On the Pulse:

Housing routes to better health outcomes
for older people

On the Pulse:

Housing routes to better health outcomes for older people

Contents

On the Pulse:

Housing routes to better health outcomes for older people

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

Health Select Committee 2012[1]

Introduction

With the number of people over 65 expected to double from eight to 16 million by 2030,[2] improving the health, care and quality of life of older people is in everyone's interest.

On the Pulse explores how health and social care commissioners can work with housing providers to enable older people to manage changes in their health, to maximise independence and reduce the need for costly interventions. It follows the National Housing Federation's report **Breaking the Mould: Re-visioning older people's housing**,[3] which demonstrates how housing associations, local authorities, health services and other partners are developing new housing and support models to meet the changing needs of older people.

To stimulate discussion, **On the Pulse** includes six case studies describing some innovative solutions which Federation members have developed. These reflect the diverse ways in which housing providers are responding to both the needs of older people at critical points in their lives and NHS priorities.

The services featured in the report deliver one or more of the following health and care outcomes. They:

- help older people to recover their independence after illness, stroke, injury or trauma

- get people home from hospital quickly, while preventing hospital admissions and readmissions

- delay the need for more intensive care and support

- reduce the likelihood of emergency admissions

- help to stabilise and manage chronic conditions such as dementia

- enable people to remain in their homes to the end of their lives

- maximise the benefits of technology, such as telecare.

These services demonstrate the value of the housing-related care and support which enables people to live well at home. They have the potential to operate at scale to reduce the need for hospital beds and in-patient stays or to close hospital wards.

There continues to be a need for efficiency savings and quality improvements from existing services. In addition, housing can be a crucial partner to health and social care in transforming services though innovation and integration.

Housing associations are independent, not-for-profit social landlords, committed to enhancing the lives of almost 860,000 older tenants, their families and carers. They are significant commissioners of services, contributing £8bn a year through housing development[4] and spending £4.5bn on maintaining and managing existing homes.[5] They are experienced local providers who understand the changing needs of an ageing population.

Housing associations are keen to use their experience, local knowledge and track record of partnership to work more closely with health and care to enable people to live well at home.

[1] Health Select Committee Report on Social Care, Fourteenth Report of Session 2012, Volume I, 2012 www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/1583.pdf

[2] Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society CLG, 2008.

[3] Breaking the Mould: Re-visioning older people's housing, National Housing Federation, 2011 www.housing.org.uk/publications/find_a_publication/care_and_support/breaking_the_mould_re-vision.aspx

[4] £1 of development spending contributes £1.40 to the wider economy (research by Oxford Economics for the National Housing Federation, 2010).

[5] 2009 Global Accounts of Housing Associations, Tenant Services Authority, 2010.

photo: Alliance Homes

About this report

For the six case studies in section 1 we describe:

- what the services do

- their contribution to NHS, public health and adult social care outcomes

- their contribution to the Quality, Innovation, Productivity and Prevention (QIPP) programme

- the cost and efficiency savings to health and social care

- the central role of housing and other factors in making the services work

- how success is evaluated

- the potential for services to be replicated and scaled up.

The case studies provide inspiration and learning points for those providers thinking about working more closely with health and care to transform the lives of residents as they get older.

Section 2 outlines current health and care priorities for older people and highlights learning from the case studies to show how housing associations can deliver improved outcomes.

The QIPP programme is expected to improve the quality of care the NHS delivers while making up to £20bn of efficiency savings by 2014/15, to reinvest in frontline care. Delivering QIPP is a top priority for the health service. **On the Pulse** uses the QIPP themes as a framework to show how and where housing can contribute. Commissioners and providers can use this to assess the likely benefits of working together.

Whether supporting patients with dementia, maximising the benefits of telecare, enabling timely hospital discharge, offering intermediate accommodation or providing end of life care at home, our case studies illustrate how housing associations are key to providing better coordinated and integrated services for older people.

Section 1: Case studies

Case study 1

Care from housing to hospital to housing: Housing 21's portable care packages

Housing 21 provides extra care accommodation across the country, offering frailer older people varying levels of on-site care and support. Using this experience, the organisation developed portable care. This was in response to national evidence that people with dementia stay in hospital longer and that for many it is a negative experience with patients suffering poor quality care, discrimination and deteriorating health. Housing 21 felt that these issues could be overcome if their staff could support their tenants, particularly those with dementia, when they stay in hospital.

Housing 21's extra care staff provide support and advocacy, for example by aiding communication with those who are hard of hearing and ensuring patients are eating properly and having their personal hygiene needs met.

It is a pilot scheme, running from April 2010 to March 2013 in two of Housing 21's extra care schemes (80 tenants) and is delivered with support from Bristol NHS, North Bristol Trust (two hospital sites) and Bristol City Council. The project is funded through the NHS Innovation and Excellence Fund.

> "By working together in a new way, we can relieve pressure on hospital staff, make better use of resources and improve tenants' hospital experience."

NHS, public health and social care outcomes	
NHS 2.6	Improved quality of life for people with dementia.
PH 4.16	Minimising the effects of dementia.
NHS 3.6	Helping older people to recover their independence after illness or injury.
ASCOF 2A–C	Delaying and reducing the need for care and support.

QIPP contribution	
Quality	• the experience of hospital, and the return to home, is improved through better continuity of care and information sharing: staff understand the hospital experience from the patient's perspective.
Innovation	• existing Housing 21 care staff resources are used in a different way, enabling timely discharge.
Productivity	• health, housing and care professionals work together and the standard of care is felt to have improved by all involved.
Prevention	• joint working with the hospital social work team and community district nurses prevents patients from moving into more expensive residential or nursing care • Housing 21 is working with the community health team, enabling early discharge, as appropriate medical treatment is provided in the person's own home • unplanned admissions and readmissions to hospital have been prevented through joint working with community district nurses and community matrons.

Cost and efficiency savings?

Care support to 16 hospital admissions, at a cost of £4,000, has contributed to:

- 27 bed days saved (£355 per bed day) resulting in a saving of £9,585[6]
- 125 bed days saved through managed readmission, resulting in a saving of £44,375.[7]

Additional savings are expected for:

- clinical commissioning groups through reductions in unscheduled care and unnecessary admissions
- adult social care in the form of reduced or stable care packages on discharge.

This is a three year pilot project, so costs and savings are in the process of evaluation.

Project management and staff contingency costs are additional to this, funded currently by the Department of Health's Voluntary Sector Innovation, Excellence and Service Development Fund.

