)*
- *In relation to mental health services: "continue to move away from institutionalised environments, focusing on effective community-based care, other than in the most serious and exceptional circumstances" (p.48)*
- *"Promote Mutual Ownership of housing, including consideration of the 'New Foundations' model" (p.65)*

It is also interesting to observe that encouragement to align health and housing in Wales has been evident in government-published documents since 2008: in their 2008 **'Review of Evidence to Inform the Development of the National Housing Strategy'** (2008), Tribal recommended that the Welsh (Assembly) Government consider a comprehensive national project on housing and health (p.136).

Looking more widely, financial constraints loom large over public services in Wales. The previous Assembly Government's **'Meeting the Challenge of Change'** (2010) publication summarises some key points:

- "In real terms, the total budget in 2011-12 will fall by more than £800 million; by 2014-15 it will be £1.8bn lower;
- These reductions are additional to those in non-devolved budgets such as welfare (reduced by £1bn at the UK level by 2014-15), which will also be felt across Wales".

'Meeting the Challenge of Change' also highlights other key pressures on services in Wales:

- "Employment: 123,000 people aged 16 or over in Wales were unemployed in the 3 months to November 2010 and a further 497,000 (26.2%) of the population aged 16 to 64 are economically inactive – these are major factors in relation to young people, child poverty and families facing multiple and complex health and social problems.
- Demographic change: the number of pensioners is rising and expected to increase by 29% in the period 2008 – 2033 – with wide ranging implications for services, in particular, health and social care; and a recent and sustained increase in the number of under-5s, putting pressure on education services.
- Climate change and environmental pressures: are impacting on service demand in areas such as waste management and flood prevention. They are also driving changes in service delivery in an effort to reduce energy consumption".

A quick review of **local health and wellbeing strategies** across Wales makes the demographic change even starker. All areas expect to see growth of their 'older' populations. Cardiff is anticipating an 11% increase of people aged 65 to 75 over the next 13 years; Bridgend anticipates 44% more older people over 15 years; Conwy anticipates 32% more people aged 65 to 74 over 20 years; and Gwynedd anticipates 40% more people between retirement age and 84 over the same period.

2.2 Summary

In summary, our understanding of what is considered publicly valuable around the health/housing interface from these sources is: closer integration of services around citizen needs – whether health, social care, housing or other services – enabling both prevention of crises and earlier intervention when problems do arise. A linked aim is to ensure such support is 'closer to home' for citizens. Thirdly, there is an urgent need to improve the efficiency of service delivery significantly, and the exploration of new models and partnerships is concerned both with improving outcomes and with saving costs.

3 What is the current picture in Wales?

In order to understand the opportunities for greater public value across health and housing, our first step was to understand the current picture of RSL and Care & Repair involvement in health service provision in Wales.

3.1 RSL involvement in health-related services – in broad terms

All housing associations are independent organisations with their own business plans. Nonetheless, a broad pattern of participation in health-related services is discernable and may be useful to health partners:

1. 'Traditional' housing associations, whose mission remains general purpose housing provision, which usually include some sheltered housing;
2. Traditional housing associations which have taken advantage of Extra Care funding, and therefore include a small number of Extra Care units alongside general and sheltered stock;
3. A smaller number of housing associations which have made the strategic decision to become care providers and which are increasingly focusing on Extra Care and nursing care.

3.2 RSL involvement in health-related services – further details

As part of this study, information has been gathered by Community Housing Cymru on the type and scale of involvement of RSLs in Wales in health-related services. We are grateful to all 38 RSLs approached for sharing their data. We can therefore offer a firm picture of current provision of health related services by RSLs in Wales. Key points are offered below; a full table of findings is provided at Annex 3.

- **Adaptations.** The vast majority of RSLs manage & deliver adaptations on their own stock (36/38); 11 RSLs also offer an adaptations service for homes in private ownership via their Care & Repair partner.
- **Telecare.** 21 of 38 RSLs provide some form of telecare service; these schemes may be open to all local residents as well as tenants.
- **Sheltered housing.** 34 of 38 RSLs offer sheltered housing schemes. In total their schemes provide over 13,447 sheltered housing units across Wales.
- **Domiciliary (home) care.** 8 RSLs confirmed they offer some home care.
- **Extra care.** We have so far identified 13 RSLs that offer Extra Care through c. 26 schemes, totaling over 1200 units. (Note: during the course of this study, we became aware of a full baseline of Extra Care provision being developed by the Welsh Government; when that becomes available it is likely to offer a full baseline).
- **Nursing care.** 3 RSLs confirmed their provision of nursing care: Hafod Care and Linc, with a Pennaf site coming online shortly.
- **Respite / convalescent care.** 6 RSLs confirmed that they are actively involved in respite care currently (using Extra Care units and nursing home beds).
- **Specialist mental health care.** 10 RSLs confirmed their provision of specialist residential mental health homes.
- **Specialist disability care.** 8 RSLs confirmed their provision of specialist disability care units.
- **Supporting people schemes.** 25 RSLs confirmed their provision of housing / housing plus support under the supporting people banner, including hostel and step-down accommodation.

In addition to these health-related services, a number of RSLs have previously been involved in the provision of NHS buildings – such as GP surgeries (e.g., Fairlake / Genus, Newport), and staff accommodation.

3.3 Care & Repair services

Care and Repair services are provided in all 22 local authority areas in Wales. Care & Repair agencies undertake home visits, enabling them to assess people's needs individually. For example, in 2009/10, Care & Repair agencies:

- Undertook 20,000 home assessments and casework visits;
- Completed over 15,000 rapid response adaptations;
- Completed a further 17,000 adaptations, many funded via Disabled Facilities Grants;
- Undertook specific falls prevention work with 3,960 clients;
- Increased benefit take up of older people by £2.2 million
- Helped 2307 older people out of fuel poverty
- Delivered over £11 million of housing maintenance, safety and security, repair and adaptations facilitated and supervised
- In total, helped nearly 4,500 older people to remain living in their own homes and improved the independence of over 6,000 more

3.4 How are these services funded?

A detailed mapping of the funding of RSL and Care & Repair services was outside the scope of this project but the following broad themes emerged and are useful to illustrate the current picture in Wales:

- Most of the services in section 3.2 are funded via local authorities, but this masks some real complexities faced by RSLs. Housing is funded separately to care packages.
- LSVT's provide significant funding towards adaptations without grant funding.
- Some additional funding – such as Supporting People grants and some Rapid Response Adaptations – are provided directly by the Welsh Government.
- Care & Repair Agencies receive a mix of funding including Welsh Government funding for core services and varying amounts of local government, health, R.S.L. and other funding, depending on local set up and governance arrangements
- Mainstream services, including Extra Care and nursing homes, are funded by social services departments.
- The NHS in Wales therefore has limited direct involvement with RSLs and Care & Repair agencies currently.

