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— Spring 2018

Creating healthier places

Outcomes from our second West Midlands health and housing roundtable

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Introduction

Following last summer's successful roundtable exploring the benefits of joint working between the health and housing sectors in the West Midlands, we reconvened the group in February 2018 to discuss progress.

The event was extraordinarily popular with a large group of attendees from a wide range of organisations across health, housing and social care engaging in a lively discussion about the benefits of closer working between sectors, some recent "wins" and ways in which to progress better integration for the benefit of individual citizens and the public purse.

For a full list of participants please see page 4.

A number of key themes emerged from the discussion and rather than providing a detailed commentary on all the points raised we have explored these main themes in more detail.

Progress update: evidence of cross-sector buy-in?

There was some positivity, demonstrated by good anecdotal examples from attendees that real progress has been made in putting housing onto the health system's radar in the Midlands. Examples of positive engagement were given for Staffordshire and Warwickshire where housing colleagues feel they now have potential to play a greater role in Sustainability and Transformation Partnership (STP) delivery moving forward. More of this kind of engagement is needed to ensure the best possible outcomes are secured for local populations and the best use of the money that funds their services.

All STPs will have different focuses and goals and relationship strengths across organisations will differ. This was apparent from the health colleagues in attendance, who all had different areas of focus. For example, some had no problem finding accommodation for staff and had programmes available for staff training and retention. Others found staffing and staff accommodation more of a challenge.

Inevitably there are competing drivers within different parts of the health system (Trusts, the property companies, GPs, commissioners) which must be brought into alignment about the best approach, taking the housing and social care sectors along on the journey, and allowing them to influence the final destination. Other organisations may also have a role, for example large accommodation providers such as universities, which may also train NHS staff. Local politics can help make things happen which is important, but policy must be fully worked through, with cross-sector buy in and political support, to avoid new services and infrastructure becoming white elephants. There are examples of successes but also of less successful projects, for example, older key worker housing which has become unfit for purpose as the nature of the workforce changed.

Local Authorities will also have a range of focuses across social care, public health and integration with acute healthcare. Housing has a role to play here, even if the Local Authority is not a housing authority. Good quality, stable housing for people with mental health issues and learning disabilities, which enables workforce development or accommodates older people were all examples offered. Providing accommodation of this kind may also help with local politics. Redeveloping hospital sites can be contentious, particularly if this means local services are reducing, even if this is to deliver a clinical strategy. Mixed-use developments incorporating GP hubs, wellbeing centres, community health and social care services, housing or other complementary services and accommodation can reduce the level of local concern.

This group has been acknowledged as contributing to the debate and to generating solutions to some of the challenges. Our work has been highlighted at and appreciated by those attending a recent meeting of the National Housing Federation on the health and housing agenda. There was a feeling that additional engagement is needed both locally and nationally, to ensure that forums do not see housing talking only to housing and healthcare to healthcare. One of our participants referenced a "speed dating" service designed to put public sector land owners together with people who would like to carry out development. The centre could consider the opportunities it has to act as an enabler. Part of the debate centred on the means through which housing providers could be formally engaged. There is no formal housing provider framework nationally or at STP level specifically aimed at the interface between health and housing and it was mooted that a formal way of networking or engaging housing might assist. It is clear that housing and in particular regulated housing associations (Registered Providers or RPs) have valuable experience and expertise to offer STPs.

The policy landscape

Again there were positives here. The recently published Government Response to the Naylor Review has been some time coming, but has been met with a degree of optimism. For those with former Primary Care Trust (PCT) estate, opportunities for release of overage provisions and the retention of capital receipts being for use in transforming local community services, is extremely helpful. This ties in with recent announcements on the use of STP capital and a need to focus on encouraging STP's and NHS Trusts to align and jointly implement their estate strategies. Government is allocating funding to those areas perceived to be best placed to take reconfiguration forward.