What makes it work: the central role of housing

- Housing 21's strong ethos of enabling people to maintain their independence at home
- continuity of tenant experience in hospital by involving key workers from the extra care scheme
- support from the North Bristol NHS Trust's director of nursing to pilot the project and from senior management in Bristol City Council to continue funding for Housing 21 care while the patient is in hospital, which would usually cease during this period
- oversight of the project's implementation by the director of nursing and a vulnerable adults senior nurse from the clinical services development department
- a comprehensive risk assessment to inform the project's development and delivery
- comprehensive North Bristol Trust training for care workers
- quality care staff are able to communicate patients' social, medical and care needs
- support from health staff for information sharing and personalised care.

Validation and evaluation?

- customer and family feedback suggests that the service is invaluable and something self-funders and those with a personal budget would be prepared to pay for
- phase 1 evaluation started in 2012 with phase 2, in early 2013, looking at the impact on patients, extra care staff and hospital resources; how helpful such interventions are from various perspectives and the feasibility of expanding to other extra care and hospital sites.

Replicable and/or scalable?

- Housing 21 is exploring the expansion to its other extra care schemes and is working with a number of local authorities and NHS trusts.

Success and sustainability challenges:

- the costs and benefits of the service are currently not shared across health, housing and local authority partners, so integrated commissioning, shared outcomes and a funding system which recognises the health gains of housing interventions is key to future development
- a perception among some older people that the NHS should be providing a good service in the first place so they are reluctant to pay for something additional.

Contact details

Dr Claire Keogh, claire.keogh@housing21.co.uk

---

[6] This figure relates to bed days saved by the intervention and getting tenants out of hospital before their estimated discharge.

[7] This figure relates to planned admissions and discharges and the number of days saved through working with hospital staff to enable the tenant to go home between treatments and avoid a longer admission.

Case study 2

Home from hospital: a partnership approach by Alliance Homes

What does it do?
One of two home from hospital case studies, this example demonstrates a partnership model of a smooth transition home. It was established in 2010 as a result of an approach from Care & Repair England to pilot its information packs, tailored for people returning home from hospital. At that time a number of agencies were delivering similar housing-related support and recognised the potential for a more coordinated service.

The assessment and referral service is delivered by Alliance Homes, Age UK Somerset, North Somerset Care & Repair, Rethink/Reconnect and Brunel Care. All partners are funded by North Somerset Council.

A partnership representative is in hospital every day, working closely with the discharge teams and ward staff to process referrals, carry out bedside assessments, arrange home visits and support patients. A single referral process has been introduced to ensure a consistent approach.

The service is particularly for individuals who do not meet Fair Access to Care criteria for social care or do not have family or friends to support them.

NHS, public health and social care outcomes	
NHS 3.6	Helping older people recover their independence after illness or injury.
ASCOF 2A–C	Delaying and reducing the need for care and support.
NHS 3b PH 4.11	Effective recovery from illnesses and injuries requiring hospitalisation.
	Delayed dependency through effective re-ablement and rehabilitation.
NHS 2	Improved health related quality of life for people with long-term conditions.
NHS 2.6 PH 4.16	Improved quality of life for people with dementia.
NHS 3.3	Recovery from injury and trauma.
NHS 3.4	Effective recovery following a stroke.

QIPP contribution	
Quality	• health, housing and care of vulnerable older people is improved; patients receive coordinated support for a timely discharge from hospital • patients promptly access specialist care, such as dementia care.
Innovation	• existing housing staff are deployed in a different way to improve support in hospital • each partner brings a range of skills and knowledge so needs are quickly identified and responded to using a common assessment • referral processes are supported by training; home from hospital is incorporated into hospital discharge training for nurses.
Productivity	• a single access point requires only one referral from hospital discharge teams • hospital staff can focus on health and care with the confidence that others are able to identify related issues and take action.
Prevention	• assessments identify housing-related issues, such as lack of heating resulting in hypothermia, and address them, enabling patients to return home and stay there.

Cost and efficiency savings?

More than 500 referrals have been received by the partnership since July 2010. Total staff time among partnership members equates to one full-time equivalent support worker at a cost of £20,000 per annum. The average cost per day in hospital is estimated at £686.[8] Assuming the hospital stay was reduced by one day per referral, this suggests a saving of £343,000.

What makes it work: the central role of housing

- a range of expertise is brought together in one service
- housing knowledge is critical as people's lives are not settled if there is uncertainty in their housing situation
- a strong ethos of enabling people to stay at home where they feel safe and in control
- a commitment to partnership working by individual organisations which have developed a single, joint assessment and referral system and meet regularly to discuss improvements
- despite pressure to reduce expenditure, the local authority is committed to this preventive housing-related support
- close working with the council's access and hospital support team
- local authority commissioning support has enabled:
  - the service to evolve within the hospital; contract management took a flexible view of outputs and targets as the service developed
  - other partners providing care, support or accommodation offer a priority service to those referred by home from hospital
  - communication at senior management level within the hospital, training to hospital staff and opportunities to input into hospital improvements.

Validation and evaluation?

- the service is overseen by a local authority housing support commissioner who reports on progress
- case studies are used as evidence of the value of the project
- the partnership was a pilot (until March 2011) for the national housing charity Care & Repair England's going home from hospital scheme, which has been evaluated[9]
- the Department for Communities and Local Government has evaluated handyperson services, which form part of the solution to timely hospital discharge.[i]

Replicable and/or scalable?

- a variety of home from hospital services operate across the country
- the partnership is expanding into the Bristol hospitals, supporting patients in north Somerset
- it has accessed the Department of Health's Warm Homes – Healthy People scheme to develop marketing materials

Success and sustainability challenges:

- evidence of its productivity and outcomes is enabling the partnership to play a more significant role in hospital discharge procedures, this is crucial to demonstrating its value.

Contact details	Miriam Newton, Alliance Homes (provider), miriam.newton@alliancehomes.org.uk Mandy Averill (commissioner), mandy.averill@n-somerset.gov.uk

[8] Personal Social Services Research Unit, Unit Costs of Health & Social Care 2011, http://www.pssru.ac.uk/archive/pdf/uc/uc2011/section1.pdf

[9] If only I had known, Care & Repair England, (2012) two reports: an evaluation of the local hospital linked pilot projects and integration of housing help into a hospital setting, http://www.careandrepair-england.org.uk/homefromhospital/index.htm

