trowers & hamlins

Creating healthier places

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Contents

1 —— Introduction

2 —— Progress update: Setting the scene

4 —— Untapped opportunities in the planning system

7 —— Themes arising from the discussion group session

7 - The policy environment

8 - The planning system

9 - Funding

10 - The politics of change

Introduction

We recently convened the third of our think tanks considering progress on and opportunities for joint working between the health and housing sectors, in conjunction with the London and South East branch of the Health Estates and Facilities Management Association (HEFMA). We were joined by representatives from NHS Trusts, local government, registered providers (housing associations) and central bodies such as NHS England and NHS Improvement.

Our discussions began with a progress update, setting the scene for discussions. Following on from this we looked at some current sector examples of new and exciting models and practices.

We had a specific look at the planning system and opportunities and barriers it creates through our planning specialist Tim Brown, whose article covers the key areas discussed on pages 5 and 6.

The key part of our event was to then take the opportunity to ask the meeting participants to consider some key questions in groups and feed back to us. Our goals here were twofold. Firstly, we wanted to ensure we obtained genuine feedback from the wide range of participants engaged in the discussion. The themes from their responses are covered in the main part of this report. Secondly, we wanted to ensure the conversation between different sector participants continued and that a range of different perspectives on the drivers, opportunities, perceived barriers and solutions to better engagement between the NHS and others were discussed. The intention is that as well as presenting this report we could stimulate better understanding and perhaps even some transactional activity between those attending the session.

As a result of all this, this report distils the content of the discussions and notes both key successes to date, but also the huge opportunity for all to gain from closer joint planning and working. We hope you find it useful.

Progress update: Setting the scene

While there remains plenty of enthusiasm on all sides there is still a language barrier and a lack of clarity on the best approaches to cross-sector engagement.

This can stem from a simple lack of knowledge about what other sectors and organisations can do. Housing associations provide so much more than just housing - community services, health and social care services, advice, employment and much more. There are also a much wider range of organisations looking to engage with health than just housing associations. Many private sector developers, providers of services and investors are seeking to engage with NHS and other parts of the health and care system to find new ways to deliver services and facilities (clinical, primary care, community care, housing solutions (affordable or otherwise), staff accommodation, parking, retail – there is a huge amount of interest in a very broad set of areas). We questioned at the most basic level whether "health and housing" is the best label for the relationships we are looking to build and the activity we are looking to foster. Is it too narrow a description? Perhaps that is a question those looking to see this idea continue to evolve should explore. Labels may seem unimportant but it's that much harder to explain something if you can't name it.

From a health policy perspective, we have a fairly clear framework arising from the Five Year Forward View, Carter and Naylor reviews and the ongoing progress of STP and ICS models and most recently the Long Term Plan. Key themes from these are efficiency, effective use of estate (and other resources) and a move away from acute settings towards provision of health and care services in community settings, in the home or as close to it as possible, wherever possible. NHS systems are adapting to meet these policy requirements. A prime example is NHS Improvement's strategic estates function being delivered via the NHS Property Board, which is helping to eliminate overlap within its constituent organisations and drive effective system-wide estate planning.

While it is questionable whether we can fully resolve all of the issues while the question of social care funding remains unresolved – with the Green Paper in a seemingly perpetual state of delay – there are plenty of opportunities. Social care has itself seen some regulatory interventions in recent times, though these have been focussed more on the customer/consumer with the CMA publishing comprehensive new guidance for care home operators on contract terms and disclosure practices and the Law

Commission and MHCLG looking at deferred payments charging structures in the (likely in our view to grow significantly) retirement housing sector. These types of provision are just some of those the non-NHS sector focuses on and which overlap with the expectations of the Long Term Plan.

From a systems perspective we identified that "NHS people" understand the NHS very well - it is a complex system with multiple layers of function and can be challenging to navigate for the uninitiated. People in the NHS are keen to see the policies discussed above implemented and are open about challenges within the current system and their ideas about how it might be improved. Generally, people in the NHS are perhaps less aware of "nuts and bolts" of non NHS provision (which is understandable). They are always keen to understand how they might do things differently and how they might engage with other sectors and organisations but there are pressures – the day job, the financial pressures on the NHS and time.