The new Strategic Estates Planning (SEP) team is also a positive. This team will support the STPs and report to NHS England and NHS Improvement. This essential resource will offer a cross-STP strategy perspective, taking a tailored approach to the needs of each STP with which it works. The team will consider the art of the possible and means to deliver it effectively.

Meanwhile, the Provider Engagement Programme (PEP), which works alongside Homes England, focuses on efficient disposal of surplus land and has seen its targets for disposal values increased to £3.2 billion. There are incentives for Trusts to bring land disposal forward though the wider policy agenda that must be considered, such as Jeremy Hunt's commitment that NHS staff will have a first opportunity to take accommodation in affordable housing on NHS land. The PEP is engaging local authorities to fit its programme around their policies. Disposals will be an important part of the process but must be balanced against other system requirements.

One Public Estate is another policy area where money has been made available for initial business case planning on specific projects, an area where lack of cash can slow progress. Examples indicated a degree of success in progressing allocations to kick-start projects to deliver housing units on health land. Enabling funding may also be available from local authority s106/CIL contributions.

For housing, there are also policy expectations. RPs have been challenged to deliver more housing and to sweat assets. They instinctively know that there is a health dividend to people being housed well. This is the case for specialist housing for older people, those with disabilities and those who need support services, but also for general accommodation for key workers and others. This dividend extends beyond housing and into other areas that could benefit the NHS. Employing older people who are stable in their community is one example. Avoiding zero hours contracting and minimum wage payments are others. All of these make for more engaged "sticky" staff who are less likely to turn over, meaning fewer vacant posts, reduced recruitment and agency staffing costs and better service quality. Having viable housing options for staff helps this too. This includes a range of accommodation types and locations - both temporary accommodation to allow staff, particularly those with families, to relocate and, of course, permanent housing. It may also mean other offers, such as training, assistance with commuting costs and childcare. Housing can offer solutions to many of these issues.

Meanwhile, social care providers, in particular not for profit providers, are acutely aware that most vulnerable people have health, social care and housing needs which must be met together or they will not be properly served.

Housing and social care providers do not need to wait for an additional evidence base proving the benefits of quality housing and related services further and will simply get on with housing people and meeting their needs as it's what they exist to do.

RP housing delivery pipelines are less grant-determined than ever with the reductions in public subsidy available. This creates flexibility and opportunity. The NHS could create opportunities to use (and exploit) RP capacity and meet multiple organisational goals simultaneously. Key questions for RPs will be:

- finance capital on the one hand (where NHS land availability can make a difference as can the flexibility of cross subsidy from a mixed-tenure model) and
- revenue on the other (they will want some certainty on income streams, though that may come from an ability to access a wider housing market without automatically requiring a committed income stream from the NHS). Where some form of income guarantee is required an awareness of the challenges that guarantees can create for Trust balance sheets is important.

The roundtable

List of participants

Trowers & Hamlins	Hilary Blackwell - Partner (Chair)
The ExtraCare Charitable Trust	Louise Bradish - Birmingham Villages Cluster Manager
Capital & Cash, NHS Improvement	Ian Burden - Property Transaction Lead
Birmingham Cross City CCG	Guy Carson - Programme Director
Care Inc Ltd	Peter Cheer - Director
Department of Health and Social Care	Richard Dickson - Provider Engagement Programme Lead
Accord Housing Association	Maxine Espley - Executive Director of Health, Social Care and Support
Worcestershire Health & Care NHS Trust	Mark Fenton BSc(Hons) MRICS - Head of Estates & Facilities
Black Country Housing Group	Peter Hoarle - Head of Business Development
Trowers & Hamlins	Kyle Holling - Partner
Community Health Partnerships	Gareth Jones - Strategic Estates Planning Programme Manager
The Royal Wolverhampton NHS Trust	David Loughton CBE - Chief Executive
Telford & Wrekin Council	Paula Meyrick - Project Manager, Housing Solutions
Telford & Wrekin Council	Susan Millward - Surveyor
Housing & Care 21	Bruce Moore - Chief Executive
Longhurst Group	Louise Platt - Executive Director of Care & Business Partnerships
Staffordshire County Council	Allan Reid - Consultant in Public Health (Public Health Strategy & Policy), Health & Care
Community Health Partnerships	Riana Relihan - Strategic Estates Adviser
NHS England	Phil Smith - Senior Estates Manager