Case study 3

Leaving hospital: Bournemouth Churches Housing Association's (BCHA's) support service
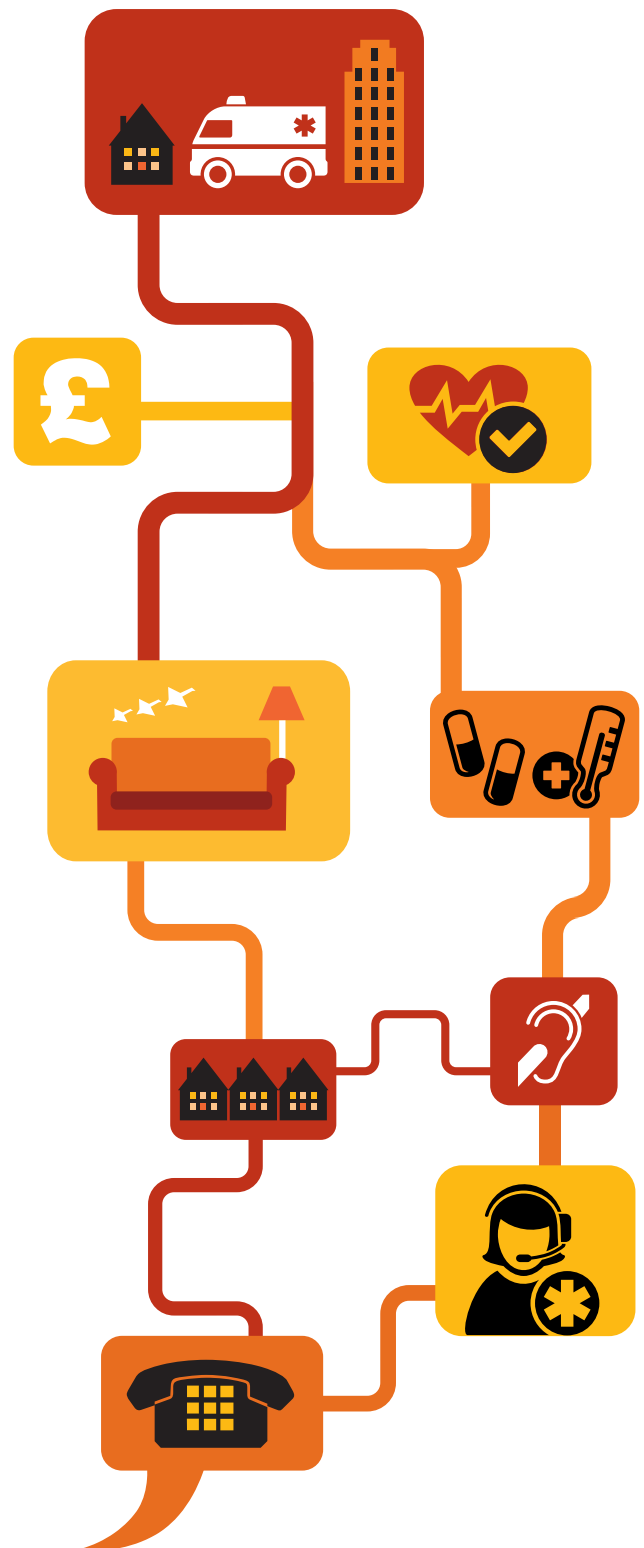
What does it do?
In the second home from hospital case study, BCHA delivers a support service to patients from the Royal Bournemouth Hospital, which successfully addresses specific needs, such as those relating to strokes.

BCHA's Leaving Hospital Support Service (LHSS) began in 2009. However, the service has existed in some form since 2003, when Bournemouth social services identified a high number of referrals from hospital wards. A team of five BCHA staff support patients with guidance and practical help in the home, while engaging with the views of relatives.

In 2010 the service expanded to include an advocacy and support worker for patients following a stroke, enabling their needs to be identified and communicated. The worker is part of the stroke coordination team.[10]

In October 2011, BCHA was commissioned for a pilot scheme with self-funders over 65 at the Royal Bournemouth and four community hospitals in the area. The scheme aims to improve the experience of self-funders and reduce hospital delays. Patients are visited to review their requirements and make necessary revisions to the services they receive, preventing readmission to hospital.

The LHSS service is jointly commissioned by Bournemouth Borough Council, the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, Dorset County Council, Hampshire County Council and the Borough of Poole.

[10] This role was commissioned in response to the National Stroke Strategy which states a clear direction for the development of stroke services within England.

NHS, public health and social care outcomes	
NHS 2	Improved health-related quality of life for people with long-term conditions.
NHS 2.6 PH 4.16	Improved quality of life for people with dementia and a reduction in the impact of the condition.
NHS 3A	Preventing conditions from becoming more serious.
NHS 3.4	Effective recovery following a stroke.
NHS 3.6	Helping older people to recover their independence after illness or injury.
ASC 2A–2C	Delaying and reducing the need for care and support.
PH 2.24	Reducing admissions resulting from falls.
PH 4.11	Delayed dependency through effective re-ablement and rehabilitation.

QIPP contribution	
Quality	• the service enables a safe and timely discharge from hospital • the patient experience has improved, as the discharge process is designed by BCHA with the individual to meet their particular needs • feedback is used to improve the service, for example patient information leaflets have been redesigned to be more customer focused.
Innovation	• the pilot scheme to improve the experience of self-funders is an innovation, which has been extended for a further year.
Productivity	• with support from BCHA, patients select more appropriate housing options for their return from hospital • referrals from the LHSS to the commissioner's social services departments have been reduced by 10% over the three years of the service.
Prevention	• BCHA's support helps to prevent readmissions and delays the need for higher levels of care, even for those with greater needs such as stroke patients.

"Being a well-established housing and support provider in the local area, BCHA maintains partnerships across traditional health, social care and housing boundaries to deliver solutions."

Cost and efficiency savings?

Between April 2009 and December 2011 the service received 13,431 referrals (around 5,000 are supported each year). In 68% of cases there was no delayed discharge and 32% were referred to social services.

The annual cost of the service is £165,000. Calculations using Unit Costs of Health and Social Care 2011[11] and the Social Return on Investment (SROI) model[12] suggest the service is saving:
- elective inpatient stays £2,931 per case
- non-elective inpatient stays (long stays) £2,334 per case
- non-elective inpatient stays (short stays) £549 per case
- weighted average for all day case stays £686 per case

In 2012/13 readmission information will be analysed to understand the impact of the service.

What makes it work: the central role of housing

- being well-established in the area means BCHA can maintain partnerships across health, social care and housing to find cost-effective solutions, tailored to individual clients
- communication is essential at all levels, from commissioners to ward staff; meeting with clinical leaders has helped BCHA integrate the service into the hospital
- knowing the patient's medical history is important; BCHA's support team has access to medical notes, the hospital's electronic patient system and social services systems
- a standard referral system from wards within different hospitals has been introduced
- BCHA has widely publicised the service to referrers, for example by targeting GPs directly
- dedicated BCHA staff and training contribute to the success of this service.

Validation and evaluation?