On the "non NHS side" – there is often, quite literally in some cases, a language barrier. The list of NHS jargon is long and can be daunting to those unfamiliar with it. Keeping up with terminology can be difficult as new systems and policies evolve. There is also a systems barrier whereby people not familiar with the NHS and its systems can find them challenging. A prime example is the NHS business case processes. NHS England's Project Appraisal Unit are clear that their roles are not just business case assurance, but also educating people about the process to save time and money. As new organisations are engaged in models and transactions involving the NHS it will be essential for them to understand effective approaches to NHS business case requirements to ensure a smooth path to delivery.

In summary, there is willingness, but barriers and challenges remain. However an evolving landscape brings opportunity and Government policy is conducive to taking them. Our group discussion looked at some ways to make this happen.

Croydon Council integrated health and social care service for older people

Trowers & Hamlins advised Croydon Council and its NHS and voluntary sector partners on their new integrated health and social care service for older people. This was the first time a collaboration of this scale has ever been developed in the UK. The new service is an alliance of those responsible for commissioning services, together with local providers.

The Alliance's members are: Croydon Council; Croydon CCG; Age UK; Croydon Health Services NHS Trust and South London and Maudsley NHS Foundation Trust.

This alliance's objective is to work holistically with individuals (and their needs) and to harness health and care support to secure the best outcomes for older people.

There is a growing consensus that social care and health need to be joined-up – the Croydon Alliance is the first concrete example in England of how that can be done, and a model that is likely to be rolled out across the country.

Providing more effective support in people's own home, it has a positive knock-on effect for both the individual and the wider health and social care service. Joint working between council staff, NHS and Age UK Croydon colleagues will mean better care for Croydon's over-65s, giving them greater independence to manage their health and wellbeing, and to avoid unnecessary hospital visits.

Untapped opportunities in the planning system

Health is embedded into the planning system directly and indirectly. For example:

- Residential development increases demand on existing primary care health facilities;
- The planning system considers wider health issues in order to encourage healthy communities, by providing parks and other facilities for children as well as sustainable transport to facilitate healthier lifestyles; and
- For Trusts and Clinical Commissioning Groups, the planning system is important for the direct development for health facilities and increasingly the release of surplus land.

Traditionally, the success of engagement of health organisations with the planning system has been mixed and the relationship tends to be one plagued by frustrations.

The current nationwide context of the housing crisis means that these issues are as important as ever – the target of 300,000 new homes per year will increase strain on stretched facilities as well as creating new areas of demand. This is a time of great challenges for health in planning, but there are opportunities as well which we need to maximise.

Plan making

The planning system is a plan-led system and every local authority has plans that dictate which types of development are acceptable and which developments and sites are suitable for development. Local plans last over a 15-20 year period and so it is very important for the health sector to engage in local plan-making.

The National Planning Policy Framework requires that all types of health and social infrastructure are integrated into local plans, so there are policies in all local plans that deal with health issues. Importantly, health bodies need to engage with this process - if local plans in particular areas are coming forward, providers should get involved in those and ensure that suitable long-term policies are in place. These will include generic health policies about encouraging healthy development and more specific policies requiring developers to engage with particular organisations when designing their developments (for example, CCGs). Policies may also exist on particular issues such as keyworker accommodation and how this is accommodated in new developments alongside other affordable housing. NHS organisations may also have surplus land sites that they wish to allocate for alternative development.

These issues should be addressed at the plan-making stage and can only be addressed properly with adequate engagement from all relevant stakeholders. The plan-making process can be lengthy (it can take up to three or four years to adopt some plans) so engagement over the entire process is important to ensure that the information provided is updated to reflect changing circumstances.

One of the key changes in the National Planning Policy Framework updated for 2018 and accompanying Guidance is in relation to viability in planning. This is a controversial area that is often perceived to be complex, time-consuming and lacking in transparency. The Government's answer is to address viability at the plan-making stage to assess what infrastructure is needed on a particular site at an earlier date. If the Government is successful in front-loading viability, the health sector needs to make sure its engagement is equally front-loaded or risk missing opportunities when planning applications for these large sites come forward. This makes it all the more important to engage properly with plan-making on an ongoing basis.

