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Key issues driving increased joint working – Outcomes from a West Midlands health and housing round table Summer 2017

Introduction

Trowers & Hamlins hosted a round table at their Birmingham office on 12 July 2017 to explore the benefits of joint working between the health and housing sectors in the West Midlands and - perhaps more importantly given the wide acknowledgement and growing evidence base for the links between good housing, wellbeing and health - the opportunities for more collaboration between those sectors. We had a range of participants from both fields in attendance - details are at the end of this report.

The discussion was open and wide-ranging, identifying both opportunities and challenges. A number of key themes emerged from the discussion. Rather than providing a detailed commentary on every point made we have explored each of these themes in further detail.

How RPs can help the NHS

Housing associations (RPs) don't just manage social housing. This is a sector that can offer a one stop shop: service delivery across the social care spectrum, nursing care, housing management (in staff accommodation, general needs housing and specialist areas such as for disabled and older people), development and development risk, capital of its own and access to funding. RPs are increasingly commercial businesses, albeit with an overall social purpose.

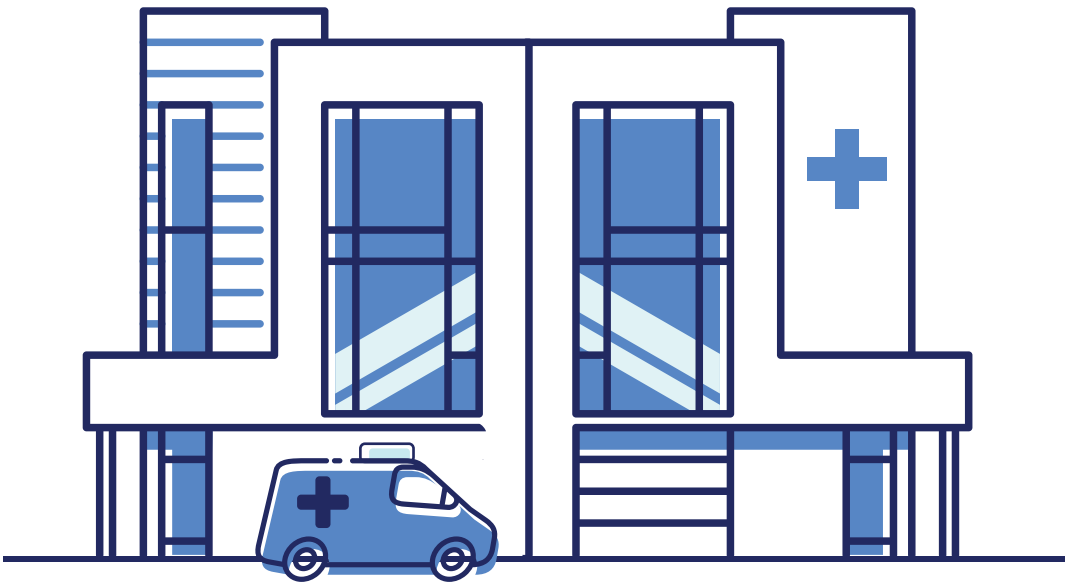
Where specialist housing is concerned, there are also incentives for RPs to look outside their traditional boundaries for delivery given proposed changes in the benefits system. Those changes would restrict rents broadly to one third of the local market rent which means RPs are in turn disincentivised to develop new units of this type through traditional routes.

The range of activities and approaches the RP sector offers is not always as clearly understood as it might be. Sometimes this is because the NHS tends to focus its conversations with housing on local authorities as they are also public sector bodies and are readily identifiable in any area.

All of these potential roles for RPs tie in with Department of Health targets in connection with release of surplus land for housing, creation of new housing units and importantly the creation of new staff accommodation for keyworkers in areas where this would facilitate recruitment and retention.

Clearly some of these targets compete with one another - surplus land can be sold to generate a receipt but cannot then be used for purposes specific to NHS objectives. Local decision-making and local priorities will need to determine the route taken in specific cases.

Perhaps the most important aspect of the RP offer is their ability to provide a different kind of strategic thinking for the areas mentioned above and looking at specific types of service in an area, such as dementia care or extra-care, and offering opportunities to achieve better value. RPs are providers of a huge range of services which overlap with and complement NHS drivers and so offer a different viewpoint to local authority housing or social services departments, which are primarily commissioners rather than providers, albeit with market shaping duties. Local authorities are clearly very important to the health and social care economy in any area, but RPs have a different and valuable contribution to make too. The NHS would benefit from engaging with the housing sector earlier in the process than it might usually expect to, given the wide range of skills housing can offer in service design and its understanding the local health and care economies and the community services available (or lacking) in them.