4 RSL & C&R involvement in health & care services: quantified evidence of public value

In this section, in response to a specific steer from the project board, we present the available *quantified* evidence on the public value of RSL and Care & Repair involvement in health and care services. RSL and Care & Repair involvement in more intensive care and support (e.g., extra care, nursing care) is a relatively recent development in Wales and so the evidence base on these topics is limited. The available evidence is summarized in 4.1.

We therefore also sought out wider evidence that might offer indicators of the potential value of greater RSL and Care & Repair involvement in health services & outcomes. Firstly, there is some powerful evidence available on the public value of prevention in healthcare. Secondly, health policy in England has included encouragement of plurality in health provision for some years now; some evidence is thus available on the value of third sector involvement in health and care services. It is worth noting, however, that much of this publicly available evidence has been produced by parties seeking to promote greater plurality. This additional quantified evidence is summarised in 4.2.

A small sample of key qualitative sources is also provided, where we felt it offered relevant insights. This evidence is discussed in 4.3. Finally we consider what – if any conclusions can be drawn from the available evidence.

4.1 Quantified evidence on current RSL and C&R involvement in health services in Wales

Only a limited amount of quantified evidence of the value of health services delivered by RSLs and Care & Repair is available. This evidence is produced by the provider organisations, and is presented below. It is useful to note at this point that a key barrier to RSLs, C&R and other providers demonstrating cost benefits is the lack of a baseline costs to compare against. Where we have identified example service costs, but no baseline has been available, we include those for potential future use.

Housing standards. The idea that good quality housing is crucial to healthy living is well evidenced and accepted in Wales, and is key to the Welsh Housing Quality Standard. Some recent statistics from one WHQS project reconfirms this position:

- Carmarthenshire’s ‘Feeling Fine through Healthier Homes’ first progress report in Spring 2011 demonstrates some strong correlations between good housing and good health:
 - 21% tenants of unimproved homes reported being treated for depression, compared with 7% of tenants living in improved homes
 - 52% tenants of unimproved homes reported being free from respiratory infections, coughs or colds, compared with 67% of tenants living in improved homes
 - 23% tenants of unimproved homes reported 4+ GP visits in a quarter, compared with 14% of tenants living in improved homes

Adaptations. Adaptations and other preventative services offered by Care & Repair enable frail or disabled people to stay in their own homes, rather than move into specialized (usually more expensive) supervised or medical care.

- Care & Repair Cymru report that:
 - 4472 (14%) of clients said they would have been unable to stay in their own homes without the assistance of Care & Repair, and 6192 stated that their independence had been improved by Care & Repair. Over 64% of Care & Repair services were provided for clients over 75, and 26% of total clients helped were over 85.
 - An annual spend on the Rapid Response Adaptations programme of £2.1m delivered outcomes of 15,529 Rapid Response adaptations (of which 10,560 prevented hospital admission and 4,970 enabled

hospital discharge). They calculate this equates to £7.50 saving to the taxpayer for every £1 invested in Care & Repair.

- Underpinning these reports is a recent paper by Shelter Cymru and the Building Research Establishment (BRE) which estimates that the most serious health hazards in the home cost the NHS in Wales £67 million pa to treat; it also suggests that 20% of homes with the most serious health hazards could be made acceptable for less than £520, and half for less than £1,600. The report also claims that the payback time in total would be c. 22 years, with the payback time for treating some of the most serious hazards shorter: "investment in addressing dangerous stairs, for example, would be paid back in 5.7 years".

Sheltered housing. The total cost of sheltered housing comprise rent, service charge and (often) an element of Supported People funding.

- Clwyd Alyn (Pennaf) example sheltered housing costs: range from £76 a week (£326 pcm) to £117 a week (£500 pcm)

Extra care. Extra care developments comprise self-contained homes with design features and support services available to enable self-care and independent living. Extra care housing is intended to benefit people whose disabilities, frailty or health needs make ordinary housing unsuitable but who do not need or want to move to residential or nursing homes.

- Swansea University has recently conducted an evaluation of extra care on behalf of the Welsh Assembly Government; our understanding is that this report will only be available publicly some time after the election.
- Linc: £110 per week rent, plus £130 per week service charge – total £240 per week
- Pennaf: estimate a difference of £410 on average between an extra care 'bed' and a nursing / residential care bed.

Intermediate care / prevention of delayed transfers of care. Some RSLs, such as Gwalia, have been able to support timely transfers out of hospital for several years. Several RSLs reported that they have provided such support on an ad hoc basis. It was notable in our interviews that several RSLs are currently discussing specific opportunities to dedicate extra care / very sheltered housing units to people leaving hospital.

- Pennaf: estimate that for 6 people they have supported an exit from hospital in the last 12 months, for on average 1 week each, the total cost was £1,920. Estimating the cost of a hospital bed at £225 per day (source: [NHS111](#)), this equates to a cost difference of £7,530.

Nursing care. As residential care is phased out, it is being replaced by a smaller number of specialist nursing and EMI care homes.

- The price per week for nursing care provided ranged from £422 pw (where block booking guaranteed by local authority), to £675 per week for nursing care; to £750 per week for EMI (elderly, mentally ill) care. Laing (2008) calculates the fair market price for nursing care for older people in 2008-09 as £665 per week outside London.
- Hafod Care's business model for nursing homes includes savings on terms and conditions, plus other efficiency gains such as locating day care services in nursing homes and co-location of out of hours care too.
- Providers were keen to emphasize that their prices reflect a high quality of service underpinned by a not-for-profit cost model.

Specialist mental health care and disability residential homes. No quantified data collected.

In their report for the Wales Audit Office, **Lean and Systems Thinking in the Public Sector in Wales**, (2010), Zakaie et al report on a project to improve Disabled Facilities Grants in Neath Port Talbot, for which it was estimated that *"four years' additional independence at home could have been possible for the 159 people who were admitted to residential care at the age of 80, if adaptations had been available earlier"* (p.15) leading to a theoretical saving of £12.57 million.

The **Supporting People Programme in Wales: Final report** (2010) included a review of the cost effectiveness of the Supporting People grant scheme in Wales and similar schemes in England. The review team found consistent evidence that Supporting People saves money by deferring or preventing more costly interventions later down the line – ‘saving’ between £1.68 and £2 for every £1 spent.