Engaging with planning has challenges – it is time and resource-intensive for health organisations and the complexity of NHS structures means that involving the right parties can be difficult for local planning authorities. Since the breakup of Primary Care Trusts, there is no natural recipient for primary care health funding through the planning system. Local authorities may therefore need to take a more active role, potentially through Health and Wellbeing boards adopting a coordinating role in this process.

Section 106 and Community Infrastructure Levy

The health sector can make far better use of developer contributions from section 106 agreements and Community Infrastructure Levy (CIL).

Developers are often happy to pay for health facilities as access to good quality facilities can assist with the marketability of new homes. However, they rely on the relevant public bodies to allocate this money. Often developers on particular sites may know they are obliged to provide a health facility or make improvements to an existing one or pay cash under section 106 agreements, but subsequently find that NHS responses to consultations are either late or not provided at all. This risks health infrastructure contributions being demoted to the 'back of the queue' or section 106 obligations being watered down, diminishing their usefulness. It is vital that consultations on planning applications are given proper consideration.

Changes are proposed to the section 106 system which aim to remove the restriction on pooling monies from multiple agreements, which has been prohibited in recent years. This would allow local authorities to use multiple sites to support new health infrastructure and could be particularly helpful in directing pooled money from several large developments towards primary care facilities impacted by those developments. However, this still requires coordinating to assess what impacts developments will have and where money needs to be spent.

There are further opportunities in relation to CIL, which is a relatively untapped pool of money. It is important to engage with local authorities to see what types of infrastructure they would be willing to look at funding through CIL monies. The Government has been criticised for a lack of transparency in relation to 'Regulation 123 Lists' which specify what types of infrastructure the local authorities can spend CIL money on. It therefore proposes to make changes to legislation, imposing a new requirement for local authorities to produce annual Infrastructure Funding Statements for section 106 and CIL monies to show what money they are receiving and what they intend to spend it on. If successful, health organisations can take advantage of this new requirement to better understand funds available and make better cases to be allocated some of that funding. In turn, this could potentially also help unlock unspent monies from old section 106 agreements.

Challenges and opportunities

Housing and population issues mean that demand for health facilities is as high as ever and the planning system must cater for those demands. However, the industry should be aware that there is significant policy support and tools within the system that can help. Whilst there are numerous successful cases of integrated health planning, for the most part, stakeholders need to take more advantage of the existing system.

ZCap®

The first project under this innovative new way of funding health hub developments will provide circa 1600m2 of accommodation for GPs, community services and bookable clinical space for community or third sector providers together with 60 car parking spaces in Little Hulton, Salford.

The project, using the unique ZCap® structure, has enabled the GPs to implement their preferred self-delivery and ownership model. Under this structure, the GPs will develop the facility as landlord via a Special Purpose Vehicle with Castle Gate's funding partner, with no requirement for NHS capital funding and no GP personal funding guarantees required. The GPs will enter into a FRI head lease for the whole building, subsequently sub-letting to other GPs via a TIR lease or short term licences providing additional flexibility.

Whilst the GPs will own the majority of the asset, and thus control its use, they will also take advantage of any future property returns. The ZCap® structure de-risks the project for the GPs by managing the partnership with the funder, and fully mitigates risks by effective risk transfer overseen by the Castle Gate professional team.

The Little Hulton ZCap® project has been approved by the Salford Clinical Commissioning Group as the best value for money option following approval of the District Valuer. Both the project development costs and lease rental are fully recoverable under the GPs' CCG contract.

Themes arising from the discussion group session

The policy environment

Many of the good examples of positive cross-sector working are driven locally and stem from one or more local system leaders championing a particular cause, bringing people together and making things happen. This is a bottom-up approach to change. Do we have a policy environment in place which creates sufficient top-down impetus for more activity between health and housing providers (and indeed between health and other providers of accommodation and services which can complement health)? If not, what kind of policy might we need to bring forward? An example we floated was that NHS business cases might be required to show suitable engagement with non-NHS sectors.

There was a healthy debate on this question. Clearly policy can create a kind of permissive culture, making it clear what is allowable and putting an impetus on people that might have been wondering whether or how to act. However, most questioned whether more top-down policy could ultimately be helpful, suggesting that it could lead to something of a tickbox exercise for some, and could be seen as (or used as) a barrier to innovation by others, particularly if too prescriptive.