> Local conversations are key to creating healthier places”
>
> —— Hilary Blackwell - Partner, Trowers & Hamlins



> It is encouraging to see the conversation moving forward with a wide range of organisations across health, housing and social care engaging positively in the debate”
>
> —— Kyle Holling - Partner, Trowers & Hamlins


Fostering a strategic approach

From a national strategic perspective, it was recognised that it takes time and energy to penetrate Government at higher levels to make concerns heard. There is also a need to counter the view that the centre is going to say more when the general view of participants was that while the policy expectations are competing to a degree, they should be seen as offering a range of options on ways forward. Rather than waiting for more clarity from the centre there is a need to get on with things using the policies and the resources available now.

At a local level there remain concerns that the NHS does not fully understand what housing has to offer and can on occasion be dismissive about new thinking, which is counterproductive. There are many opportunities within the community estate to better utilise low-rise buildings and sites and housing will engage in programmes to take forward a strategy of that kind. Land disposals are, as noted, one solution and in some respects are simpler than retention and redevelopment or re-use for a greater array of services and needs. However, this has to be a consideration to ensure efficient long-term use of the finite NHS estate and secure better overall health and wellbeing outcomes, as well as potentially generating a welcome income stream for the NHS.

A perceived lack of receptiveness within the NHS is likely in many cases to be a lack of bandwidth. Trusts in particular are firefighting. Stable organisations innovate but the demands and financial pressures on the NHS to do not foster stability. An obvious problem is finding the time, expertise and resources to take forward novel projects to create new services. Housing can help here too by taking the lead on options appraisals and on delivery. The PEP and SEP programmes offer NHS bodies a strategic resource of their own which should be utilised where appropriate. Combining these resources will maximise the potential for good quality housing and service models which meet needs, or generate revenue (or both) and which are repeatable and “investable”.

As well as the how, there is a need to focus on the what. Non-NHS community providers of services remain concerned about a lack of joined-up commissioning opportunities which can lead to separate contracting arrangements with social services and CCGs for overlapping services. This is inefficient on cost and creates artificial barriers to quality outcomes. The need for more joined up commissioning has never been greater with the pressures on funding in the NHS and Local Authorities. The development of the NHS estate through the STP programme must not miss the opportunity to align clinical strategy in the widest sense with the physical environments being created.

Communication and cross-sector engagement

Communication remains a significant factor. Finding effective ways to join up the NHS bodies looking to achieve specific strategic goals with housing organisations keen to help them do so is essential. Centrally driven approaches and formal procurement mechanisms such as the impending Project Phoenix can provide opportunities but must supplement a local approach to problem solving rather than replacing it.

There remains a lack of clarity on how health engages with housing and vice versa. There is a risk to health that an opportunity might be missed, with RPs pressed to deliver volume and focusing attention elsewhere if getting their ideas and innovations in front of decision makers - and seeing activity as a result - is not happening. Even those RPs who deliver community health and care services may revert to established relationships with Local Authorities to deliver additional housing and services. RPs were encouraged to start in places where the NHS and Local Authority relationships are strong as that is likely to simplify the discussions about new ideas. A question was raised about working alongside Homes England to ensure they are maximising their influencing role, through the PEP but also through its involvement in the Healthy New Towns initiative, which is aligned to this type of thinking, and more generally.

The best solutions to better health economies will be locally driven. All STP footprints will, as we have noted, have different points of focus and different overall needs, as will the organisations that make them up and which are seeking to support them. Housing can unlock some of the detailed thinking on approaches without the NHS spending lots of money and has commercial expertise and the ability to create value, adding value by ensuring the right services are delivered for the local communities they know so well. The best solutions will be driven where health, housing and social care combine to solve local problems. Procurement issues will need to be considered but are not a barrier to progressing schemes.