The review panel also highlighted an innovative project in Brent where supporting people funds were used to improve delays in hospital discharges:

“For a relatively small investment (£40,600 in 2007-08), this support service proved to be an efficient and effective service. For example it:

- *Freed up expensive hospital beds by facilitating the timely discharge of older people from hospital and reduced readmissions i.e. the revolving door is partially closed. Based on Audit Commission work from 2005 this is calculated to save up to £35k p.a. in reduced DTDC reimbursements;*
- *Diverted people away from (or delays their progression to) residential and nursing care. The Review estimates this saves Brent Council around £388k each year;*
- *Helped to reduce voids in general needs or specialist housing resources, although the data necessary to estimate the level of savings from this was not readily available; and*
- *Achieved sustainable benefits e.g. our sampling work found that 80% of people who it supports remain in a community based placement for at least 2½ or more years after their support ceases or until they die”.*

4.2 Quantified evidence on the public value of prevention

A research base on ‘what works’ in terms of prevention is only slowly emerging, in part because of renewed emphasis on demonstrable cost/benefit of interventions but also owing to numerous methodological challenges (how do you know?).

Allen & Glasby’s 2010 paper, **‘The billion dollar question: embedding prevention in older people’s services – 10 high impact changes’**, offers an authoritative current perspective. They offer an overview of the key opportunities to help older people to maintain their health and welfare:

	erm/more ational
	ip working
	alisation

Allen & Glasby, 2010, p.4

Allen & Glasby’s key findings, gathered from across the latest literature and with relevance to the role of RSLs & C&R in health and care, are:

- Adaptations:

- 1 year's delay to providing an adaptation to an older person's home costs up to £4000 in extra home care hours
- Postponing entry into residential care by one year saves £28,080 per person
- Hospital discharge services can speed up release from hospital, saving c. £120 per day
- Low intensity practical support services had by far the highest impact on health-related quality of life in a 2009 evaluation
- **Telecare:** covers a range of schemes, and not many evaluations yet available. The English Department of Health's Whole Systems Demonstrator programme should however report soon.
 - Benefits reported range from increased autonomy, to ability to remain in home, to a reduced burden on carers and fewer accidents in the home.
 - West Lothian reduced overall costs by £85,837 owing to a rapid response scheme integrated with a 'smart technology' programme.
- **Intermediate care – time-limited services to facilitate discharge or prevent entry to hospital:** Allen & Glasby cite 2 national evaluations which show mixed results so far, despite the logic and promise of intermediate care. In summary:
 - Intermediate care's strength is as a bridge – between home / hospital, illness / health, sectors – and there is evidence it *can* make a significant difference
 - However there is work still to do to overcome fragmentation – particularly shifting focus from service provision to the whole system, and more accurately identifying the people who should benefit
- **Re-ablement:**
 - One review showed that a re-ablement process reduced the need for home care by 28% [however the length of time for which that level of ability was maintained was not measured]
 - Norfolk First Support reduced care hours for those going on to longer term care by 90%; 25% of users completing the course required no further care
 - However, c. 25% do not complete re-ablement, and evidence on the long-term implications of re-ablement still emerging

Interestingly, Allen & Glasby also note that the idea of health and social care collaboration leading to an earlier and more holistic response to need "remains almost entirely a matter of faith at present". They note that the idea has merit, but highlight the need to have practical ways of extracting potential cost savings in practice. (This is a barrier common to preventative work across the public sphere).

The Telecare Services Association [website](#) quotes a 2010 **Newhaven Research** evaluation of the Telecare Development Programme in Scotland. The research claims:

- *"The estimated value of efficiency savings topped £11 million in 2008/9, against an expenditure of £1.645 million.*
- *The total estimated efficiency savings from 2006 to 2009 totalled £23.18 million, against an expenditure of £7.347 million.*
- *For individuals in receipt of telecare, reductions in unplanned hospital and care home admissions, together with significant increases in the number of individuals able to maintain themselves at home, made a real difference to quality of life".*

In Money well spent - The effectiveness and value of housing adaptations (Joseph Rowntree Foundation, 2001). Heywood concludes that "minor adaptations are a highly effective use of money" with a positive impact on the health of 77% of people in her study.

Priebe et al (2009), **'Housing services for people with mental disorders in England: patient characteristics, care provision and costs'**, report findings of a national survey on all types of services for people with mental disorders. Findings of particular interest include:

68% of people surveyed had previous experience of housing services

- Care provision and costs differed significantly between care homes, supported housing services and floating support services
- Mean charge per week varied significantly across the service types:
 - Care homes the most expensive (£474)
 - floating support the least (£147).
- Overall weekly costs of non-housing services (i.e. not funded from the weekly charge) on average are £97, with the highest mean for people in supported housing and lowest for those with floating support.
- When the housing service charges and non-housing service costs were summed, mean total cost across the full sample was £430, highest in care homes (£542) and lowest for people with floating support (£202).

The authors highlight that differences between types of housing services, although statistically significant, are not clear cut – and so the report does not offer any conclusions of costs compared with service levels.

Finally, they offer an interesting concluding recommendation – that greater clarity is required on what care different types of housing services [in England] provide so that patients and referring clinicians know what to expect from such services.

In **'Costs and outcomes of an extra care housing scheme in England'**, Baumker et al (2010) present findings of a detailed evaluation of an extra care scheme in Bradford. Their study revealed that:

- Overall, costs rose as a result of moving into the extra-care housing scheme. However, the residents also experienced better social care outcomes and quality of life.
- On average, it cost £380 per person per week before moving into the extra care scheme, compared with £470 after moving (£360 of which fell to the public sector).

In **'Calculating the costs of efficient care homes'**, Laing (2008) estimates fair market fees for operating a modern, efficient care home outside London in 2008-09 were:

- £665 per week for nursing care (all categories of older people)
- £538 for the personal care of frail older people, and
- £566 for those with dementia.
- He also recommends a maximum weekly difference of £74–£76 between 'ceiling' and 'floor' rates.

The NHS Alliance's 2008 report on **'Social enterprise, not-for-profit and the NHS'** highlights a number of the new social enterprises delivering healthcare services. Examples include SCA Trafalgar Dentistry, City Health Care Partnership, Your Healthcare and Central Surrey Health. In the main, these services are too new for useful evaluation data to be available. However the report includes a case study of Central Surrey Health, one of the first NHS social enterprises. Its 650 staff were previously employed by the PCT and now deliver community nursing and therapy services to Central Surrey's 280,000 population as a commissioned provider. The report claims that "the move has allowed the organisation to develop innovation. For example, a telemedicine service to support patients with COPD has succeeded in reducing admissions by 32%".

In **"The cost-effectiveness of community care for adults with learning disabilities leaving long-stay hospital in Northern Ireland"**, Beecham et al followed a cohort of people discharged from seven long-stay hospitals in Northern Ireland. Although nearly three-quarters of the sample were living in private sector residential or nursing homes, a six-fold variation in the total costs of support was found. However, at the mean, community care was less expensive than hospital care. For only ten people in our sample of 192 clients did the costs of community care exceed the average cost of long-stay inpatient care. Multivariate analysis revealed that the costs of community care 'packages' were linked to some client needs, but higher spending was not unequivocally associated with better client outcomes.