Health and Care Space Newham, a joint venture between the Council and East London NHS Foundation Trust intended to shape the local integrated care estate, was noted as a positive example here. The desire there is to deliver integrated health and social care services in a fit for purpose estate and has drawn in all key partners, including GP's, creating the right kinds of influence in the right places to ensure good public health and wider health system promotion.

This did not require additional policy and its genesis was a local relationship between people and organisations, responding to the need that was identified locally, rather than to a central policy. The Croydon local health integration for older people is another service-led example of a local authority, NHS bodies and in that case Age Concern coming together to deliver locally in response to identified need.

Clearly strategy is important, but individual organisations - or groups of organisations when looking at Sustainability and Transformation Partnerships and Integrated Care Systems – can act strategically within existing policy frameworks without needing to be told in any more detail what to do and how to do it.

It was felt that the structural changes with STPs coming forward, and moving into regional focuses could assist. Perhaps a way forward is to use STP frameworks as a catalyst to form local policy agendas through which better engagement across health and housing and more generally between with wider health and wellbeing services can occur.

Participants suggested that we already have some positive and enabling policy and strategy structures in place which often work well, with plenty success stories, including work that One Housing and Look Ahead have done on step down care with some London mental health trusts, albeit these are often fairly isolated and have not yet resulted in system-wide structures being adopted. Perhaps that stems from the need for local solutions locally. It may also stem from relationships between organisations and those leading them - invariably relationships and local "small p" politics play a role in how interactions occur and the success of projects which rely on such interactions. So does simple resourcing. If there are other major issues drawing people's attention away from health and care solutions it will be harder for new ideas to come forward. At present we have many such demands on already limited time for people across the public sector – pressures include Brexit, Grenfell and austerity. This is perhaps why the "local champion" remains so essential to success in many cases.

The upshot seemed to be that good policy, implemented correctly, has the capacity to act as an enabler. However, the likelihood of everything coming together such that we have that kind of policy and uniformly positive implementation across geographies and sectors means that, on balance, the preference is to work within existing policy frameworks rather than adding to them.

The planning system

What are the planning system barriers to effective integration and delivery of services across multiple sectors and provider types. Is it possible to make the existing planning system and existing planning policy work effectively or does that need to change?

One of our participants pointed out the disconnect which seems to exist between some of the policies in the planning system and delivery. The national planning policy framework has thrown up examples of outcomes which have not aided the health system. It was also noted that planning policy on occasion leads to significant amounts of resource being expended on interpretation and the fighting of battles, rather than focusing on efficiency and delivery.

As a more specific set of examples around this issue, it was noted that there was something of a "hit and miss" approach to the NHS achieving the value it should derive from planning gain, Section 106 obligations and Community Infrastructure Levy payments. An interesting example was raised around the quality of a hospital development suffering as a result of the approach taken to the negotiations on the Section 106 agreement and the participants involved in the discussions on that agreement.

The feeling was that in many cases local planning authorities make key decisions about the nature of the obligations to be imposed on developers without necessarily understanding the estate and infrastructure requirements the local health and care economy might have through a close relationship with NHS and other health and care commissioners and providers – whether acute, community, mental health or otherwise. Although it was generally felt that individual NHS providers and/or commissioners are involved in discussions with councils about developer contributions, there does not appear to be a uniform approach to this, with outcomes seeming to be derived from the strength (or lack of strength) of local relationships. It was felt that this was not the ideal approach to planning for the future of the health and care estate.

As such there was something of a call for a revisiting of planning policy to make it more conducive to the delivery of the right kinds of services and infrastructure for services going forward.

This may sound partly at odds with the majority view on our first question, that more policy is not a panacea. However, the concern here was not about more policy being needed but about the right kind of policy coming in to supplement or replace what is currently driving delivery. This is very much in keeping with the initial discussion about policy needing to be on-point and then implemented effectively in order to facilitate positive change.

It was also highlighted in the wider discussion that the planning system needs to accommodate all of the key players in the health and care system. As an example, GPs have a very, very active role to play in terms of primary care and this has, for example, been an important part of the Health and Care Space Newham project succeeding. We need systems which can hear the voices of all key contributors to the health and care system. This is of course one of the areas we have identified in our previous reports on health and housing as a challenge for the housing (and wider non-NHS provider) sector and those looking to engage with it – simply because of the huge range of providers and the nature of services they offer in local geographies. Understanding who to start talking to can be daunting, as although the local social services, planning and housing authority in a specific area can be identified simply enough, the providers of housing and social care services will be many and varied. This remains a challenge for all those looking to evolve this area to work. Building and improving local relationships and connections and the forums through which they can be grown, both formally and informally, seems the best approach here.

