Reconnecting housing, health and care through housing interventions

Foundations Seminar Programme

Introduction and Welcome

Chris Pratt, Foundations

How low-level housing-related services contribute to the DH preventative agenda

Clare Skidmore, Housing LIN,
Department of Health Care Networks

Some Facts and Figures

- 90% of older people live in ordinary housing, whether rented or owned
- 67% of older people were owner-occupiers in 2005
- Disabled people are twice as likely as non-disabled people to be social housing tenants
- In 2004, 3m older households lived in non-decent homes
- Every year around 20,000 more older people die in the winter months than in other months
- People aged over 65 spend over 80% of their time at home. Both contact with neighbours, and the number of trips made outside the home, tends to decline with age
- In 2006, 1.5m individuals reported having a medical condition or disability that required specially adapted accommodation
- Research suggests that while most older people would prefer to continue living in their existing home, the most common reason for those people who were considering a move was that their home was inappropriately adapted for their (often progressive) mobility difficulties or health problems (Scottish Government 'Time to Move?' 2006, CLG New Horizons Research 2008)

Prevention in Housing, Health and Care

"We will boost preventative housing services through investing in proven approaches, such as advice and information, adaptations and repairs, which can prevent health and care crises for individuals"

Lifetime Homes, Lifetime Neighbourhoods:

a national strategy for housing in an ageing society, 2008

"The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focussed on prevention, early intervention, enablement, and high quality personally tailored services"

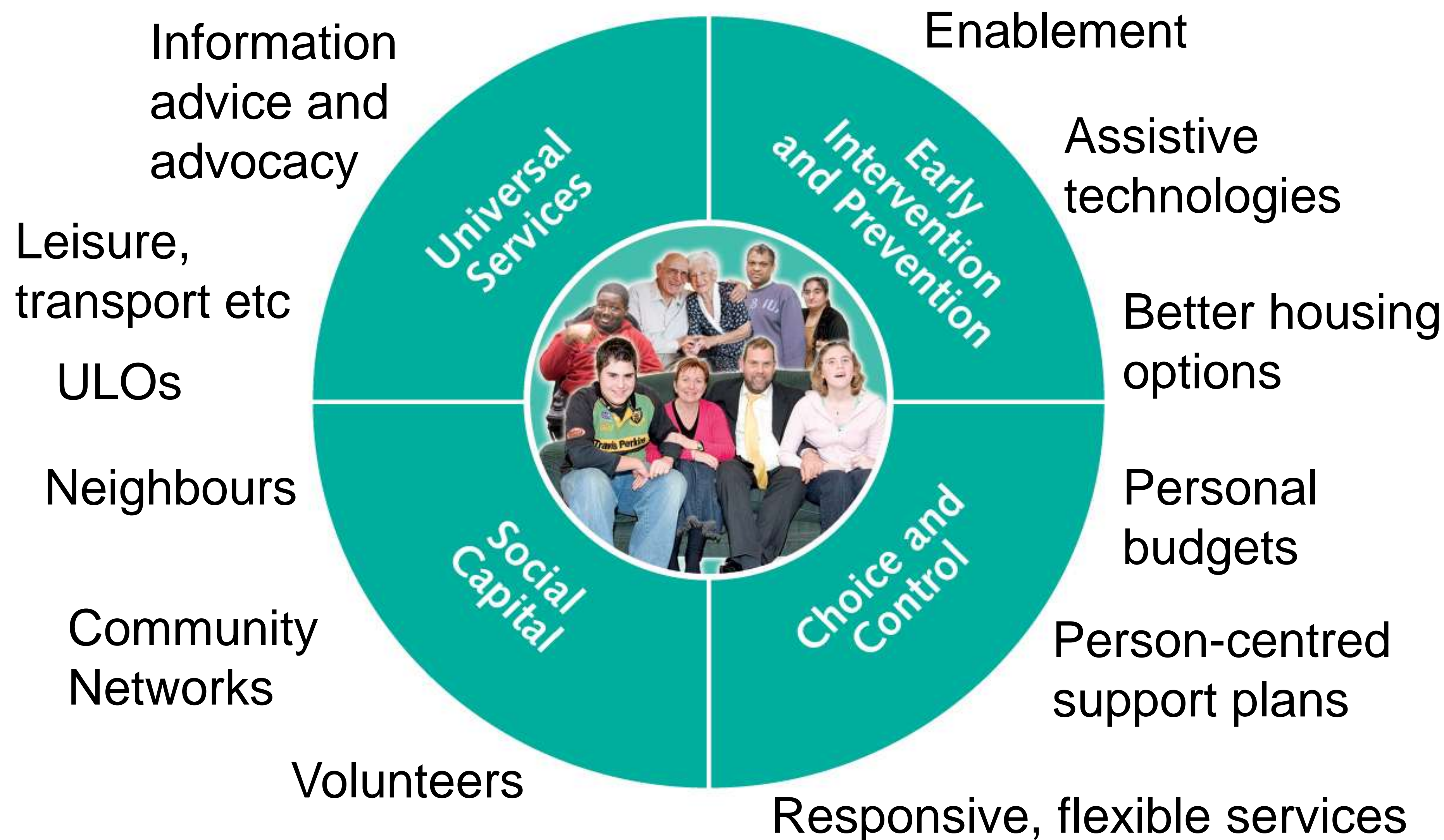
Putting People First, 2007

"An integrated approach to health and wellbeing will require a step change in the relationship between local NHS organisations, local government, other relevant statutory services, employers, third sector and independent sector providers. We want to ensure synergy between the development of vibrant primary and community care services and the 'Putting People First' transformation programme led by local government"