Lastly, in 2006, Patricia Hewitt – then Secretary of State for Health – issued a pamphlet on **'Social Enterprise in Health and Social Care'**. The aim of the pamphlet was to promote not-for-profit delivery of health and care services in England and in it, Hewitt:

- Makes the case for the operational capacity the third sector can bring, citing “the passion and commitment it generates in staff, and its capacity for innovation and rapid change... [and] a stronger voice both for the users of services and the staff that deliver them”.
- Profiles Sandwell Community Caring Trust, which reduced the average cost of a place in a residential care home from £452 to £328 per week, “without sacrificing quality or staff pay and conditions”

4.3 Wider qualitative evidence

In seeking out quantified information on the public value of housing and other third sector participation in healthcare in the UK, we uncovered a small number of reports emphasising qualitative evidence of interest.

In a 2010 King’s Fund paper, **‘Avoiding hospital admissions, What does the research evidence say?’**, Purdy offers a cool analysis of the evidence to date. Of particular relevance:

- Integrating health and social care may be effective in reducing admissions.
- Integrating primary and secondary care can be effective in reducing admissions.
- Telemedicine seems to be effective for patients with heart failure, but there is little evidence that it is effective for other conditions.
- Hospital at home produces similar outcomes to inpatient care, at a similar cost.
- Case management in the community and in hospital is not effective in reducing generic admissions.
- Developing a personalised health care programme for people seen in medical outpatients and frequently admitted can reduce re-admissions.
- Structured discharge planning is effective in reducing future re-admissions.

In their final (2009) report, the **Housing for Our Ageing Population: Panel for Innovation** in England present a range of exciting and innovative models from across Europe for older people’s housing in response to the question, ‘what further reform is needed to ensure that new build specialized housing meets the needs and aspirations of the older people of the future?’ The report focuses on accommodation both for *“the 11% of over-65s currently living in nursing care or retirement housing, but the majority of this age group, who will not move in later life and whose independence and well-being could be improved by appropriate housing”*. The Housing LIN (Learning and Improvement Network) present a similar range of models in their report **‘Homes for Old Age: Independent Living by Design’** (2009).

The National Housing Federation’s pamphlet, **‘Invest in housing. Invest in health’** (2011) highlights a range of health benefits delivered by RSLs and health partners in England, including early discharges, promoting independent living and preventing accidents. In **‘Breaking the Mould, Re-visioning Older People’s Housing’** (2011), the National Housing Federation again attempts to set out an alternative view on the future of housing, care and support for older people. In this publication, they argue that housing associations should be creative and take some (calculated) risks to achieve such benefits as:

- Providing a better range of housing for older people
- Reducing expenditure on adaptations
- Freeing-up of family-sized stock
- Reducing demand on care and support services
- Achieving a better quality of life for older owner occupiers as well as tenants

In the 2007 Joseph Rowntree Foundation report **‘How can funding of long-term care adapt for an ageing population?’**, Collins asserts that the current long-term UK funding model is unfair, not clear and unlikely to be sustainable in future. She proposes instead

- more sustainable methods of funding, including equity release, higher capital limits for care home fees, the doubling of the personal expenses allowance, free personal care for more people in nursing homes, and payment by the State of a fixed percentage of all care costs;
- practice innovations including a co-payments/social insurance scheme and a loan stock/bonds scheme.

Croucher et al (2007), in '**Comparative evaluation of models of housing with care for later life**' note that "the evidence base for housing with care is relatively limited. Evaluations have usually focused on single schemes (e.g. Croucher *et al.*, 2003; Bernard *et al.*, 2004) or on the provision of one provider organisation (e.g. Valleley *et al.*, 2006)". They also concluded that:

- Currently [2007] there is no single dominant model that works best, although those schemes participating in this study with an on-site or linked residential care facility came closest to providing a 'home for life'.
- Larger schemes appeared to offer some advantages to residents with regard to social networks, activities and additional amenities and resources that might not be viable in smaller schemes.
- From the perspective of residents, no single model appeared to be more greatly favoured or to generate lesser or greater levels of satisfaction
- The housing element of housing with care is not secondary, nor should housing need be a secondary consideration in the allocation of places.
- In a number of schemes there were apparent 'service gaps'... some of the oldest and frailest residents, particularly those without the support of close family, may struggle to meet providers' expectations of independence.
- Moreover, the levels of funding available from Supporting People grants do not always appear to be adequate to cover a wide range of support needs, particularly around social activities and engagement.
- One of the biggest challenges for providers is to keep pace with the changing needs of residents. In-house co-ordination of provision appeared to provide the greatest flexibility in response to changing needs
- New schemes may need to make convincing cases locally that housing with care offers value for money in order to attract capital and revenue investment. It may be argued that housing with care plays a preventative role by supporting older people's independence, as well as preventing hospital admissions, facilitating early discharge from hospital and delaying/preventing admission to long-term care. The wider range of benefits to residents, including the impacts on national objectives such as independence, well-being and choice, should also be considered.

4.4 A note on cost benefits

Any comparison of costs across the spectrum of housing and care available to older people must be undertaken – and treated - with caution. The services are intended to meet different ranges of need; secondly, we have not found any detailed modeling of the flow of people through these services and therefore of prevention/delay 'savings' (i.e., how many people could be prevented from entering more expensive provision through additional care closer to home). Thirdly, claims to savings made in the literature are not always cashable savings – and rarely accrue to the organisation that is investing in the preventative measure.

4.5 What can be concluded?

The evidence above seems to suggest real value can be derived through investment in preventative services and services closer to home for older people. The case is however not yet proven in terms of cost benefits, both owing to the relative newness of many schemes, and owing to the lack of baseline and comparative data. The cost-benefit evidence that is available seems positive, but is limited.

Going forward, each opportunity must clearly be fully assessed in its own context. Given the financial and demographic pressures on public services, the opportunity cost of *not* innovating should also be explicitly considered.

5 Barriers to realising opportunities

Typically, interviewees spent a significant portion of interviews discussing the difficulties of working across the health-housing divide, before moving onto ideas for closer joint working. Here, we present the key issues that were repeatedly raised.

5.1 An uneven relationship

RSLs and some Care & Repair agencies report that building relationships with NHS partners can be difficult. They see the main causes as the traditional NHS focus on acute / secondary care plus the impact of the recent NHS reorganisation, which has absorbed NHS managers' energy where they have remained in post, but which has also resulted in a large number of new appointments.

As smaller organisations, RSLs and Care & Repair also say that the relationship with the NHS feels 'uneven' to them - "health only talk to us when they want something from us, for their agenda" - and they would like to feel more equal partners in a joint pursuit of better outcomes for their communities. Interviewees highlighted some structural reasons for this mismatch: NHS Boards are much bigger than RSLs and Care & Repair agencies; boundaries are not aligned; and each sector is completely separately funded. RSLs and Care & Repair agencies also feel that their potential and actual value to the health agenda is not fully appreciated.