- BCHA meets health and social care commissioners bi-monthly to discuss performance and identify improvements
- an annual report is provided
- BCHA reports to commissioners on needs and gaps in services
- the team seeks regular feedback from ward staff.

Replicable and/or scalable?

- following its success in the Bournemouth area, the service has subsequently expanded to help patients in Hampshire, Dorset and Poole, commissioned by Hampshire and Dorset county councils and the Borough of Poole
- the potential to integrate with further re-ablement services is being explored.

Success and sustainability challenges:

- funding pressures mean the service is currently not available at weekends and on bank holidays, so there's a risk people will return home without the correct care in place.

Contact details   Jennie Osborne, jennieosborne@bcha.org.uk

[11] Personal Social Services Research Unit, Unit Costs of Health & Social Care 2011, http://www.pssru.ac.uk/project-pages/unit-costs/2011/index.php

[12] SROI measures change in ways that are relevant to the people or organisations that experience or contribute to it. It tells the story of how change is being created by measuring social, environmental and economic outcomes and uses monetary values to represent them.

Case study 4

A good death: Home Group's end of life care

Home Group's vision is to provide homes for life and its 'good death' pilot supports this. The pilot aims to give people a positive experience in the last years of life by providing community-based services. It launched in September 2011 after Home learned that many people were unable to access the support they needed to die in their own home.
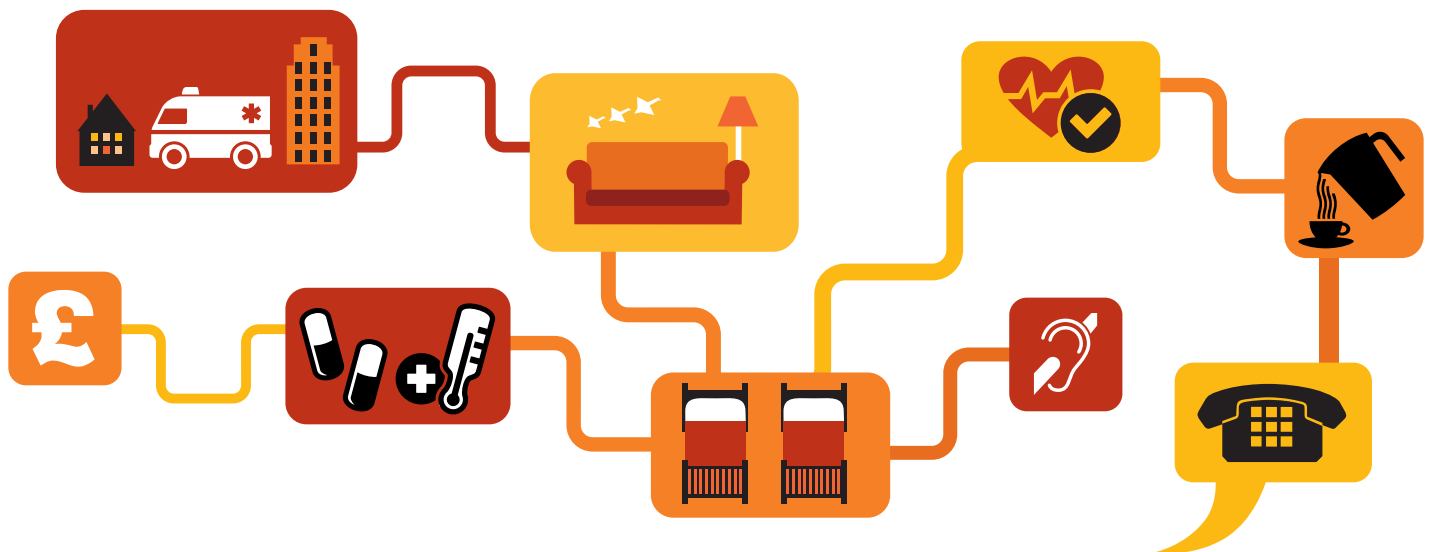
Working with family and wider support networks, the service helps people to plan and prepare for their death. It also supports those with a terminal illness. It enables people to make a choice about where they will die and offers emotional and practical support.

Digital technology options, including telehealth are explored. A one-off personal budget of £1,000 can be used to achieve personal outcomes such as access to social networks through smart phones or hand-held tablets.[13]

At any time the service can support up to 30 people who live in the most disadvantaged areas of Tyne and Wear. It is targeted at people over 75 but it does not exclude the over 55s. Referrals come from Macmillan Cancer Support, hospital social workers, Cancer Connections (a local third sector organisation) and self-referral.

"This service increases capacity to enable people approaching the end of life to be cared for and die in their own home."

NHS, public health and social care outcomes	
NHS 2	Improved health-related quality of life for people with long-term conditions.
NHS 2.1	A greater proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition.
NHS 4.6	Improving the experience of care for people at the end of their lives.

QIPP contribution	
Quality	• people can express their preference for support at home, so mental and emotional wellbeing is improved for them and their families • customers, families and friends report that Home's support to talk about the difficult topic of dying is very useful • practical interventions, such as support to manage personal affairs, are proving as important to people as pain relief • the service is improving staff skills and coordination of care for people at the end of their lives.
Innovation	• with Macmillan, Home has developed Home Achievement Programme modules (collectively called a Happy Ending), providing a structured way of helping people sort out their affairs • digital technology is being used to increase wellbeing and productivity with support from Newcastle University's Social Inclusion through the Digital Economy project (SIDE)[14] • the service is enabling integrated pathways and support networks across the whole continuum of care.
Productivity	• housing-based services reduce or slow the need for intensive nursing or residential care, delivering better outcomes at lower cost • Home's existing support services have been refocused to address end of life care • volunteers befriend people who are housebound and have restricted access to community networks.
Prevention	• the service aims to prevent people from spending their last days in hospital, if this is their choice.

Cost and efficiency savings?
The service is at full capacity (30 people). Indicative revenue costs are: • support at home – £78,000 (including individual budgets) • digital technology – £18,000 • befriending service – £48,000. Savings are expected (evaluation is due after publication of this report) from a reduction in: • days spent in hospital • ambulance call-outs and accident and emergency attendances • time spent on non-nursing/clinical inputs by nurses/clinicians • the demand for GP services • crisis management • prescribing of pain relief medication • moves to more costly services eg hospices.