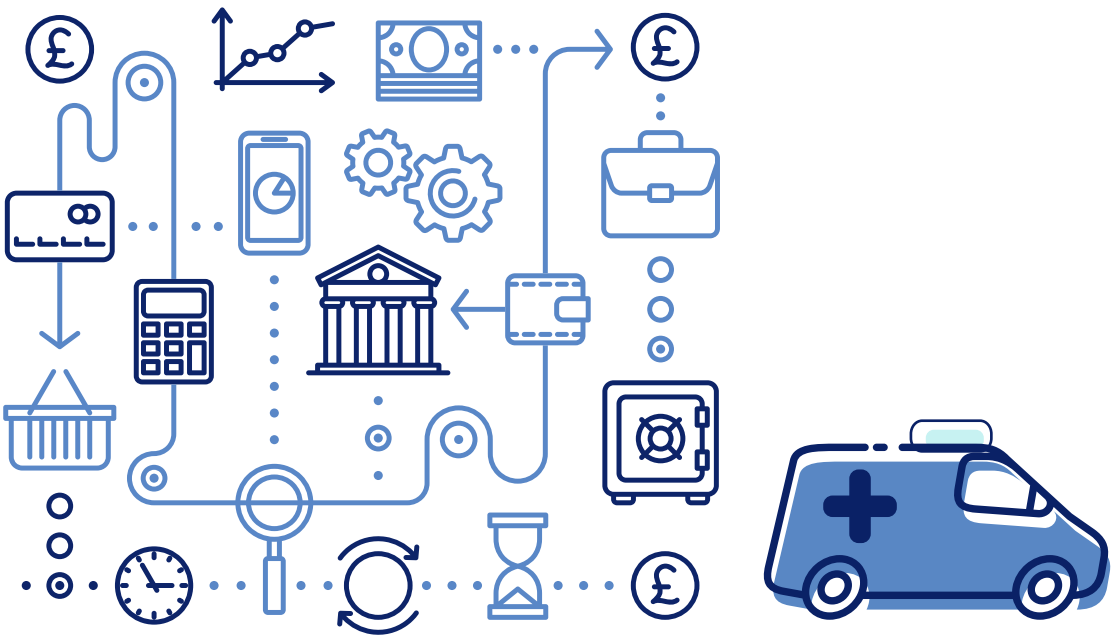
What are the NHS's real objectives?

One of the NHS participants made the point that housing is one of the biggest issues in healthcare throughout the entire life cycle of care and RPs can clearly help with that. However, a fundamental question was raised: what is the ultimate priority for the NHS? Is it accelerating disposal receipts, or maximising results? This is an obvious question to ask given the range of delivery tasks the NHS has, as mentioned above.

There is a clear shortage of capital in the NHS. Disposing of estates can give Trusts an opportunity to access additional capital and maximise value. Therefore, there are clearly incentives to rationalise the estates. However, it was also identified that it is down to individual Trusts to make decisions that are best for them depending on their own requirements. This might be simply maximising a financial return, but should be considered in light of the fact that this is not a cycle that can be repeated endlessly - the NHS estate is finite. Other Trusts may find it preferable to focus on activity which changes outcomes e.g. in relation to delayed transfers of care, or recruiting and retaining staff. These are not mutually exclusive and one Trust presented a drive for a mixed model to maximise health outcomes and the wellbeing and retention of staff using a combination of student accommodation, keyworker accommodation and other facilities.

Trusts will not be prevented from taking this sort of approach by the centre - if proposed a use complements Trust activities and disposal value is reduced as a result, e.g. a sale of land for staff accommodation with Trust nomination rights, the business case can be made. More than one person in our discussion highlighted the challenges of recruiting and retaining staff and the impact that good quality accessible accommodation can have.

These are all areas where the RP sector can deliver benefits both through service delivery and through risksharing in respect of both development and operations. RPs are well used to delivering new accommodation and new services through all sorts of joint venture arrangements, both contractual and corporate, which would lend themselves well to outcomes of the kinds desired by many in the NHS.



Are the perceived barriers to cooperation real?

There was a very strong view expressed by some that there are no real barriers; people can create or remove barriers to achieve or prevent outcomes. Leaders within local health and housing systems must work together to drive great ideas and solutions to problems. One of the challenges, is putting the leadership teams of the right organisations together at the right times to drive better results.

Of course there are complexities. Some of those identified are:

- 80% of the land value to be released is in London, which makes the delivery of land-based transactions and projects more challenging elsewhere.

- Politics can get in the way of the best long-term outcomes for service reconfiguration. Politicians can be passionate about hospital closures or other significant changes to services, even when there is no loss of services locally. Working with housing associations for example on an offer which complements the NHS, such as extra-care, can smooth the political pathway where a straight sale of vacant land for future development by the private sector may not.

- Sustainablility and Tranformation Partnerships (STPs) look different and will be implemented differently in different parts of the country and planning constraints must be recognised. There is a challenge in joining the dots across the estate, with various initiatives such as One Public Estate, the Homes and Communities Agency (HCA), NHS Property Services and the Naylor Review not necessarily all working to the same agenda and timescale. Local authorities and especially local housing authorities may not always be engaged and where they are they will have different levels of involvement.