Next Stage Review, Darzi, 2008

Putting **People** First

Transforming Adult Social Care



Housing and Prevention – Examples

Primary Prevention

Housing Options information and advice, enabling older and disabled people to plan ahead for their own futures. Preventing decisions being made too quickly and without the right information after a health or social care crisis.

Secondary Prevention

Integrated housing, health and social care interventions, targeted at the people most at risk of needing social care support in the near future. This could include low-level signposting services providing information about a wide range of services available locally.

Handyperson services, offering 'that bit of help' to enable people to stay living in their own homes for longer, whether it be assistance with the garden, small home repairs, or advice about assistance with fuel costs.

Tertiary Prevention

Home improvement agencies, providing large scale adaptations to older and vulnerable people's homes, enabling them to maximise their mobility in the home.

Complexities of Building an Evidence-Base for Prevention and Early-Intervention

- It has long been accepted that low level support to older people is highly valued by them. 'Low level support' is a label conferred on services that are relatively low cost and associated with definitions of a low level of need in older people associated with rationing processes.

- However, Clark et al. argue that:
- *'...the services described as 'low level' by professionals are those very services identified by older people as being of high value to them.'*
- Areas consistently identified by older participants in the research as of high value were help with housework, gardening, house repairs and maintenance, security, laundry and opportunities for social participation (Clark *et al.,1998, p. 9).*

- Complexities of proving the benefits and cost-efficiencies often include establishing a causal link between a specific service and its outcomes, the fact that costs and savings often fall to different sectors and organisations, the inevitable difficulty of trying to assess what would have happened had a particular intervention not been available, and the subjectivity of many quality of life measures.

Housing and Prevention - the Evidence

- DH Partnerships for Older People's Projects including housing -based services

- DH Predicting Social Care Costs Project building on the PARR tool – focus on targeted intervention

- LinkAge Plus led by DWP, providing older people with wide range of integrated services, including housing

- Supporting People Benefits Realisation Local Model led by CLG – important that SP funding continues to be used to support preventative interventions, and that commissioners avoid temptation to divert this funding to support more intensive services

- Foundations Future HIA Project highlighting preventative benefits of HIA services including to the health and social care system

- Health and Safety Rating System - hazards in the home and links to health inequalities – opportunity to inform evidence base on links between housing and health

Partnerships for Older People's Projects: 2008 Findings

- 99,988 individuals had received, or were receiving, a service within the POPP programme across 470 projects and within 29 pilot site areas, including universal information and advice, handyperson services, equipment, and home adaptations.
- POPP pilot sites continue to have a demonstrable effect on reducing hospital emergency bed-day use when compared with non-POPP sites. The results show that for every £1 spent on POPP, an average of £0.73 will be saved on the per month cost of emergency hospital bed-days, assuming the cost of a bed-day to be £120. Initial savings are mostly to the health system.
- The POPP projects are having an effect on how users perceive their quality of life as a whole. Following the project, users report that they see their quality of life as improved.
- Users also reported that their health-related quality of life improved in five key domains, (mobility, washing/dressing, usual activities, pain and anxiety), following their involvement in the POPP projects.
- An analysis of those sites where data are currently available (11 out of 29 sites) appears to demonstrate the cost-effectiveness of POPP projects.
- The POPP programmes also appear to be associated with a wider culture change within their localities. Generally, there seems to be a greater recognition of the importance of including early intervention and preventative services focused toward well-being.
- POPP partnerships across the health and social care economy seem to have strengthened and accelerated developments around joint commissioning. In particular, there has been recognition of the value of involving voluntary and community organisations in service planning and delivery.
- Involvement of older people within the POPP sites appears to be focused on the delivery of services; almost half the staff in the projects across the POPP programme are older volunteers.

Targeted Intervention – Predicting Future Social Care Costs

- Commissioned by Care Services Efficiency Delivery unit (CSED) and Department of Health, project led by Nuffield Trust.
- Explore feasibility of building predictive models for future social care usage.
- Using health and social care data to forecast which individuals in a population are at greatest risk of incurring social care costs through loss of independence due to age-related conditions and ill health.
- Preventive interventions would be more cost-effective when offered to people who would, without intervention, go on to require intensive social care.
- Therefore if more effective investment is to be made in prevention, councils need ways of identifying individual risk accurately across their population so they can target effective interventions.
- Model builds on PARR tool and Combined Model which identifies patients most at risk of emergency hospital admission and re-admission.
- Project explores feasibility of using pseudonymous routine electronic health and social care data to inform the model.
- Strong evidence that this modelling is possible, however the amount of data currently available in relation to social care events means that the algorithms will initially have poor predictive power compared to that of the PARR tool.
- Nevertheless there is strong interest in this project in terms of continuing to explore ways of exploiting health and social care information in the common aim of maintaining individuals' independence and developing more cost-effective approaches.