Funding

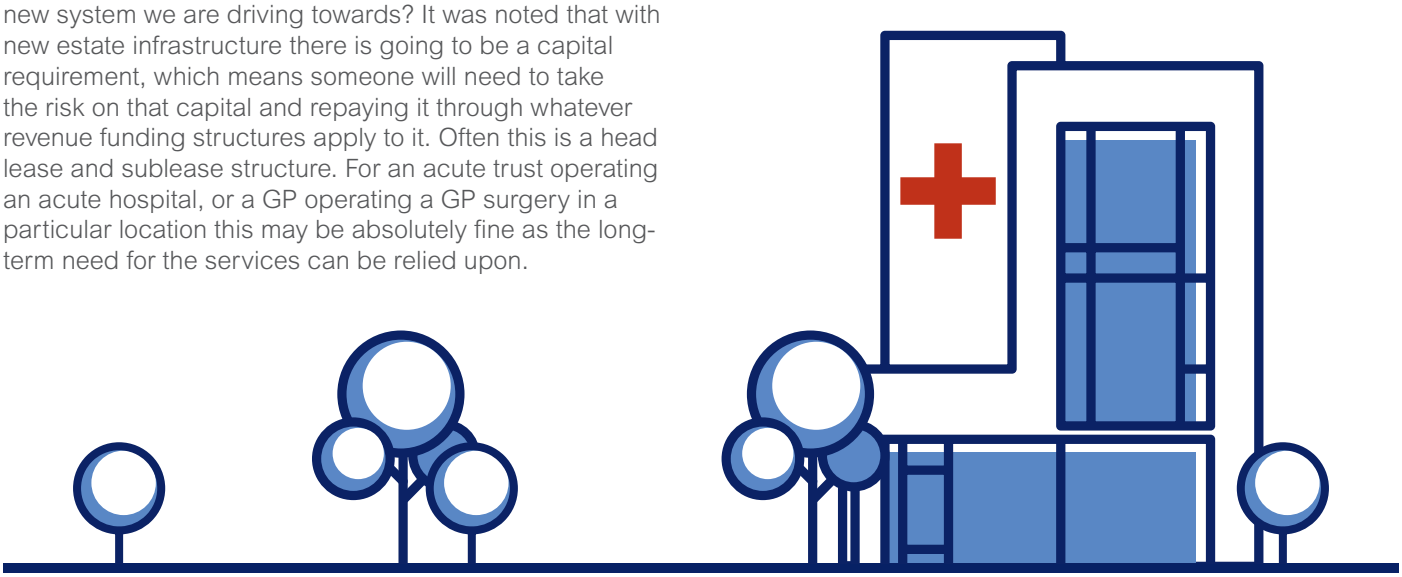
Is it possible to create a system-wide community-based health and care system which meets everyone's needs and can be afforded by all who must contribute, fairly? We asked participants to consider this in light of the recent (though slowly relaxing) constraints on NHS funding growth in real terms, and the ongoing lack of clarity about the long-term funding of adult social care - both from a Council funding reductions/austerity perspective and in light of the lack of a Green Paper and any clarity about citizen contributions to lifetime social care costs.

Funding was noted as a very significant issue across the health and care spectrum. It was felt that there is a need to take an approach which allows organisations and funding streams to come together and think of new models which are efficient and effective. We believe this means efficiency and effectiveness both in terms of the cost of the provision in question but ideally also the upstream savings to wider health and care economies which can be generated. Simple examples exist, such as dedicated retirement community settings leading to lowered demand from older people on GP and emergency acute services, or community-based learning disability accommodation providing a much better quality of life for individuals while also avoiding the often significant comparable expense of institutional settings. These and other sector examples need to become more mainstream, or perhaps more accurately an evidence base needs to continue to build around them in order for that to occur.