[14] SIDE is the UK's largest research project on using digital technology to address social exclusion http://www.side.ac.uk/

What makes it work: the central role of housing

- the ability to adapt housing-based services to people as their needs change offers timely support in a familiar setting
- Public Health North East's (PHNE's) end of life strategy highlighted the need to work more closely with housing providers (PHNE is a member of the project steering group)
- funding for the pilot has come from the Health Innovation and Education Cluster North East under a programme to support innovative developments in public health and social care
- financial support for the digital technology aspect has been provided by Newcastle Science City's Community Engagement Research Programme
- Home's support staff are joint partners with nursing, social care and palliative care professionals and specialist agencies such as hospices
- Home has established partnerships with Newcastle University, Marie Curie Cancer Care and Age UK to ensure that people access the most appropriate care
- befrienders are volunteers so training and development is critical given the nature of the pilot and the impact on them as individuals.

Validation and evaluation?

The pilot will be externally evaluated by its funding partners. Robust data will be available after publication of this report.[15]

Replicable and/or scalable?

As awareness of the service has increased, so has demand. It is currently at full capacity and indications are that demand will exceed supply. Subject to positive evaluation, Home intends to extend a good death across its national customer base (50,000+ users). Initial training has been undertaken with St Christopher's Hospice.

Success and sustainability challenges:

- although targeted at the over 75s, the average age of users is between 50 and 60, most with a cancer diagnosis
- perhaps a reflection of high levels of deprivation in Tyne and Wear, the service's customer base is at odds with the national focus for end of life care on older people, those with dementia and those in care homes
- it is apparent that a different approach is needed in the context of chaotic lifestyles and long term conditions such as poor mental health, dementia and substance misuse.

Contact details	Sarah Ford, sarah.ford@homegroup.org.uk www.homegroup.org.uk/news/Documents/A%20Good%20Death.pdf

[15] The data will be available from www.homegroup.org.uk

Case study 5

Supporting re-ablement through telecare by Coast & Country Housing

What does it do?

Coast & Country Housing has been providing telecare as part of re-ablement packages in Redcar since March 2011. Coast & Country is the approved assistive technology provider in the area and works with Redcar and Cleveland Borough Council. Local partners are using telecare to reduce home care calls and hospital readmission.

The majority of re-ablement and telecare customers are over 75. Forty five people have received re-ablement support since March 2011, 22 using telecare and half of these service users with mild to moderate dementia.

Referrals for assistive technology are made by the social care re-ablement team following an assessment. Coast & Country installs and activates tailored telecare packages, suited to personal needs and the home environment. Crucially, installation takes place within 48 hours of referral. From this point, re-ablement assistants help people to learn to use the technology, showing them, for example, how to wear their pendant alarms. Monitoring devices are linked to Coast & Country's 24/7 customer contact centre, so if required the centre can alert a warden, next of kin, carer or emergency service.

"Good housing, with person-centred services like telecare, provides independence, stability and reassurance in people's lives which act as a springboard to better health."

NHS, public health and social care outcomes	
NHS 2.6	Improved quality of life for people with dementia.
PH 4.16	Minimising the effects of dementia.
NHS 3.6	Helping older people to recover their independence after illness or injury.
ASCOF 2A–C	Delaying and reducing the need for care and support.

QIPP contribution	
Quality	• 96% of all telecare users say the service is helping them retain independence at home • telecare packages are personalised to ensure service users are living safely at home whatever their needs.
Innovation	• combining re-ablement and telecare builds on existing use of telecare in the area to enable people to connect when they need it, in their own home.
Productivity	• introducing telecare at an early stage in re-ablement means staff can teach use of the equipment alongside other living skills, rather than as an add-on • trained staff understand telecare's potential as a cost-effective solution.
Prevention	• the service responds swiftly to device activation, minimising the impact of falls or threats such as fire • more than 97% of telecare activations are handled within 60 seconds, with an emergency warden response in 19 minutes (where appropriate) • in January 2012, 90% of those receiving telecare as part of a re-ablement package (22 in total) were still living independently at home • re-ablement combined with telecare has reduced the need for social care intervention in the longer term.

Cost and efficiency savings?

For the main three support needs managed with telecare, the weekly costs are approximately:
- dementia support – £17 per week
- falls prevention/management – £13 per week (67% of the re-ablement service users are receiving telecare to prevent falls)
- home environment safety and security – £13 per week

Total – £43 per week.

These costs include provision and installation of equipment, maintenance, 24-hour call handling and 24-hour warden response.

This can be compared with:
- the cost of care in the home where re-ablement and telecare has not been introduced, on average £351.75 per week
- the cost of residential care, on average £441 per week.

This represents potential cost savings of up to £400 per person, per week.

What makes it work: the central role of housing

- Coast & Country's knowledge and understanding of tenants' needs and expectations
- tailored assessments focusing on independence and management of risks in the home, as confidence in daily living is restored
- well-established contacts and a decentralised structure enables Coast & Country to deliver an efficient service to local communities
- awareness raising about the potential of telecare among referring agencies, through a combination of visits and the use of a demonstration suite
- clear referral criteria, developed through research and discussions with social workers
- integration with related services such as minor adaptations and equipment loan, and with other healthcare professionals in hospital and social care settings.

Validation and evaluation?

- a strategic telecare working group meets regularly and is attended by council managers and Coast & Country
- quarterly activation reports give information on responses and outcomes
- Coast & Country is accredited by the Telecare Services Association and adheres to its code of practice.

Replicable and/or scalable?

Coast & Country provides telecare to over 700 customers and is increasingly shaping provision for specific needs, for example dementia.

Success and sustainability challenges:
- telecare is relatively simple to scale-up and diversify, but integration with re-ablement and other services is critical to its success
- there is limited awareness of telecare and its potential among health and social care staff
- the service will need to continuously evolve to meet individual needs
- although relatively inexpensive, evidence of savings is needed on an ongoing basis.

Contact details	Jason Lowe, Coast & Country jason_lowe@cchousing.org.uk Karen Bowers (commissioner), Redcar & Cleveland Council karen_bowers@redcar-cleveland.gov.uk

Case study 6

Breathing space by Bedford Citizens Housing Association

What does it do?
Breathing space has been delivered by Bedford Citizens Housing Association since 2004 when evidence suggested that people were staying in hospital for longer than necessary. Breathing space offers older people time out to prepare for independent living, whether this is in transition from hospital back to home, or for respite.

Ensuite accommodation, care and support are available, for up to five people at any time, alongside an existing residential care home. Re-ablement activities are provided with a focus on mobility, confidence building and reducing the risk of falls. Social interaction through various activities and space for people to receive visitors are also important. People typically stay for around four weeks.

Bedford Citizens is a small and community-based provider of housing, support and care to older people. The scheme is commissioned by Bedford Council social services through re-ablement funding from health. Current referrals to breathing space are from the hospital and social services. With the onset of personal health budgets, it is planned to extend referrals to any eligible patients or their carers.

"Our service offers continuity between health, housing and social care at a much reduced cost."