LinkAge Plus: 2009 Evaluation

- LinkAge Plus (LAP), funded by DWP, provides a comprehensive approach for accessible joined-up services for older people, in which older people are at the centre of policy making and service delivery.
- The LAP pilot sites have developed services that are providing that 'little bit of help' in order to promote older people's wellbeing and independence. These 'upstream' approaches are also there to prevent or delay the onset of more intensive support.
- Services include housing choices advice; home safety checks; and other housing-related interventions.
- Benefits included: promoting older people's independence; acting as a catalyst for the increased join-up of services across public services, and the community and voluntary sector.
- Older people stress that it is the small things that make the difference and keep them out of hospital, delay deterioration and delay institutionalisation.
- Benefits of LAP included preventative savings, which can be costed, although this is a highly contested area.
- Interim evaluation uses a case study approach to demonstrate benefits including savings to the public purse.
- Further evaluation report expected soon.

Useful Websites and References

- Clark, H., Dyer, S. and Horwood, J. (1998) ‘That bit of help’ The high value of low level preventative services for older people, Community Care into Practice Series, Joseph Rowntree Foundation.
- Curry, N. (2006). ‘Preventive Social Care: Is it Cost Effective?’ Kings Fund Publication attached to the Wanless Social Care Review ‘Securing Good Care for Older People’
- ODI’s ‘Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence’ by Frances Heywood and Lynn Turner, 2007
- http://www.kingsfund.org.uk/publications/kings_fund_publications/appendices_to.html
- http://www.dwp.gov.uk/ageing-society/linkage/evaluation.asp
- http://www.dhcarenetworks.org.uk/prevention/
- http://www.dhcarenetworks.org.uk/independentLivingChoices/housing/
- http://www.careandrepair-england.org.uk/pdf/healthyhomes.pdf
- http://www.viewcare.co.uk/Publications/fallsint.pdf
- Look out for the new Supporting People Benefits Realisation Local Model soon to be published on the SPK website - http://www.spkweb.org.uk/

Conclusion and Questions

- There is evidence of the cost-benefits of low-level housing-related services to health and social care as well as wider improvements in quality of life.
- However, achieving conclusive quantitative proof is difficult in such a complex area with multiple variables and competing definitions of the key concepts.
- This is a difficult time to be expecting health and care commissioners to be investing in prevention as well as managing increasing intensive demand – however, given the evidence which does exist of the benefits of early intervention, can they afford not to?
- This has to be set in the context of the wider transformation agenda, including personalisation and increased choice and control for users of services and patients, as well as better partnership working.
- Opportunities may include marketing HIA services to self-payers and those wishing to spend their personal budgets (or indeed personal health budgets) on housing-related services, as well as persuading health and social care commissioners to invest in HIA services through a business-case approach, including GP commissioners.
- Health and social care commissioners: What are your experiences of commissioning preventative housing-related services in your local area? What have been the challenges? What were the success factors?
- Providers: Do you have experience of working closely with health or social care commissioners? Again, what have been the challenges and success factors?

The Service Provider's Perspective

Sue Sinclair

Hyndburn Homewise

Accrington

Health and Housing

Examples of good practice in the delivery of low level services contributing to the preventative agenda

WORKING WITH HEALTH

- The beginning
- Working with Health
- The schemes/funding
- The relationship

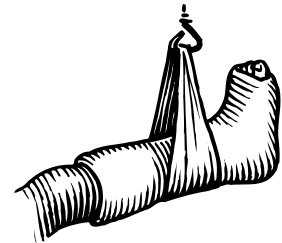
ACCIDENT PREVENTION SEIZE THE OPPORTUNITY

1993-1994

Accident Prevention Scheme

1994-1995

Handyperson/Hardship Fund and Decorating Scheme



1995 -1998

Prevention of Accidents – Children

1998- 2001

Home Safety Emergency Service

2001-2002

Handyperson service

EVALUATION/FEEDBACK

- Monitor progress
- Evaluate scheme
- Added value
- Report back

PREVENTION AGENDA

- Excellent value for money services
- Meeting their prevention agenda
- Relationship with Health

HEALTH PRIORITIES

- Coronary Heart Disease
- Teenage pregnancies

FINDING A WAY

- Local Implementation Team

- Presentation:
  - Poor housing, poor health
  - Healthy Homes, Healthy Lives

HEALTH CONCERN

- Affordable warmth
- Alleviating fuel poverty
- Reducing winter deaths

WORKING TOGETHER

- Spreading the word
- Maximising resources
- Making a difference

HEALTH RECOGNISING HOUSING

- North West Public Health Award

- NHS East Lancs Staff Excellence Award (Design in Health – Social Project)