NHS colleagues acknowledge that partnership with the housing sector struggles to compete with day-to-day priorities. NHS managers have to deliver tough in-year budget reductions - a huge job, which some feel external partners do not truly appreciate. In terms of the improvement agenda, integration with social services is the main priority, and is complex in itself. RSLs and C&R agencies are broadly positively viewed, but their 'offer' to Boards is unclear; one interviewee commented that he was regularly approached "at conferences and so on" and could see the logic of closer working with RSLs but wasn't clear on specifically what they would do together. Finally, our interviewees from the NHS felt there was no clear signal from the top of the NHS either politically or from executive leaders on partnerships with the housing sector.

5.2 Some current partnerships at risk

Some interviewees highlighted that existing partnership arrangements with the NHS are at risk. For example:

- Newport City Homes has inherited a telecare service following stock transfer; 2 years later, statutory partners are reluctant to continue funding (both the Council and NHS)
- In some extra care schemes, medical care is currently provided by the local health board; several interviewees were concerned that this care might be suddenly withdrawn owing to budgetary pressures elsewhere in the NHS

A number of RSLs have previous experience of early NHS enthusiasm for a project waning or disappearing (along with resources); these experiences underpin some managers feelings about the current state of relationships with NHS partners.

5.3 Silo provision

Interview discussions revealed the clear impact of current policy, service and funding structures. Health, housing and care have become separate policy objectives, underpinned by separate funding streams and accountability structures. One interviewee pinpointed a symbolic gap for him: "there are no NHS targets around preventing people entering into acute care". That this separation is artificial is widely acknowledged, and reintegration around need is emerging as the desired ambition - see 'Setting the Direction' - but work to realise this ambition is in very early stages.

For example, the current structure of funding separates health, care and housing 'sectors' and separates types of provision within sectors. Sheltered housing, extra care, nursing homes, day care and domiciliary care all attract different core funding, and attempts to work jointly (for example by placing an NHS team in an Extra Care facility) require a lot of managerial work to get authorised. The current funding approach particularly seem to mitigate against mixed or 'hybrid' provision. (E.g., Extra Care funding provided in a wave several years after a wave of sheltered housing funding).

A number of RSL interviewees said they spend a lot of time 'knitting together' budgets to cover needs, and some end up running a deficit to cover the costs of those residents who end up not qualifying for the anticipated benefits. The removal of wardens from some schemes is a result of trying to manage this patchwork of budgets.

5.4 Silo languages and cultures

The terminology used in each sector reflects the different funding and policy roots from which services have emerged. For example, 'housing support' carries a whole different set of assumptions and knowledge to 'care'. There have been recent attempts to bridge this gap – such as describing sheltered housing as category 1 and 2, and extra care then as 'category 2½', with nursing care as level 3 - illustrating the cultural challenge to be overcome. This leads to conversations which can be frustrating for both sides.

Professionals on both sides are steeped in the practices and experience of their sectors too. For example, one NHS interviewee acknowledged that typical clinical attitudes can be over protective, creating well-meaning but unproductive resistance to re-ablement and community treatment. Unpacking language and assumptions - and holding conversations that result in both sides taking away the same understanding – can however take time.

5.5 Procurement challenges

Where the NHS commissions directly from RSLs, spot purchasing of beds / units is the norm. While understandable when thinking about annual budget limits, RSL interviewees argue that spot purchasing limits the investment RSLs can make in new and existing schemes. Providers also of course include the cost of risk in prices offered.

Some interviewees see a 'lack of maturity' in commissioning underpinning the preference for spot purchasing, and would prefer to move to a stronger partnership model. Specifically:

- There is a perceived constraint in procurement regulations: NHS managers feel they cannot consult with providers prior to a procurement exercise, even if the proposal is only at concept stage – or that provider may not be able to compete for the resulting contract. There is confusion as to whether these procurement regulations apply to third sector bodies.
- Some RSLs and Care & Repair Cymru are concerned that local authority procurement consortia in particular are becoming cost- rather than value- focused (exacerbated by weak commissioning skills in some areas)

Our reflection is that strong relationships are not (yet) in place between most NHS Boards and RSLs, which would give NHS managers the confidence to move to multi-year commissioning should that prove to be valuable.

A related specific issue emerged too: there is no clear guidance for the NHS on how they can transfer properties which are no longer needed to other state or third sector services. Currently, the only 'safe' option is to sell on the open market. This was flagged as potential opportunity missed.

5.6 Pressure on Extra Care?

A number of interviewees highlighted a concern that there may soon be over-provision of extra care units. The availability of capital funding encouraged lots of organisations to diversify into Extra Care at the same time, but Extra Care is relatively an expensive option both for statutory funder and for individuals and so take up may be less than originally predicted.

Interviewees report that some extra care schemes are under pressure to accept more and more frail elderly people; for maximum benefit, however, extra care schemes are expected to be home to people with a range of care needs (“ $\frac{1}{3}$, $\frac{1}{3}$, $\frac{1}{3}$ ”) if social benefits are to be realized. As one interviewee commented, “they shouldn’t be seen simply as an alternative to hospital”. Extra Care schemes in other areas face the risk of lower demand: because Extra Care is expensive, some commissioners are cautious when deciding on placements. One RSL reports that involvement of the local authority in the panel responsible for making placements results in delays to decisions – the cost implications of which are then included in the unit price offered!

Two interviewees raised a concern for the reputation of the sector if / when an Extra Care scheme fails.

5.7 A need for hard evidence

As the findings of this study illustrate, there is little hard evidence available on the value of integrated or joint working between housing, health and social care in Wales. The gap is currently filled mainly by qualitative and anecdotal evidence around the experience of residents of new schemes, which is powerful but not complete. A desire for evidence was mentioned in a number of interviews, to make the case for greater joint working.

6 Opportunities to increase public value

RSLs offer a combination of characteristics that may be attractive to the NHS as they seek to implement the vision articulated in 'Setting the Direction': they are third sector partners, closely tied to their communities; they can raise capital on the markets; and they have expertise in building and managing public assets. Care & Repair agencies offer similar trusted access to vulnerable people.

Five key opportunities to increase public value through service integration between the NHS, RSLs and Care & Repair agencies emerged through our interviews. These opportunities are relevant for all areas of Wales, and are presented in 6.1. Further opportunities with more specific application were also raised; these are presented in 6.2.

All the opportunities discussed here seem to offer the potential of supporting better outcomes for citizens, potentially at reduced cost to the public purse. Each opportunity must of course be fully scoped and explored prior to adoption. These opportunities also sit alongside ongoing joint working on health education and prevention.