NHS, public health and social care outcomes	
NHS 3.6	Helping older people recover their independence after illness or injury.
NHS 3b	Effective recovery from illnesses and injuries requiring hospitalisation.
ASCOF 2A–C	Delaying and reducing the need for care and support.
PH 4.11	Delayed dependency through effective re-ablement and rehabilitation.

QIPP contribution	
Quality	• after a stay at breathing space people are more physically and mentally able to sustain independent living • patients report that the stress following a stay in hospital has been greatly reduced • carers, often older people themselves, have a break from caring.
Innovation	• breathing space makes use of existing accommodation to offer a range of services.
Productivity	• the scheme is located near the hospital, enabling a short move for patients and close proximity to services • re-ablement support from breathing space (mobility, confidence building and falls prevention) can be completed more quickly as the team is onsite.
Prevention	• the scheme prevents hospital readmissions and has helped overcome fears of residential care, meaning some people living at home have returned for respite breaks.

Cost and efficiency savings?

Being housing-based, the service provides improved coordination and continuity between hospital and care settings. The costs and demands on clinicians' time are much reduced. Up to 60 people stay in the scheme every year, for an average of four weeks, at a cost of £68 per day compared to an average estimated cost of £686 per day in hospital,[16] or the cost associated with hospital readmission. The annual scheme cost is £140,000 per year of which BCHA contributes £15,000.

What makes it work: the central role of housing

- residents benefit from 24/7 specialist support in homely surroundings, structured around their combined housing and care needs
- funding is from Bedford Council social services (through health for re-ablement budgets) and Bedford Citizens Housing Association
- awareness raising among health partners has resulted in relevant referrals
- accommodation within the residential home means that care and support are close at hand and proximity to the hospital is also a positive.

Validation and evaluation?

- as a service commissioned by Bedford Council, the adult social care department is responsible for validation and evaluation.

Replicable and/or scalable?

- similar schemes across the country provide a small amount of recuperation accommodation allowing people and their families time to take decisions about the longer term (also referred to as step down accommodation)
- feedback from customers and families suggests that breathing space may be attractive to self-funders and those with a personal budget.

Success and sustainability challenges:

- reductions in local government spending have prevented some residents from moving on within the four week period
- further integration within the re-ablement process, and clearer information about choices when leaving hospital, would further improve outcomes.

| Contact details | Vanessa Connolly, vanessaconnolly@bchal.org |
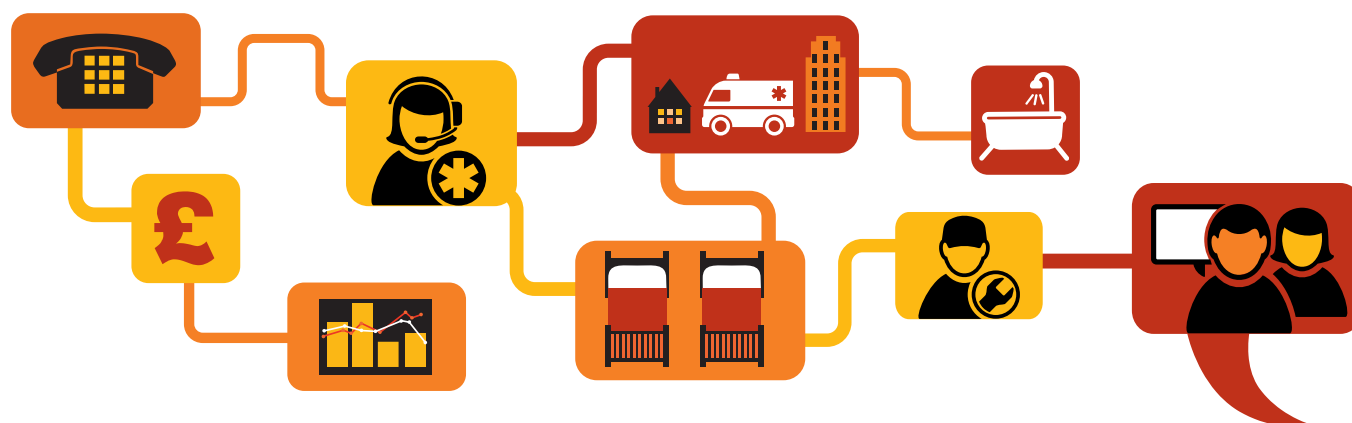
Section 2: Understanding and responding to the housing and health priorities for older people

This section explains current health and care priorities for older people to help inform local discussions between housing providers and commissioners.

Priorities are presented under the headings of Quality, Innovation, Productivity and Prevention (QIPP). The QIPP framework is a major driver of reform within the NHS and the QIPP themes are a way of focusing commissioners and providers on ways to deliver big efficiency savings, while sustaining or improving quality.

Quality

"The NHS is moving to a system where quality and outcomes drive everything ... 2012/13 is the year to make that change happen."

NHS Operating Framework 2012/13

There's an expectation that quality in health and care will be achieved by focusing on outcomes, giving real power to patients and devolving accountability to the frontline.

The NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Outcomes Framework are the starting point for understanding the desired outcomes.

What are the priorities for improving quality?

A number of NHS outcomes require contributions from public health and social care:

- support received in hospital, at home or in residential care
- care in hospital that supports timely discharge
- support provided to carers
- rehabilitation services.

Quality of care for older people is a priority. Seventy percent of acute hospital beds are occupied by older people, 20% of acute beds are occupied by people with dementia and 75% of residents of care homes have dementia.[17] Priority areas for improvement in quality are:

- services to people with dementia and their carers
- care for adults looking after people in the final three months of life
- mental health services.

Increasing direct patient care time and improving clinical quality and patient safety are relevant priorities, particularly to services for people with dementia.

Assessing and using patient and carer feedback is expected to play an increasingly important part in improving services in the future.[18] Staff satisfaction is also to be taken as an indicator of the quality of services.

Quality in the NHS is defined by the NICE quality standards, a set of specific, concise statements and associated measures.[19]

What do housing associations contribute to quality?

The case studies provide the quality care and support services the NHS is seeking with many targeting their approach to priority areas such as dementia. This is because they are:

- developing, improving and evolving in response to customer, carer, family and staff feedback; housing providers seek feedback on a regular basis for this purpose
- taking into consideration national and local evidence of need, and subsequent policies and plans to meet this
- sharing the same values and ethics as their colleagues in health and social care; they want to improve quality of life for people as they get older
- leading improvements in quality from the top of the organisation; from the board and the chief executive.