WORKING TOGETHER

- Local Strategic Partnership
- Local Area Agreements
- Targets -

  Performance Indicators

WHAT NEXT

- EVIDENCE

- EVIDENCE
- EVIDENCE

Greater Manchester Health Partnership

Maximising the Third Sector's Contribution to Health and Addressing Health Inequalities

Neil Walbran, GMCVO

25th June 2009

'For a strong, diverse and influential voluntary sector'

GMCVO

- Works across Greater Manchester
- Works through partners in each district and diversity organisations that reach seldom heard communities
- Formal partnerships with AGMA, the GMPTA and AGMPCTs
- Lead body for the Third Sector with reference to the GM Multi-Area Agreement

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Health Partnership Project

- GMCVO member of Health Leadership Group
- Audit Commission review of Health Inequalities 06/07
- Pledge to reduce Health Inequalities signed
- Initial project funded to scope out work necessary to build involvement of sector – combines four elements

'For a strong, diverse and influential voluntary sector'

HPP - Four Elements

- Building Positive Partnerships
- ***Informing Commissioning***
- ***Supporting Commissioning***
- Supporting Localities

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Informing Commissioning

Bringing clarity on the third sector 'market offer' to commissioners

'Directory of Third Sector Services'

- Ongoing piece of work – soon to be web-based
- Local providers mapped & at your fingertips
  - Reduce transaction costs
- Evidence-base for what Third Sector does best in a commissioner-friendly language

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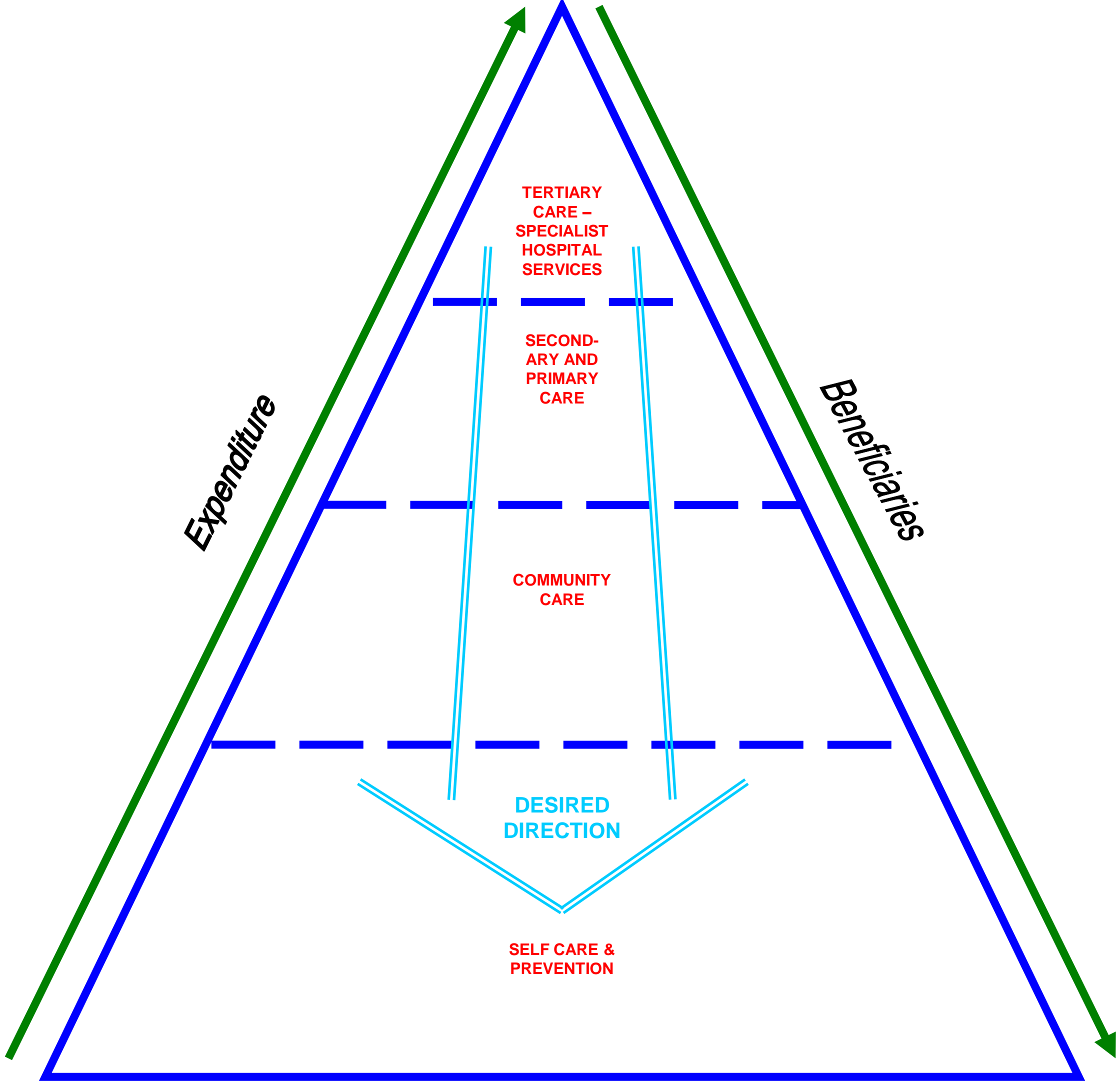
Care Pathway