This is partly about service delivery. However, an important element, which has suffered due to pressures on finances, is the prevention agenda. It is not enough to move people with learning disabilities out of institutional and into community settings, or to re-able people to move them out of hospital and back into their own homes before they lose essential skills. Steps must be taken to support people to remain in those places without needing to be re-hospitalised, or finding themselves homeless or in the criminal justice system. The Transforming Care agenda is there to do this for those with learning disabilities with some progress being made. Good communication between families, commissioners, clinicians and providers is essential to ensure the opportunity is not lost, particularly as the programme will finish next year. This is a key area for Trowers & Hamlins given our interest in and contacts within both the NHS and specialist housing sectors and one we will continue to work to influence positively.

Positives and opportunities

Easy wins are available. There is a need for long-term strategic development of new facilities and a need to consider what they will look like and how they will be utilised. Co-location, investability/replicability and the flexibility to change uses will be essential in developing a best-in-class modern health estate aligned to and able to adapt with clinical strategy. Plans must be locally agreeable and strategically formulated.

In the meantime, there is a wide range of existing stock available for the delivery of community health and social care services. A striking example discussed by participants was the use of specialist extra care housing for reablement. There are a number of large providers of this kind of housing with the capacity to accommodate a sizeable provision of service, potentially using voids within existing stock, without the need for new buildings or service models to be developed. With the right providers this could be funded on a spot purchase model, or commissioners could block book a minimum number of units to be available across a defined period. Revenue funding may be needed and the health and social care providers and commissioners seeing benefits in reduced costs and reduced demand on acute services will need to agree how savings are shared. This should not be impossible to achieve. Alongside this the commissioners and providers need a good understanding of the scope of the service model in order to utilise it effectively, which comes down to communication - relationship building and maintenance.

There are overlapping examples in mental health, with short term outcomes a focus and potentially funding to reward effective reablement and move-on, while maintaining a person-focused service which recognises that outcomes will differ for individuals.

Two clear themes from the discussions were the desire to deliver more community based services and, related to this, to offer mixed-use and co-located service delivery models. RPs want to deliver communities, not housing estates. In some cases space for on-site health provision has been factored into designs but not then utilised, with the space eventually used in other ways.

Another theme was staff and recognising their needs and expectations. Staff in some areas will be willing to travel if there is a good transport link creating a viable opportunity to live in a city and commute. For others it is clear that staff will not travel, even if offered enhanced wages and benefits. Staff accommodation will, therefore, solve some problems but not others. Not everyone wants to live on a hospital site. For those that do, the kind of accommodation available has to be suitable. Not all NHS staff want to live in single-unit accommodation; they have, or may in the future have, families.

Putting these themes together, there has to be an opportunity to redevelop the NHS community estate to provide modern, co-located clinical services and buildings with staff accommodation alongside (or, more realistically, above) which can meet a range of service needs and may also create a cross-subsidy for development and could even create a long-term income stream to be shared between participants. Where speed of delivery is a factor, modular build could be a solution. This may be of particular interest for keyworker housing.

Chair's conclusion – The Trowers view

Progress in recent months shows some room for optimism but also that challenges and barriers remain to effective working between health and housing (and ultimately between health, housing and social care). The time for action is now upon the sector, the centre has set the rules and may supplement them but is unlikely to radically change the policy landscape anytime soon. STPs have the job of revitalising the NHS clinically and the estate to go along with it. There is variable engagement with STPs outside of health, whether with housing authorities, social services authorities or providers of those services.