[17] NHS Confederation, as quoted in the Health Select Committee Report on Social Care, Fourteenth Report of Session 2012, Volume I, 2012

[18] The Department of Health is developing new models of assessing and using feedback. Patient surveys are one source of intelligence, undertaken as part of the NHS Survey Programme by the Care Quality Commission.

[19] NICE Quality Standards are:
- derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence
- developed in collaboration with NHS and social care professionals, their partners and service users
- intended to enable better decision making by health and social care professionals, patients and carers, service providers and commissioners
http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

Innovation

"Innovation is the way – the only way – we can meet [the] challenges. Innovation must become core business for the NHS."

NHS Operating Framework 2012/13

What are the priorities for innovation?

The NHS defines an innovation as "an idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied."[ii] It doesn't have to be something entirely new.

For innovation to be of interest to health it should:
• improve patient experience and productivity
• add value, not cost; value can be reflected in non-clinical outcomes such as patient experience
• be replicable across similar settings.

Particular areas highlighted for further innovation are:
• improving and extending life
• the use of telehealth and telecare to improve long term conditions
• bringing services closer to the customer, in their home and community
• supporting carers for people with dementia
• service integration.

In more detail:

The Department of Health's 3 Million Lives[20] initiative aims to spread the use of telehealth and telecare across the country to improve quality of care, and potentially deliver significant cost savings. This follows initial findings from the Whole System Demonstrator programme. Face-to-face contact accounts for nearly 90% of all healthcare interactions, but sometimes electronic means can be used. Every 1% reduction in face-to-face contact saves up to £200m.

Photo: Coast & Country Housing

[20] 3 Million Lives initiative http://www.3millionlives.co.uk/About-3-Million-Lives.html

Carers save the public purse £6bn every year, while an estimated 600,000 people act as the primary carers for people with dementia. Carer breaks and support, both emotional and practical, are critical to their continuing in this role.

The NHS needs innovations that challenge traditional delivery systems and strip out the processes that no longer add value. Useful sources of information and ideas on integration are:

• the Health Select Committee's report on social care,[iii] focusing particularly on people aged 65 and older

• a joint report from the King's Fund and the Nuffield Trust[iv]

• the NHS Future Forum paper on integration[v]

• the All Party Parliamentary Group on Housing and Care for Older People's inquiry report.[vi]

These reports are all feeding into the Social Care White Paper 2012.

What do our case studies contribute to innovation?

The case studies offer the innovations the NHS needs because they are:

• seeking to understand the combined experience of health, care and housing from the customer's, carer's and family's perspective

• researching local supply and demand for services, to learn from these

• committed to seeking support from health or care commissioners to enable innovations to be adopted

• engaging with research establishments and national organisations, such as Care & Repair England, to enable new approaches to be piloted and evaluated

• introducing different ways of working within health and care environments, changing workforce cultures along the way

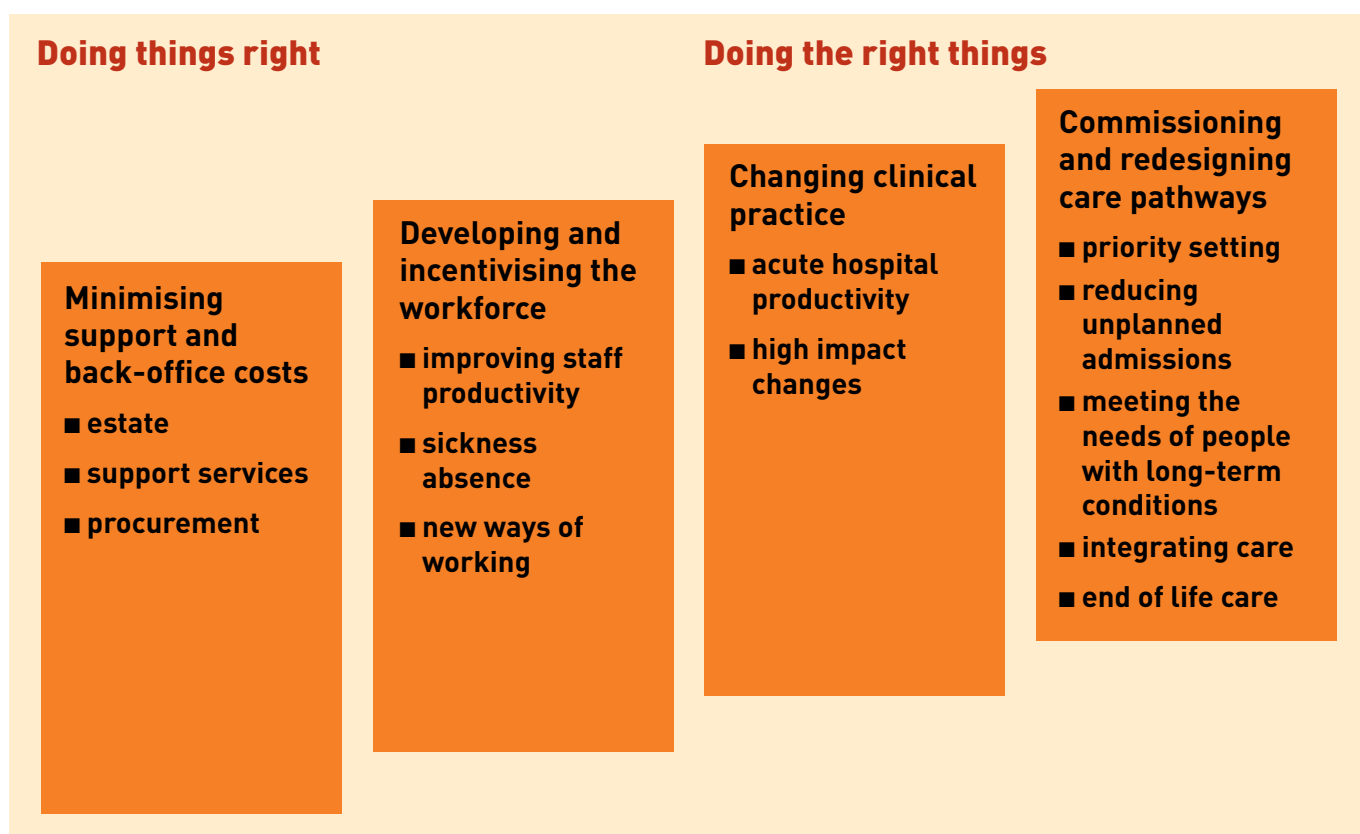• seeking to diffuse innovation across organisations.

Productivity

What are the priorities for productivity?

Improvements in productivity are vital to the NHS. Even with a real term increase in spend on health in the financial period to 2015, there is not enough funding to meet anticipated demand.[vii]

The diagram below, from the King's Fund, outlines different approaches to improving productivity. It highlights the need for QIPP to stretch beyond efficiency savings and transform services, practice and pathways.