6.1 Five key opportunities

All five key opportunities relate to prevention/delay of admission to hospital or effective discharge. The first - assisting discharge - is the most immediate opportunity, and the fifth - older people's communities - is the most radical. Each opportunity stands in its own right, but may offer most benefit as key elements of integrated pathways for frail older people which overcome artificial barriers between housing, care and health.

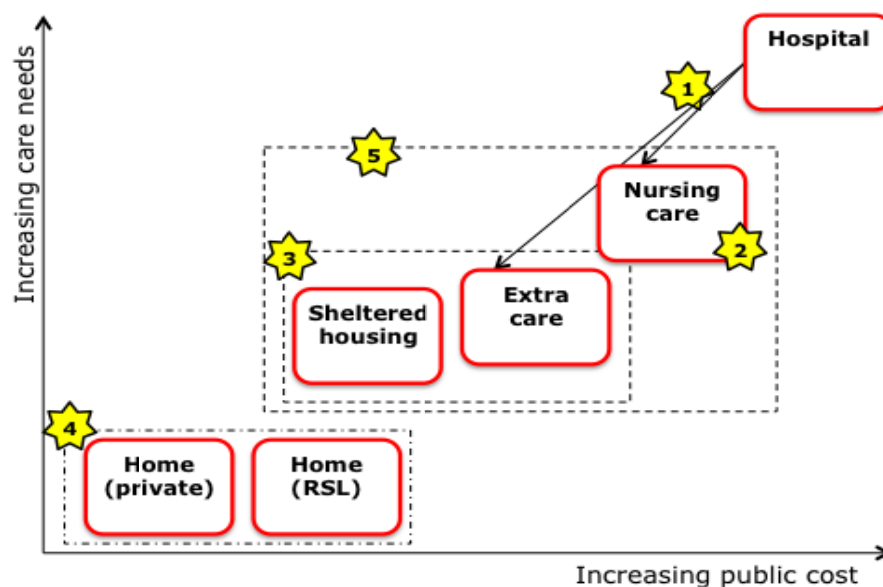






Diagram: five key opportunities



6.2 Early discharge support in Extra Care schemes & nursing homes

Extra Care schemes and RSL nursing homes located near district general hospitals may offer a cost

	<p>effective option for high quality care to enable earlier hospital discharges of frail older people.</p> <p>RSLs in at least three areas are in active talks to create or consolidate such services. Others are interested but conversations have not yet been held. To date, most such bookings have tended to be ad hoc and involve a handful of beds; during our interviews, just one RSL confirmed they had a block booking arrangement for a small number of beds. Other RSLs are keen to explore the possibility of annualised block bookings for planning and cost reasons. Some Health Boards are however wary of block booking, wanting to retain maximum financial flexibility.</p> <p>The partnership arrangement to support this form of early discharge will depend on the scheme involved. Nursing homes have existing trained healthcare capacity, and arrangements with local GPs; there is scope to upskill staff in Extra Care schemes to some degree – but location of NHS staff onsite may be preferred.</p> <p>One important challenge identified through our interviews is for any agreement with Extra Care schemes to be well communicated to the operational staff making discharge arrangements in order for the option to be taken up.</p>
	<p>6.3 Expanding not-for-profit nursing care</p> <p>Hafod Care, Linc and Pennaf are three RSLs that have made the strategic shift to make ‘care’ part of their core offer alongside housing. All three offer nursing care, aiming for a mid-market price – aiming cheaper than publicly provided services but maintaining quality standards.</p> <p>Such nursing homes can form the hub for a range of other services. For example, day care is offered from several homes (if the residents are content); they can also host other teams such as out-of-hours teams; Hafod Care is exploring the possibility of hosting continuing care joint assessments in one home.</p> <p>Not-for-profit nursing / EMI care may be of particular interest to NHS Wales, given predictions of increased need evident in local health, social care and wellbeing strategies and given the Welsh government’s ongoing commitment “placing public interest above private profit” (Welsh Labour Manifesto 2011, p.21). One interviewee commented that the risk of private providers ‘going bust’ makes not-for-profit providers more attractive; not all NHS interviewees in our study were however aware of the availability of not-for-profit nursing care.</p> <p>The opportunity for RSLs to offer nursing care across Wales seems significant; yet the move into a highly regulated service area can be daunting and many RSLs may decide to remain focused on their core housing mission. For those already committed to nursing care, and for those considering the move, clarity about potential demand is welcome. (One NHS interviewee highlighted that speculative building of nursing home provision is unhelpful too).</p>
	<p>6.4 Increasing the level of care in sheltered housing and in Extra Care</p> <p>A number of RSL interviewees, particularly those who do not offer Extra Care, said their organisations would like to offer a wider range of care within the sheltered housing (SH) setting. Most immediately, they would like to be able to support residents to stay in their SH homes for as long as possible, as they become more frail.</p> <p>A number of interviewees observed that in reality few people move from sheltered housing to extra care; anecdotally, people move from their own homes (whether private or rented) either to sheltered accommodation or extra care, and move in and out of hospital from that base; few move from sheltered housing to residential or nursing care. If borne out by evidence, this points to the need for overlapping ranges of care to be available across all housing settings. Enabling sheltered housing schemes to cope with</p>

	<p>greater levels of frailty could meet people's preference for staying at home, for couples to stay together, and reduce the risk of institutionalization in a nursing home.</p> <p>For example, RCT Homes see this option as reasonably quick to deliver as it would not depend on a new build; they estimate that 40 of their existing sheltered housing units, across 3 schemes, could be used for more frail residents. Gwalia has formed the Habren partnership with the University of Glamorgan to develop innovative support services for people with dementia and their families.</p> <p>Interviewees anticipate that residents of Extra Care schemes will become increasingly frail too, and reluctant to move from what are now their homes. Bringing additional (continuing) healthcare into these schemes may help prevent admissions to hospital and provide a community base for other services.</p> <p>Underpinning proposals to increase the level of care offered in RSL accommodation is the idea of training RSL staff to be better able to support professional health workers. Ideas suggested in interviews included training up technical staff to Occupational Therapist assistant level and for others potentially to be able to provide care support. These staff would work in NHS led mixed teams.</p>
<p></p>	<p>6.5 Ongoing support to enable older people to live more independently and healthier at home</p> <p>The value of investment in services that enable people to live at home longer has been recognised by the Welsh Government, most recently in the form of a £4.77 million package (plus £2.1m for the Rapid Response Adaptations Programme, and £1.5m for Independent Living Grants) awarded directly to Care & Repair in Wales for 2011-12.</p> <p>The trusted access that Care & Repair agencies have into older people's homes can be used as a channel for other forms of support too. For example in Monmouthshire, the Healthy Homes project has seen the initial assessment expanded to a more holistic case assessment, supporting older people to access additional care support, benefits etc. This has been highlighted as good practice within the Gwent Frailty project but as a classic 'cinderella service' is now at risk of losing funding. The Hospital to Home projects in Conwy & Caerphilly offer similar support, but targets people before they leave hospital.</p> <p>The key opportunities to support older people to live healthier at home via Care & Repair breaks down into three parts:</p> <ol style="list-style-type: none"> 1. Increasing the current rapid response adaptation programme (RRAP) to meet demand; 2. Expanding RRAP to all tenure, from its focus on private housing; 3. Expanding the programme to have a wider preventative purpose, building on models such as the Monmouthshire Healthy Homes and hospital to home type schemes – as well as specific support to dementia sufferers. <p>All these opportunities should save / delay NHS spend on frail older people and – more importantly – improve people's lives. A recognised challenge is that such preventative work requires investment alongside ongoing increasing demand for acute care.</p>
<p></p>	<p>6.6 Mutual continuing care 'villages'</p> <p>Ideally, people should be able to access a full range of care as they need it, close to where they live. Their experience of graduated housing, support and healthcare should be integrated around their needs and not shaped by administrative silos.</p> <p>Some working models for such schemes exist, both in the UK and in Europe – for example, Joseph Rowntree Housing Trust's Hartrigg Oaks in York, which includes 152 bungalows and a 42 bed nursing home. Access to</p>