A significant question is of course appetite for risk on funding. Which organisation(s) will take capital and revenue risk within new funding structures designed to create the new system we are driving towards? It was noted that with new estate infrastructure there is going to be a capital requirement, which means someone will need to take the risk on that capital and repaying it through whatever revenue funding structures apply to it. Often this is a head lease and sublease structure. For an acute trust operating an acute hospital, or a GP operating a GP surgery in a particular location this may be absolutely fine as the long-term need for the services can be relied upon.

However, for many services in the NHS and in social care, contract lengths are typically three or five years. Committing to responsibility for assets beyond the life of a contract without any comfort that it will be renewed (or that you will win it, if it is renewed) is a risk, and so a challenge, for any organisation. These are challenges within the current environment. Making changes to the approach to delivering services and the funding of them, as STPs and ICS's aim to do, has many benefits but carries additional uncertainty. This was identified as a potential barrier, specifically associated with funding risks but also procurement risks. It was noted that there seem to be cyclical views about best approaches to new ways of working - joint ventures, new vehicles, new procurement methods – but that the system needs to focus on coming up with a few solutions with genuine mileage in them, acting collectively, to drive some real action.

At a macro level there is a question of delivery by the public sector. For the average citizen, a debate about one part of the public sector taking a particular risk over another is a debate about nothing more than which line on a set of public sector accounts their tax money sits – ultimately it is all taxpayer money funding services, and risk allocation is academic. Ultimately perhaps a move to single organisations with overarching responsibility is what will be needed. This is of course what Integrated Care Organisations systems would aim to do. At present these seem unlikely to be taken forward as legislative changes would be needed and so again the system must focus on workable solutions within current legal and organisational structures.