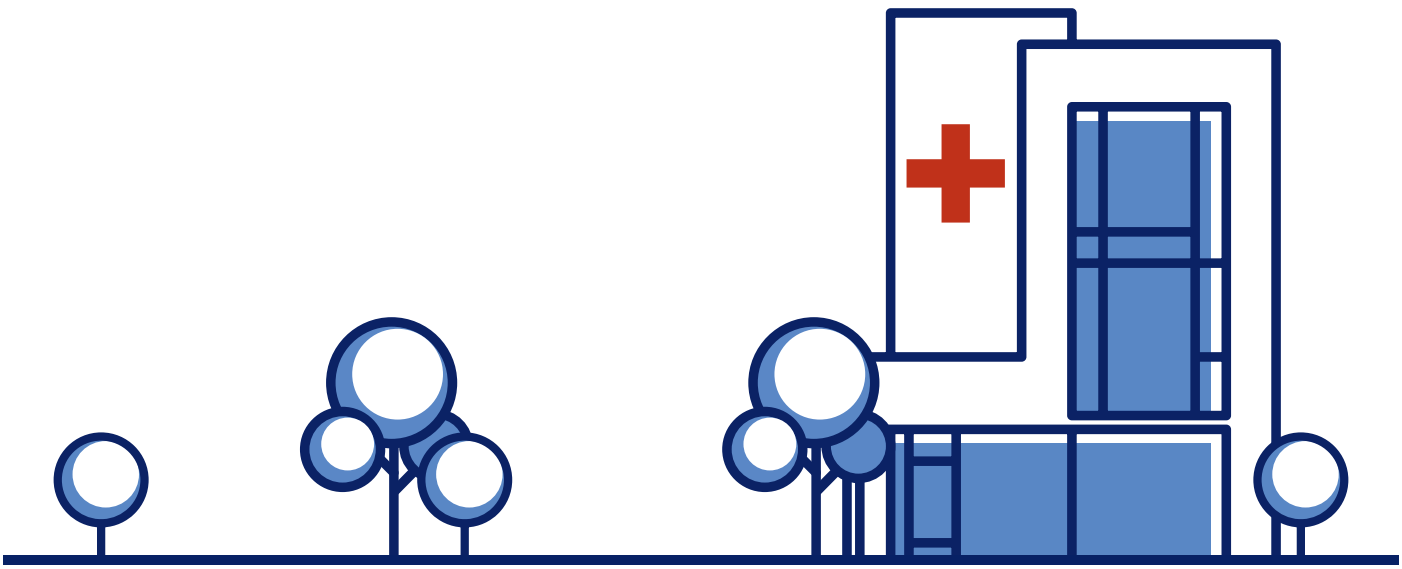
The opportunities, particularly to grasp the nettle and look at new service delivery models using existing provider capacity and new development on smaller sites – in particular community estate – are real, and can be utilised by the NHS at minimal cost by engaging the providers actively seeking to work with them and which have the skills and capacity to progress projects. What those projects are will depend on the specific needs in a local area - it could be staff accommodation, step up/down/reablement, longer term services for people with disabilities or acquired injuries or for the older population. These could aid in solving care pathway issues, staffing needs or provide an income stream.The Department of Health and Social Care has an opportunity to influence when reviewing business cases: ensuring that commercial opportunity is thoroughly examined. There could be a mixture of cash and social outcome as the "best value" receipt from the disposal of land.

The sectors must continue to talk to one another, facilitate and make connections and learn what is needed strategically and understand the resources each has available in local areas. Making these connections and taking the time for this learning will build relationships that will deliver a better health and care system for local populations. Central Government guidance would help and we need to keep having the conversations. Central Government guidance pushing organisations and leaders towards this model will certainly do no harm but should not be waited upon.

Trowers & Hamlins continue to support the DHSC and NHS Improvement on development of deliverable solutions in several areas discussed, for example in keyworker housing. We anticipate being involved in a number of further workshops and seminars and have developed procurement and contract solutions that could help to deliver all the elements of schemes identified as desirable by the participants. The thinking has been done – it's time for action. What are you doing about it?

Hilary Blackwell - Chair
Partner

t +44 (0)20 7423 8366
e hblackwell@trowers.com



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