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Mapping Example – Manchester Care & Repair

Care continuum/points of operation/referral

Specialist Hospital Services	Secondary & Primary Care	Community Care	Self Care	Prevention
		Larger repairs service e.g. draughty windows, sturdy doors, leaking roofs for people with long term conditions or mental health issues	Generation project – volunteers encourage self help	
		Intermediate care e.g. key safe		
		Housing related support		
		Smoke alarms (on behalf of fire service)		
		Self referral – e.g. friends family		
		Social services referrals e.g. community nurse		
		Training for all home visitors in healthy homes – recognising health impact of bad housing		
		Third sector referral e.g. Age Concern		
		Local authority direct services e.g. grab rails, furniture raisers		

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The Challenges

- Providers
  - Health Impact Assessment
  - Professionalising and Quality
  - Mission drift
- Commissioners
  - Negotiated Tendering Process
  - Balance across sector spending

Supporting Commissioning

‘Commissioning: Possible’

Third Sector Organisations’ experiences in Public Sector Commissioning

- Qualitative analysis with recommendations
- Willingness to engage from both sides
  - No support framework for engagement
- Highlights good practice
  - No one shining example
- No GM consensus from commissioners & little flexibility

http://www.gmcvo.org.uk/?q=node/1098

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Working Together

- Greater Manchester Third Sector Health & Well-being Consortium
  - Contracting opportunities
  - Success in Sheffield – sheffieldwellbeing.org.uk
  - Clusters around specialities

- Sustainability for smaller providers through the supply chain

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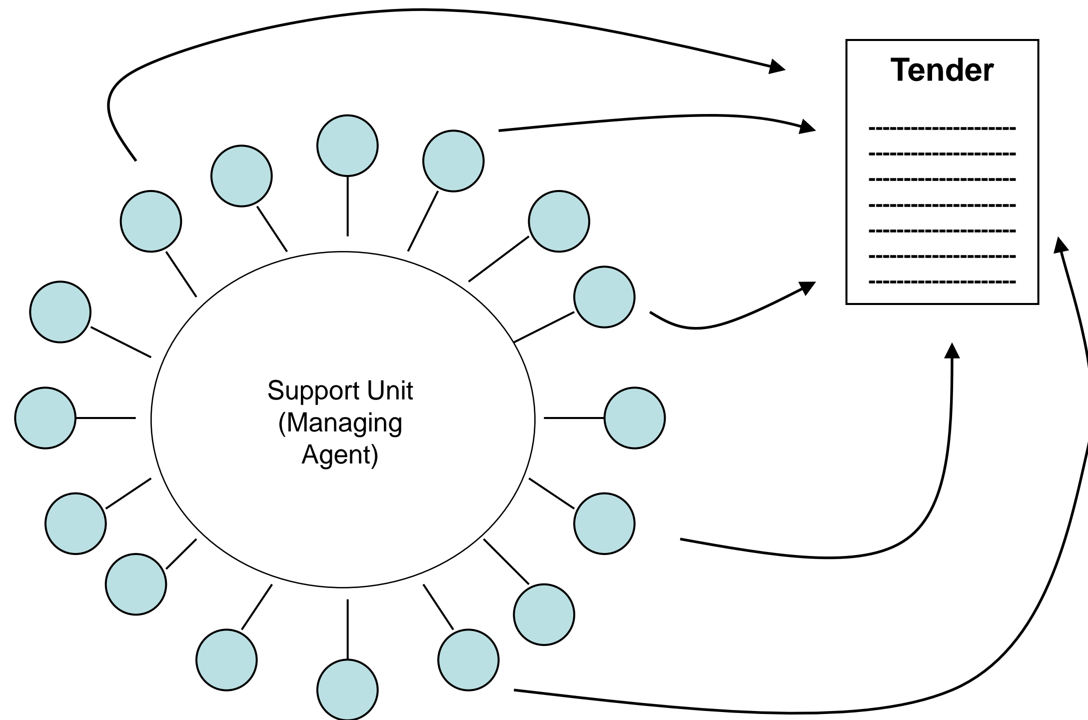
Hub and Spokes Model



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Health Commissioning

- SHA & NHS Next Stage Review
- **'Transforming Community Services'**
- NW Event – 'Time for Change'
- Next Stage – **'Meet the Commissioners'**