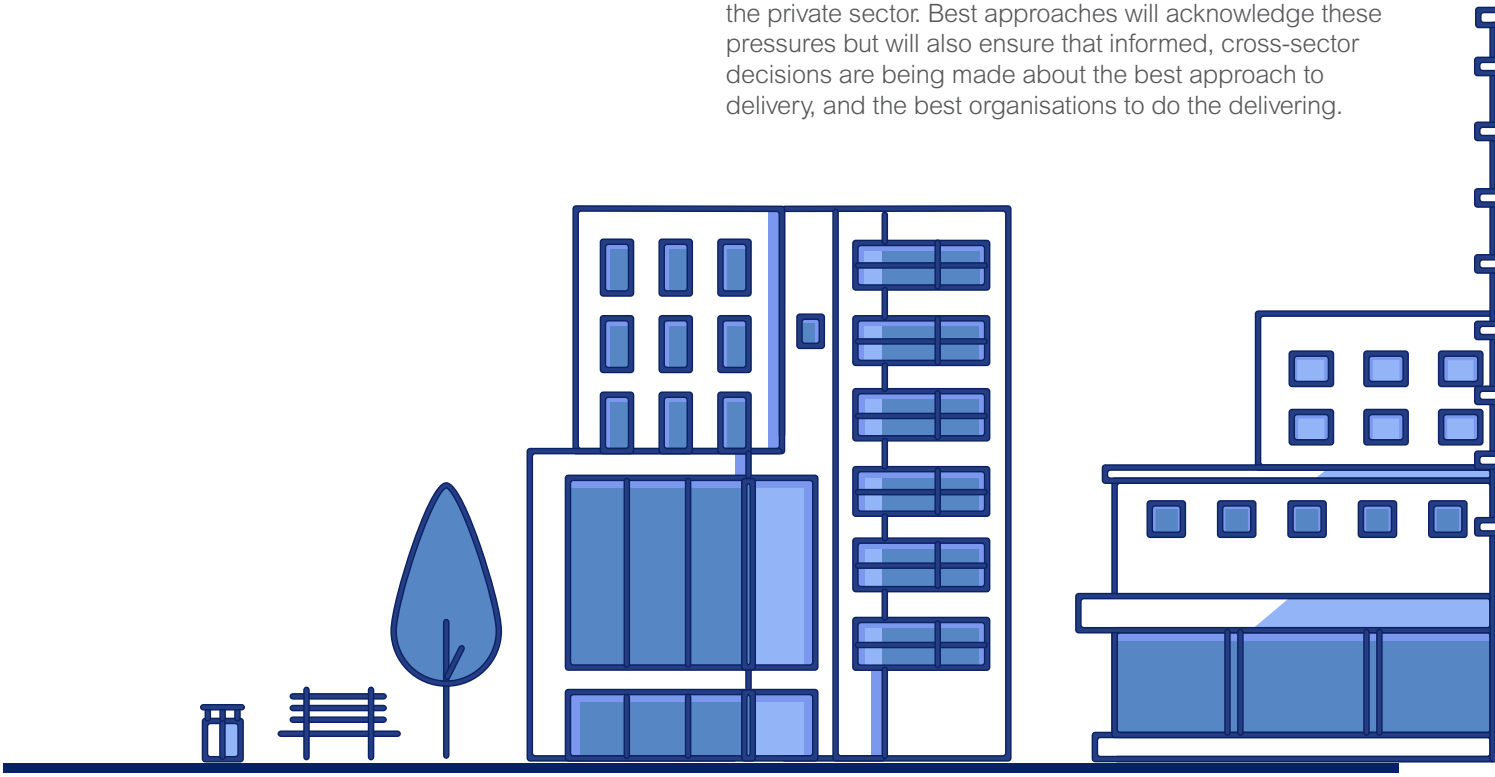
The politics of change

The NHS is, rightly, nationally treasured. However, this has made it something of a political hot-potato. There is a difference between reducing acute services which are demonstrably no longer required because other, less expensive and community-based services have stepped in to replace them, and simply closing services because they are unaffordable. Can politicians and the general public be helped to understand this nuance - or must we build the new system while operating the current one before we start to decommission what is no longer needed? How could that be funded?

Part of the discussion here focussed on culture shifts which might be required to make the changes to the system needed to implement the sorts of new models we are talking about. There is potentially a ten year period rolling out such new systems and new personnel will be here delivering them. As different people come into roles with more of a background in both housing and in NHS services, perhaps they can push forward a different agenda. We have certainly seen more examples of this sort of cross-sector recruitment and approach to working within organisations in the last five years than was previously the case. Similarly, those whose careers evolve within the new frameworks being adopted now will have a different approach to those who have "grown up" under different policy frameworks.

It was noted that the NHS primarily is good at clinical delivery but of course must take a positive and effective approach to the built environment and its delivery, management, reporting on use and efficiency. This is as much about finding the right people for those relationships which are necessary to do this where the NHS does not have the resource to do so itself. There is something in this about "unknown knowns" and organisations being clear about their overall skillsets and gaps in those skillsets. The alternative could be risk-taking without fully appraising risks, or could be simply delay while the "right" person is found, or sought for and not found. Clearly the right skillset entails both the ability to understand and take key decisions on risks in a commercial (and legally compliant) way, but also the authority to take those decisions.