Doing things right

Doing the right things

Minimising support and back-office costs
- estate
- support services
- procurement

Developing and incentivising the workforce
- improving staff productivity
- sickness absence
- new ways of working

Changing clinical practice
- acute hospital productivity
- high impact changes

Commissioning and redesigning care pathways
- priority setting
- reducing unplanned admissions
- meeting the needs of people with long-term conditions
- integrating care
- end of life care

Improving NHS Productivity, Kings Fund, 2010

In the last year, the focus has been on improving the productivity of support and back office functions. In 2012/13 this approach is shifting to clinical practice in areas where housing providers have most to offer. Everyone in the health system, in hospitals and in the community, is involved in improving productivity. From frontline staff to commissioners, the priorities for quality and innovation are aligned to those for productivity, for example, use of telehealth, transforming care for long term conditions and bringing care closer to home.

The NHS Better Care, Better Value Indicators (www.productivity.nhs.uk) support commissioners and providers looking for efficiency improvements. These guides provide insight into opportunities for reducing length of stay and emergency readmissions. They are also relevant to housing providers seeking to work with the health and care sector, with ideas for connecting with commissioners across acute, community and social care services.

What do our case studies contribute to productivity?

Our case studies demonstrate expertise in improving productivity, and by integrating housing, health and care, they are:

- using knowledge of the local operating context to improve productivity; they know what works

- redesigning services while delivering quality; making a better use of existing accommodation, staff and technology

- providing leadership within their organisations and among partners; inspiring people to achieve change

- working productively with NHS and social care staff, sharing information, knowledge and experience, and adding to staff capacity

- participating in health initiatives to identify and achieve efficiencies, for example Rapid Improvement Events;[21] they are able to understand where they can assist

- recognising the need to generate income from alternative sources, raising awareness of their services among self-funders and those with a personal budget.

Prevention

What are the priorities for prevention?

The three health and care outcomes frameworks provide the best guide to what prevention should focus on. Thinking about people as they get older and their changing needs, the priorities are:

- delaying and reducing the need for care and support

- preventing and reducing emergency readmissions within 30 days of discharge from hospital, including for people with chronic conditions, for those recovering from injury, trauma or stroke and for people with dementia

- preventing or diverting acute admissions as a result of fall injuries and preventing crises for people with dementia.

Prevention improves quality of life and reduces health inequalities among older people. The following are priorities for acute and public health and care:

- good quality, rapid rehabilitation services on discharge from hospital to reduce risk of readmission and which are responsive to specific needs such as strokes and dementia

- re-ablement services – the 2012/13 PCT revenue allocation includes an additional £150m for re-ablement assistance for regaining independence if daily living skills are lost through illness or injury

- telecare

- community directed prevention and early intervention, for example, falls prevention

- community equipment and adaptations

- good quality environments that enable recovery and rehabilitation and provide an alternative to residential care.

The NHS Operating Framework 2012/13 is clear that PCT clusters should be working with local authorities to agree joint priorities, plans and outcomes for the investment allocated for re-ablement in 2012/13 and beyond.

[21] Rapid Improvement Events bring together NHS and other agencies and seek to make radical changes to current processes see http://www.institute.nhs.uk/quality_and_value/rie/rapid_improvement_events_%e2%80%93_introduction.html

What do our case studies contribute to prevention?

Our case studies contribute to the NHS prevention priorities:

- Providing a quality home environment, and support services, for older people while they are recovering from illness, stroke or other trauma, or in preparation for the end of their life.

- Developing and delivering services that are in the right place at the right time. Ideally these will prevent a crisis, but where this is unavoidable, housing providers will take the opportunity to talk to older people about their plans for the future, their care, support and housing needs, preventing further crises arising.

- Seeking to transform preventive services so they are sustainable at a time when local government funding is reducing. There is evidence that preventive services delivered £3.41bn of financial benefits to the public purse for an investment of £1.6bn.[viii]

- Identifying new routes for those who may need preventive services, for example self-funders.

- Working constructively with health and social care colleagues, including occupational therapists and hospital and social care discharge teams, to enable a holistic approach to prevention and independence.

Conclusion

A settled home is integral to improving the health and social care of the growing numbers of older people. Housing associations are essential and willing partners in this challenge as they do so much more than build homes. They have a strong ethos and an impressive track record of enabling people to maintain their independence at home as they age or as their needs change, which reduces the need and cost of more intensive services. They are well placed in the local community to develop and deliver services that are in the right place at the right time. They are committed to using their knowledge of customers and the local operating context to find new and cost-effective solutions.

These pages have shown just some examples of the innovation, expertise and experience across the social housing sector and the diverse ways in which housing associations are improving the health and care of older people.

Further information

Our website will feature new case studies, so keep up to date at: www.housing.org.uk/careandsupport

For more resources on housing, health and social care, visit the publications page of the Federation's website http://www.housing.org.uk/publications.aspx

These include:

Submission to the Health Select Committee on Social Care, (2012), outlines the role and value of housing to social care.

Breaking the Mould: Re-visioning older people's housing, (2011) demonstrates how housing associations, local authorities, health services and other local partners are developing new housing and support models to meet the needs of older people.

Invest in housing, invest in health, (2011) shows the improved health outcomes and cost savings to the NHS that can be achieved for different client groups through working in partnership with housing associations.

Health and housing: worlds apart? (2010), explores the link between housing and health and how the two sectors work together.

References

i   Department of Communities and Local Government (2011) Handypersons evaluation http://www.communities.gov.uk/publications/housing/evaluationhandypersonprog

ii   Department of Health (2011) Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131784.pdf

iii Health Select Committee (2012) Committee Report on Social Care http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/158302.htm

iv   The King's Fund and the Nuffield Trust (2012), Integrated Care for patients and populations: improving outcomes by working together http://www.kingsfund.org.uk/publications/future_forum_report.html

v   NHS Future Forum paper on integration http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132026

vi   The All Party Parliamentary Group (APPG) on Housing and Care for Older People Inquiry report http://counselandcare.org.uk/pdf/living-well-at-home

vii Appleby et al (2010) Improving NHS Productivity: More with the same not more of the same. London: King's Fund http://www.kingsfund.org.uk/publications/improving_nhs.html

viii Research into the financial benefits of the Supporting People Programme, 2009, Department of Communities and Local Government http://www.communities.gov.uk/publications/housing/financialbenefitsresearch

NATIONAL HOUSING FEDERATION

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

Our members provide two and a half million homes for more than five million people. And each year they invest in a diverse range of neighbourhood projects that help create strong, vibrant communities.