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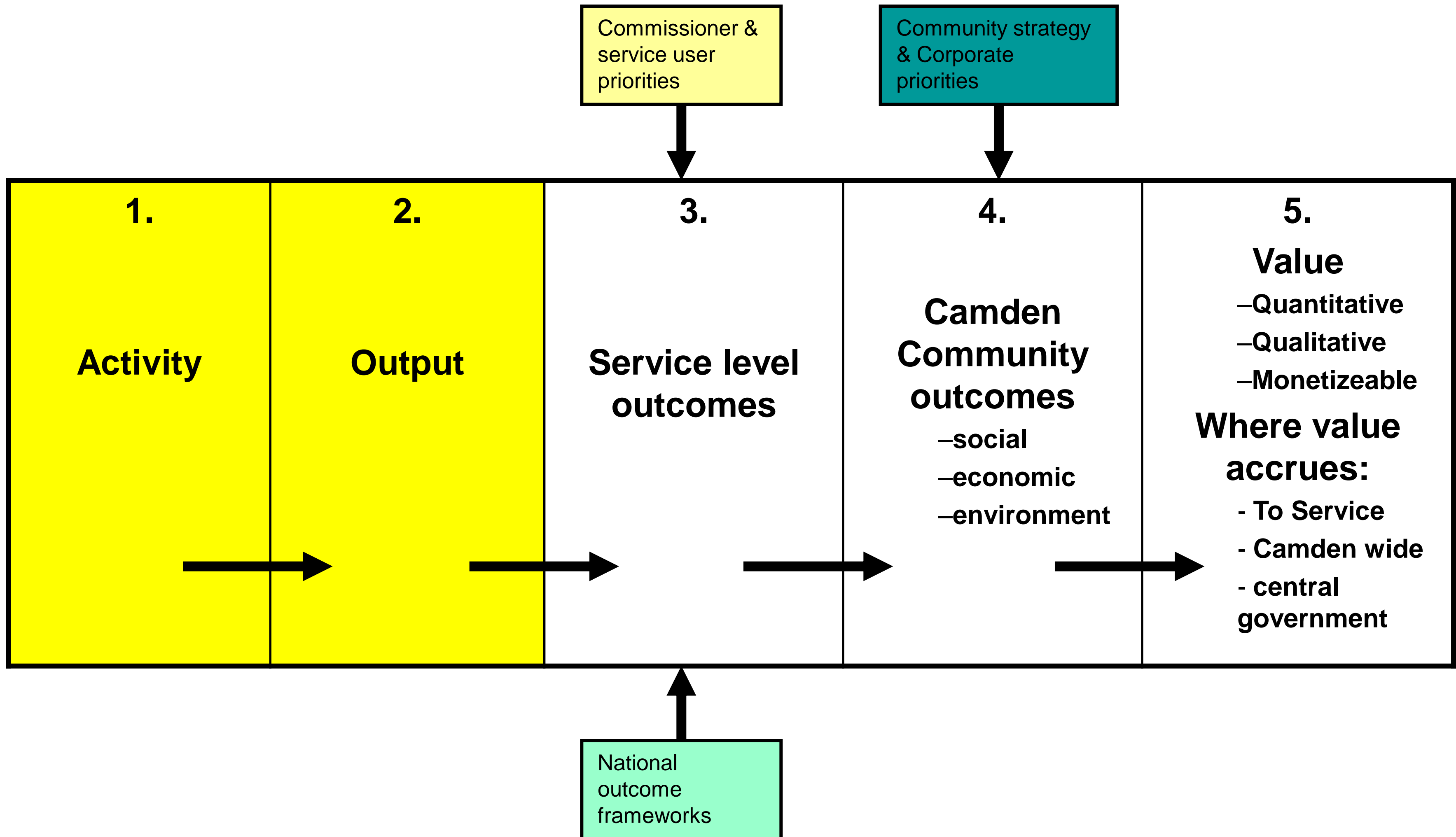
A Two-way Street

- Influencing Commissioning
- New Models and Systems
- New Economics Foundation
- Sustainable Commissioning Model

Sustainable Commissioning Model



Why commission outcomes?

- Focus on service users
- Value provider expertise
- Encourage innovation / sustainable procurement
- Achieve strategic economic, environmental and social impacts
- Maximise value for money
- Understand return on our investment
- Successful pilot in Camden
- Now being trialled in Salford
- www.procurementcupboard.org

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Making the business case to commissioners

Malcolm Ramsay, Foundations

Commissioning issues affecting HIAs

- Supporting People into Area Based Grant
- Local priorities → commissioning strategy
- Commissioning for outcomes – but which ones?
- Integrated care and support pathway planning
- View that providers stuck in their respective silos – sheltered, homecare, residential, day care etc.
- Opportunity for market led creative solutions based on language of outcomes

Putting People First

- Live independently
- Have the benefit of the best possible quality of life irrespective of illness or disability
- Sustain a family unit which avoids children taking on inappropriate caring role
- Exercise maximum control over their own life and/or lives of family members
- Participate as active and equal citizens, economically and socially
- Stay healthy and recover quickly from illness
- Retain maximum dignity and respect

LAC 2008(1): Transforming Social Care

- Improving people's health and emotional well-being by enabling them to live as independently as suits them
- Enabling people to make choices and be in control of their own care to deliver successful outcomes first time. Promoting shared decision making to encourage ownership
- Ensuring information is Available and accessible for all to support decision-making and access to care services, irrespective of people's social circumstances and eligibility for statutory services
- Focussing on prevention, early intervention and enablement, rather than crisis management, to bring long-term benefits to individuals' health and wellbeing
- Supporting people to maintain or improve their well-being and independence within their own homes and local communities and through avoiding unnecessary admission to hospital
- Designing systems that build on the capacity of individuals and their communities to manage their own lives, confident that they have access to the right information and interventions at the right time should they need more support
- Strategic working with NHS partners to enable people with long term conditions to manage their health and wellbeing more effectively
- Providing quality care that promotes dignity, and is safe, effective and available when and where people need it