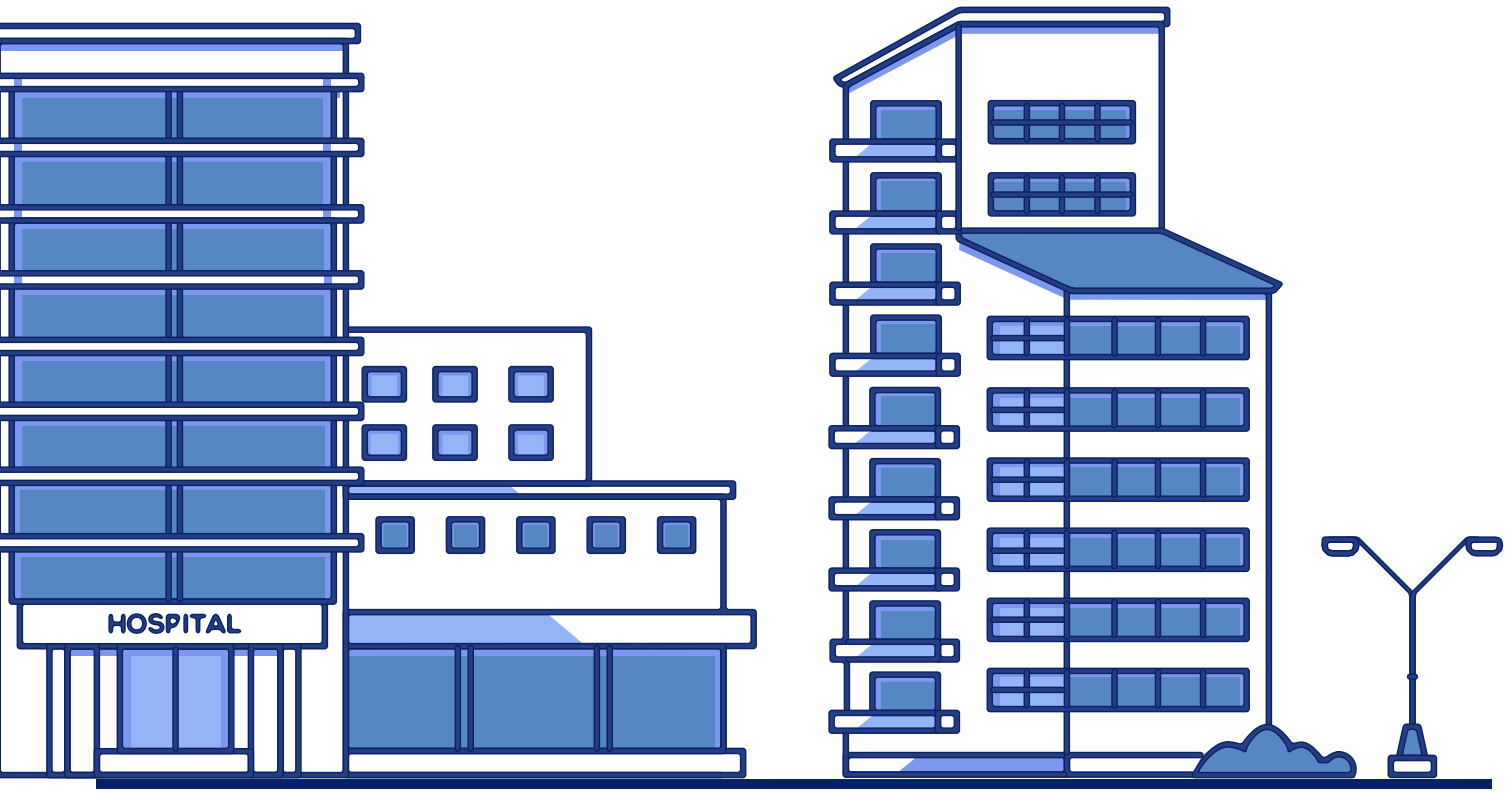
The oft-recited concern about the private sector's role in UK health provision was raised. There is clearly a role for the private sector but this needs to be balanced against overall policy and what is most effective from a cost and risk perspective for health and care systems. It was also noted that there is a different kind of pressure within the public sector, partly overlapping with the comment above about what the average citizen is likely to think about risk-passing within taxpayer-funded organisations. Aligned to this we see competition between NHS organisations and others on pursuing planning gain infrastructure and funding, and competing for business "out of patch". These are a new pressure in addition to working out the most effective role for the private sector. Best approaches will acknowledge these pressures but will also ensure that informed, cross-sector decisions are being made about the best approach to delivery, and the best organisations to do the delivering.



Different opinions were voiced about approaches to most effectively move services from acute settings and into the community. Reiterating comments already made, there was a degree of consensus that making sure the relevant decision makers in the respective partner organisations were around the table and deciding together the most effective approach had to be best. Following on from that of course it is essential to ensure that those organisations then resource the project fully and effectively – not just from a funding perspective but from a personnel, public relations and other perspectives. Having done that the likelihood of success and positive movement seems much greater, as some of our identified examples show.

There was a question about the best means through which to approach estates strategy and whether local estates directors of trusts would be the best starting point. While we didn't come to a firm conclusion on this perhaps one answer is that STP's should have an estates strategy and a lead for that strategy and they are one opportunity. The NHS Property Board is intended to have a finger on the pulse of activity and so may also have the ability to help.

It was noted that inevitably new models require new thinking. This requires different organisations when coming together to form new structures, particularly joint ventures, to spend significant time and resource thinking through their powers and duties and how far they can go in terms of their participation and the risks they can take. Collaboration between organisations and an open policy landscape allowing different approaches were felt to be key here. This brings us back to the balance between policy which acts as an enabler not a barrier, and coming up with structures within the policy frameworks that can be proven and then rolled out rather than cycling through lots of different possibilities without real action being taken. And that - action - seems to be the key to the health and housing and the wider health and related services proposition progressing.



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