	<p>care is assured via an insurance like scheme, whereby residents pay a fixed annual charge covering 3 hours a day of home care and all care costs for those who move into full time nursing care. (Case study provided in the English 'Housing for our Ageing Population: Panel for Innovation' report).</p> <p>The Cooperative Party's New Foundations report cited in the Welsh Labour manifesto argues that mutual models offer the only route to affordable provision of this type (and more general housing) in the new economic climate, enabling those with even small amounts of equity to participate.</p> <p>We have noted during this research that there is very little debate about this more ambitious type of scheme. Yet current and projected demand suggests that we need to do more than respond to immediate pressures. This is an argument – and a model - passionately supported by Dr Chris Jones, author of 'Setting the Direction'.</p> <p>A key opportunity is therefore to pilot a mutual continuing care village. Some Government / NHS support to a pilot might be justified on the basis of both developing a model for later replication, and in signaling commitment. Such a pilot would involve a range of partners from at least housing, health, social services and the Welsh Government.</p>
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6.7 Further opportunities

Some further opportunities were highlighted during interviews. These opportunities have equal potential, but may not have pan-Wales application.

Mental health provision

Mental health care is acknowledged to be a specialist field, but one that some RSLs feel competent to enter. The need for increased housing / care provision in Wales is well documented – for example in the Wales Audit Office report of November 2010.

An immediate opportunity for collaboration is in the repatriation of mental health patients back to local facilities. Health Boards in Wales are currently funding very expensive placements – some up to £250,000 a year – elsewhere in the UK because appropriate accommodation is not available locally.

Action is already underway in one region. Gwalia is currently scoping the potential for a low-secure mental health unit to be located in Cardiff (and to be run in partnership with a London based housing association). The availability of such a unit will mean that users currently placed out of county – often in Bristol – can be located closer to home, in a not for profit service. Cost calculations are not yet available, but significant savings are anticipated.

A number of other RSLs also provide some residential facilities for people with mental health needs (8 confirmed in our survey – see 3.2). There may thus be an opportunity to replicate the Gwalia initiative in north Wales.

Expanding (protecting) telecare

Several RSL interviewees highlighted their interest in increasing the provision of telecare to residents across their stock. Telecare varies from scheme to scheme, but generally involves a community alarm service and regular contact by telephone. Further technology may be included such as detectors which monitor motion, falls or fire and gas risks. When activated, these technologies then trigger action by a response centre.

Some current telecare schemes are at risk because they are not statutory and are voluntarily funded by local authorities. Newport City Homes (NCH) highlight that their scheme supports hundreds of vulnerable people in the city, both their own residents and people in private housing. As a recent stock transfer organisation, NCH was pleased to inherit operational responsibility for the scheme but cannot afford to finance the scheme. Discussions with Newport City Council suggest they also may not be able to fund telecare in the next few years.

Some RSL interviewees point out that should telecare be removed, there is likely to be an immediate cost implication for the NHS – for example, owing to an increase in severity of need following a fall at home. Can continuing care funding, therefore, be used to cover telecare support?

NHS facilities build & management

The potential role of RSLs as a partner bringing borrowing capacity is of clear interest to health boards needing to build new facilities in the next five years. A number of RSLs – but not all – are interested in acting as facilities partners to NHS Boards.

One obvious opportunity is staff accommodation. A significant proportion of NHS staff, such as nurses, junior doctors and peripatetic staff require short to medium term accommodation at some point in their careers. Some of this stock needs to be replaced, and some Boards are deciding that provision of staff accommodation is a non-core activity and that any new provision will be bought in. While traditionally this would mean a new build on NHS property, different options can be considered. For example:

- Aneurin Bevan Health Board has decided that the accommodation element of a proposed specialist community care centre will be commissioned;
- Betsi Cadwaladr Health Board is considering options for a former mental health hospital in Denbighshire.

Further opportunities may include, for example, an RSL partner taking responsibility for the build of a whole community services project – or conversely, an NHS Board funding the building of a community service hub within a housing scheme. Early exploratory conversations are crucial for any such opportunities to develop. There is some confusion however as to whether the NHS can partner with RSLs or other third sector partners outside formal competition and procurement regulations. Interviewees both from the NHS and RSLs agree that clarity on the competitive position of RSLs (are they subject to EU procurement rules or not?) would make discussions between them much easier.

7 Realising the opportunities: ideas for policy-level action

This study was commissioned because RSLs and Care & Repair agencies are struggling to make progress towards the opportunities outlined in the previous chapter. This study has established that these are opportunities that offer real *potential* to improve outcomes and efficiency through closer joint service delivery between them, NHS Boards and local authorities. We have however also identified a range of barriers to realising those opportunities. In this chapter, we suggest some ideas for policy-level action to break through those barriers.

7.1 Giving a strategic signal

Perhaps most importantly, NHS Boards and executive teams need to be confident that any partnership involving RSLs or C&R agencies fits within the NHS' strategy. While our research suggests that there is a clear fit, interviewees feel the matter is less clear:

- Such strong emphasis is being put on health and social services integration that integration work is progressing to the exclusion of other partners;
- In some areas, initiatives exploring the merger of social services are pulling in a different direction – but again to the exclusion of localized integration;
- The Government's quiet dropping of the not-for-profit nursing homes commitment from its previous manifesto has been noted; absences can speak as loudly as pro-active statements at times.