Our Health, Our Care, Our Say

- Improved quality of life
- Exercise choice and control
- Making a positive contribution
- Economic wellbeing
- Improved health and wellbeing
- Maintaining personal dignity and respect
- Freedom from discrimination and harassment

Our NHS Our Future

- Effective – improving people's health, wellbeing and quality of life
- Personalised – responding to individual needs and preferences
- Fair – treating people with equity and dignity at all times
- Safe – making sure people are not put at risk of harm

Every Child Matters

Supporting People

- Enjoy and achieve
- Make a positive contribution
- Achieve economic wellbeing
- Be healthy
- Stay safe

Carers' Strategy

- Carers will have access to integrated and personalised services to support them in their caring role
- Carers will be able to have a life of their own alongside their caring role
- Carers will be supported so that they are not forced into financial hardship
- Carers will be supported to stay mentally and physically well and treated with dignity

Independent Living Strategy

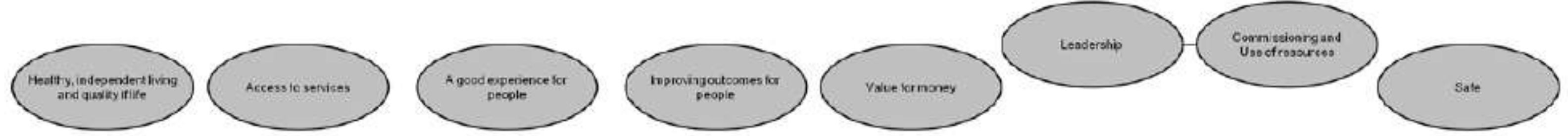
- Disabled people who need support to go about their daily lives will have greater choice and control over how support is provided
- Disabled people will have greater access to housing, transport, health, employment, education and leisure opportunities and to participation in family and community life

Valuing People

- Independence – Services provide the support to maximise independence
- Choice – A real say in where they live, what work they should do and who looks after them.
- Inclusion – enabling people to do ordinary things, make use of mainstream services and be fully included in the local community
- Legal and civil rights – Treat people as individuals with respect for their dignity, and challenge discrimination on all ground

CSCI domains

Dimensions of Quality



Mapping the aspirations and outcome frameworks of recent government initiatives

- Outcomes for individuals fall into five categories:
  - Quality of life
  - Choice and control
  - Inclusion and contribution
  - Health and wellbeing
  - Dignity and safety

foundations

Home Improvement Agencies
Making Homes Warm, Safe & Secure

Care Services Efficiency Delivery (CSED)

- Recognise the importance of housing to care and support efficiencies
- Current weaknesses/opportunities
  - Potential for generating efficiency offered by breaking the link between care/support and accommodation
  - Weaknesses in building the business case evident
  - Wider system understanding of the potential of housing under-developed
  - Lots of innovation but small scale and infrequently replicated

Home Improvement Agencies

Making Homes Warm, Safe & Secure

Care Services Efficiency Delivery (CSED)

- Developed concept of Support Related Housing
  - Partnership with National Housing Federation
  - A concept that builds on the idea of providing care at home and emphasises the need to integrate housing with health and social care
  - Showcased examples of innovative cash releasing schemes:
    - Supported housing, Hospital discharge, Floating support models
  - Strong emphasis on developing a business case

Willow HA case study

- Tackling delayed discharges in Brent, which were causing:
  - Deterioration of independent living skills during long hospital stays leading to increased demand for residential and nursing placements
  - Unnecessarily high DTOC reimbursements from Brent to the local hospital
  - Expensive NHS acute beds occupied inefficiently due to above average lengths of stay and avoidable readmissions to hospital
- Willow Housing Association offered a service to facilitate timely discharge from hospital

Home Improvement Agencies
Making Homes Warm, Safe & Secure

Willow HA case study

- Working with local authority hospital discharge team and occupational therapy team, Willow offered:
  - Housing related support, jointly agreed support plan. The support plan encourages clients to maintain independence in home regardless of tenure and helps them make planned decisions about alternative housing and practically supports the move if needed
  - Advocacy for client to help them access a wider range of support services
  - Cross agency coordination of support to facilitate a timely hospital discharge for people aged 60 or above

Willow HA case study

- Examples of support given
  - Advice on home aids and adaptations and help accessing grants etc
  - Referrals for telecare equipment
  - Referrals to specialists such as Age Concern
  - Benefits applications
  - Budgeting and debt management skills
  - Advice on housing options
  - Help getting electricity and gas supplies set up
  - Support with GP registration and prompting to attend key appointments
  - Emotional and other practical support when moving house, e.g to sheltered accommodation

Home Improvement Agencies

Making Homes Warm, Safe & Secure

Results

- Increased numbers of older people return to live independently after hospital
- Each client achieves jointly agreed support plan – quality of life issues
- 100% client satisfaction with service
- Reduced re-admissions to hospital and reduced proportion of older people supported in residential or nursing homes leading to savings for PCT and adult social care

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Home Improvement Agencies
Making Homes Warm, Safe & Secure

Savings

- In 2005 the Audit Commission calculated this saved £35k of DTOC reimbursements for all 79 cases dealt with by service
- Ongoing support costs were £4,900 p.a. less per user after support from the hospital discharge service
- Net savings in the region of £420k p.a. assuming the sample of 20 cases we used was representative
- Budget for the Willow hospital discharge service was £41k

The message to commissioners

Councils first need to develop

- a detailed understanding of the support needs of their population,
- then identify and quantify the level of need that could be effectively supported in a range of different supported housing settings and, finally,
- determine which needs genuinely justify residential or nursing accommodation.

"This approach can then inform a commissioning strategy to ensure the right balance between residential/nursing care and support related housing and accurately justify a strategic shift in resources. "

Building a business case for HIAs

- What the textbooks say:
- **Context** - Business objectives/opportunities, strategic alignment (priority).
- **Value Proposition** – (what the customer gets for his/her money) Desired business outcomes, benefits, costs, ROI, and costs of not proceeding.
- **Focus** - Problem/solution scope, assumptions/constraints, options identified/evaluated, scale and complexity assessment.
- **Workload** - Approach, delivery plan
- **Required resources** - Project leadership, governance, resources, funding.
- **Commitments (required)** - Project controls, status reporting

Focus on key issues

- Context – how your service meets the commissioner’s objectives
- Value proposition
  - costs
  - benefits
  - desired outcomes
  - return on investment
  - cost of not proceeding

Scenario Planning Exercise

- All HIA services will be funded through health and social care budgets. We need to redesign the global model of HIA services to ensure survival.

1. Produce a short strategy statement indicating how you would achieve this change
2. Indicate your approach to demonstrating cost benefits across the (new) range of services
3. Greatest challenge? Biggest opportunity?
4. Help needed?

Summing up

- Clear government policy to encourage joining up of housing, care and support services
- Targeting and correct timing essential to realise potential of prevention and early intervention
- Services to become more person-centred, need for consortium-based delivery?
- Business case approach to commissioners
- Build evaluation and outcomes monitoring into process, focus on “results” over “experience”

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Home Improvement Agencies
Making Homes Warm, Safe & Secure

Better outcomes, lower costs *(Heywood and Turner, 2007)*

Investing in housing interventions offers 4 routes to cost savings:

- Reducing or completely removing an existing outlay
  - Saving the cost of residential care, adaptation delays entry into residential care, saving £26k per person per year, less cost of adaptation (average £6,000)
  - Reducing the cost of home-care, with adaptations reducing the need for daily visits (savings from £1,200 to £29,000 per year)
- Preventing an outlay which would otherwise have occurred
  - Preventing hip fractures from falls
  - Preventing other health costs, e.g. timely discharge from hospital
- Saving through prevention of waste
  - Delays leading to more costly options or money spent with no useful outcome
- Saving though better outcomes for the same expenditure

Evidencing the value of HIA services for health and social care commissioners

- Supporting People Benefits Realisation Local tool (CLG/Capgemini)
- BRE/CIEH HHSRS Cost calculator tool
- Health Impact Assessment of Decent Homes Delivery in Private Sector Housing (led by Rochdale)
- Local adaptations vs. home care package calculator
- Handyperson services evaluation
- Local evaluations of HIA services
- Methodology to convince clinicians - Aimwell Mk 2?

Adaptations

Microsoft Excel - fINANCIAL ASSESSMENT dm draft

D2 | annual costs

Care package without adaptation (gross costs)

service	*Number of visits/Units*	weekly costs	annual costs
Home care internal		£ -	£ -
home care external		£ -	£ -
respite weeks per year		£ -	£ -
day care days per week		£ -	£ -
transport		£ -	£ -
residential care	*1*	£ 359.00	£ 18,668.00
nursing care		£ -	£ -
direct payment		£ -	£ -
Total	1	359	18668

Estimated Client Contribution

	Weekly Charge	Annual Charge
Without Adaptation	*£ 100.00*	£ 5,200.00
Net Cost to WCC	£ 259.00	£ 13,468.00

Care package with adaptation (gross cost)

service	*Number of visits/Unit*	weekly costs	annual costs
Home care internal		£ -	£ -
home care external	*10*	£ 87.00	£ 520.00
respite		£ -	£ -
day care		£ -	£ -
transport		£ -	£ -
residential care		£ -	£ -
nursing care		£ -	£ -
direct payment		£ -	£ -
Total	10	87	520

	Weekly Charge	Annual Charge
With Adaptation	*£ 50.00*	£ 2,600.00
Net Cost to WCC	£ 37.00	-£ 2,080.00

Calculations | Standard Costs | Sheet3

Ready