One suggestion for the format of a strategic signal is the development of an accord between NHS Wales, [social services] and the housing sector. This will provide health boards with the assurance that closer partnership with RSLs and C&R agencies is in line with policy. While key Ministers have encouraged health and housing collaboration, the lack of an accord or concordat similar to that with the trade unions - in combination with a raft of practical barriers to greater cooperation - has sent a less positive message.

A second suggestion, emerging from the RSL sector, is for Health, Social Care and Wellbeing (HSCWB) partnerships to be encouraged (or mandated) to include housing partners in the development and delivery of their plans. In many areas, RSLs are already active partners in relevant partnerships, including HSCWB partnerships; in other areas, RSLs are frustrated that they cannot get involved.

7.2 Facilitated opportunity conferences

A major barrier to practical discussions is simply that managers in the housing and health sectors approach similar issues with different professional lenses, and with their own languages. What appears simple or clear to one side can be missed or misinterpreted by the other. And when each side is under pressure and has little time, this can result in good opportunities being missed.

A second major barrier is a limited set of strong direct relationships between health and housing professionals. NHS reorganisation has resulted in new structures, divisions of responsibilities and new faces. Many RSLs and C&R agencies have also only just begun to seek to build relationships within the NHS over the last few years.

A practical mechanism for overcoming these barriers may be a short series of facilitated opportunity conferences, bringing together health, housing and social services executives in the same region to consider specific opportunities. Preparatory work will be crucial, as each conference should consider potential opportunities with data on demand, costs and benefits on the table. In this way, however, some rapid progress may be possible. Community Housing Cymru might consider running the conferences; endorsement by the Welsh Government Departments of Health and Housing may assist in getting people to the table.

A similar type of discussion has recently been brokered in the Swansea region by Professor Michael Williams. Any future opportunity conference would benefit by learning from this experience.

7.3 Clarity on procurement and state aid policy

Interviewees in our study offered varying interpretations on whether public services can engage RSLs outside procurement regulations. Some were clear that RSLs must compete in the open market, others firm that they did not need to. NHS interviewees were not sure, and were wary of holding early exploratory conversations with RSLs in case such discussion prejudiced any later procurement competition.

According to CECODHAS Housing Europe, a change in the Commission's working document on state aid should exempt RSLs from state aid regulations in future:

"Social housing provision in Europe encompasses development, renting/selling and maintenance of dwellings at affordable prices as well as their allocation and management, which may also include the management of housing estates and neighbourhoods. Increasingly, management of social housing can encompass social aspects: for example, care services are

- *involved in housing or rehousing programmes for specific groups or in debt-management for low-income households. In most cases, however, specific care institutions cover the care*
- *component and collaborate with social housing providers".*

Legal advice on the implications of this development for RSLs in Wales would be welcomed, including any implications in terms of standard procurement.

7.4 A fixed-term health & housing lead in the Welsh Government

Joining up services in the field can be greatly facilitated by close support from the Welsh Government, particularly by making the connections internally across departments. Working links are improving between Welsh Government departments, and there is an appetite for improving these further.

One interviewee highlighted the appointment of a dedicated homelessness nurse in the Department of Health as a potential model. An alternative interesting model is the Social Entrepreneur in Residence programme, pioneered in the UK by the Young Foundation. In NHS Birmingham East & North, for example, a proven social entrepreneur was embedded to identify and drive through innovative projects, using operating capacity outside as well as inside the Trust. An equivalent fixed-term position within the Department for Health & Social Services, or one of the seven Health Boards, with an explicit remit to consider opportunities with housing partners (of all types) may be worth consideration.

7.5 Involve housing partners in the design and piloting of community service models

Future models of community services will include a far greater range of services than are currently provided in the community setting. The majority of this work will rightly be led by NHS and social services partners. Involvement of community housing partners – including both RSLs and Care & Repair – at key stages might be helpful in:

1. Extending clinical pathways for key groups, such as those with dementia or chronic conditions, to cover care in the home. Equally, RSLs and Care & Repair hold useful intelligence, for example on falls and accident prevention in the home, which could be useful to key clinics;
2. Identifying cost effective locations close to target communities;

3. Financing and building community hubs.

This work could be overseen by the New Models of Service Delivery group of the Welsh Government's Efficiency & Innovation Board, to encourage multi-partner involvement.

7.6 Detailed information on 'who does what'

Interviewees from RSLs and Care & Repair feel that NHS Wales managers and staff do not understand fully what their organisations do, and the health benefits they help to deliver. NHS interviewees, similarly, feel they do not really understand RSLs' and Care & Repair 'service offering' – or that they are clear on the range of services they might commission from them. Nonetheless, interviewees on both sides feel that there is potentially real value to be realised for patients and residents if the two could work more closely.

Fuzzy goodwill needs to be translated into a more in-depth mutual understanding. A further practical action would be to create a short guide and 'who's who' for the RSL, C&R and NHS sectors. Social services contacts could also be included.

7.7 Longer term policy interventions for consideration

A range of further ideas to free up the housing, health and social services sectors to collaborate more freely and creatively were suggested during this study. Some may take longer to implement, but could still have important benefits.

- Reduce / simplify the volume of policies and strategies, regulations and guidance that have to be taken into account by RSLs
- Remove the funding silos that result in sheltered housing, extra care and nursing home schemes being built separately: can funding for older people be pooled for example?
- Enable local authorities and NHS Wales to move away from spot purchasing to more strategic commissioning of all home-based care by developing high quality service levels (avoiding a rush to the bottom) and indicators – based on clear values
- Encourage block purchasing to drive down unit costs, and so (partly) mitigate potential reductions in housing benefit
- Provide a model or guidance for pooled resources, to underpin operational partnerships between NHS Wales, local authorities, RSLs and Care & Repair. Gwalia, for example, would find this useful for the proposed Dementia Centre for Excellence.

7.8 Further research and evidence

This study has drawn together current publicly-available, quantified evidence on the public value of RSL and C&R involvement in health-related services, on preventative models, and on a range of third sector health service delivery models (see chapter 4). The evidence from within Wales is particularly sparse.

The NHS has a strong philosophy of invest to save. Specific detailed research in 'invest to save' terms on the value of partnership delivery with RSLs and C&R (and other third sector partners) may help to plug this evidence gap. It may require the explicit quantification of the costs and benefits of services currently delivered within the NHS as a baseline / comparator for third sector delivery.

7.9 Concluding remarks

All the ideas for action presented here should help operational managers and executives in the NHS, housing associations, social services and Care & Repair agencies to explore the practical opportunities put forward in chapter 6. We believe

they are all opportunities which can result in integration of services around citizen needs, enabling both prevention of crises and earlier intervention when problems do arise – and which hold the promise of better value for public money too.

We recommend that the first 3 ideas in particular – giving a strategic signal, facilitated opportunity conferences and clarity on procurement and state aid policy – are tabled at the Ministerial summit planned for July 2011.