- Procurement is also an issue that can arise, although it can be managed. As has been noted above, partnership working, preferably at the proposal design stage, is essential to look at what can be done on a site. This is different to the simple land disposal model because it could identify, for example, that a cross-subsidised project using an element of market sale or rent allows the retention and use of estate rather than a one-off disposal. Procurement doesn't have to get in the way of this, as long as it is considered at the right time.

- The ultimate holding of ownership can also be an issue. This can lead to a fundamental change in the nature of working relationships from a partnership basis to one with a landlord - tenant dynamic.

- Funding is inevitably a challenge, but there is access to investor capital.

None of these challenges is insurmountable and early and genuine engagement between market enablers, including housing associations and authorities can be a winning formula.

It was agreed that focusing on immediate financial strain will not resolve issues in the long term, including funding issues. A local example was given - Birmingham City Council responding to homelessness issues, despite funding cuts. It is a matter of local decisions and priorities as to how all public sector land and resources are deployed to best meet the balance between the financial envelope and the need to meet and hopefully ultimately to reduce demand.

Is the HCA a solution?

The HCA disposal model was identified as a potentially attractive one for NHS bodies looking at land disposals. The HCA is actively acquiring sites and there was an additional £1.7 billion allocated to it in the last autumn statement in order to deliver 15,000 new homes. The criteria is that they need to be on site by March 2020 and the target is accelerated disposal of land for housing.

As identified above the NHS has a number of competing priorities. The HCA accelerated construction programme is a means to achieving housing supply as it includes a commitment to bring housing to the market within a timescale. It can also help with capital shortfalls in specific NHS Trusts (provided they can retain those monies which is another question to be considered). Of course, a simple land transfer would not achieve any of the upsides of delivering on staff or patient wellbeing, joint working, enhanced service delivery models, keyworker accommodation and all the other potential benefits available. It was acknowledged that these could be negotiated as part of the HCA transfer however Trowers, having dealt with the first transfer to the HCA under the new statutory scheme, confirmed that this is not envisaged in the standard form process.

As such the HCA disposal route may be attractive for some NHS bodies particularly where an accelerated receipt is desirable. although it is not going to be right for everyone.

STP development

The consensus was that in order to implement STPs as effectively as possible there is a need to involve the whole community i.e. local authorities (both social services and housing) and the provider sector, especially voluntary and third sector organisations including local housing associations. RPs were pleased to hear that there is an appetite from Trusts for service-delivery models they can be involved in, such as step down accommodation, highlighting that this can include conversion of existing NHS facilities (e.g. redundant wards) as it would be beneficial to be able to provide these types of services on-site.

Some highlighted, however, that housing is simply not prominent in STP conversations. There has even been a negative reception when a suggestion has been made to bring in housing providers on STP discussions. One participant described housing in a specific STP as “invisible”.

Others have had more success. This is often driven through a connection in both camps, such as those in housing who have previously worked in the NHS and have good connections within leadership groups involved with STPs. Early discussion is essential and the RP movement needs to keep pushing for these discussions. The benefits are clear - as are the challenges. Inevitably conversations must happen in a local context. RPs interested in working in specific areas should discuss together what their combined offer might be, and how they can deliver on it. They can then approach STPs with a unified message and approach.

An important point made is that everyone involved in the health and housing sectors, where they overlap or otherwise, were aiming for better outcomes for people and would do better if they looked at them together. This is partly about local solutions and partly about lobbying upwards to central government.

Chair's conclusion – the Trowers view

Our discussion highlighted many points of interest, focusing attention and articulating some of the key issues facing both the housing and health sectors and considering how they might work together to better address those issues. Many of these are well known to those keen to see closer working between these sectors.

Trowers' view, formed from several recent engagements we have facilitated between these sectors, of which the roundtable discussed above is only one, is that a two-pronged approach to the issue of enabling closer working between the two sectors may well be the best one.

First we have the important "bottom-up" localised approach to solving the service delivery pressures facing local health economies. This requires leaders within those local economies to come together. There are many ways for this to happen, but it seems most often to happen where someone with a foot in both camps is able to use that to drive conversations with their own connections. This must be encouraged, and expanded on - the lack of connections with or insight into the operations of NHS bodies cannot be a barrier and we among others can facilitate conversations with like-minded organisations through the contacts we have on both sides.

Second it must be noted that there are no formal forums through which RPs and NHS bodies are compelled to engage with one another though there are a number of obvious places where it could happen, such as Health and Wellbeing Boards. As a matter of policy a "top-down" approach, which would see better working between these sectors, could be to require NHS bodies to demonstrate a level of engagement with the provider (social services and housing) sector rather than only with (but by no means in place of) local authority commissioners. This could be a requirement for the approval of STP-linked local business cases, for example. It is acknowledged and understood that the NHS has numerous constraints and priorities so such requirements should be structured not as a further burden, but rather as the opportunity to engage with a part of the related public funded sector which can add value and provide better outcomes for those receiving and those delivering NHS services.

As one of our participants said the issues that the NHS and housing associations have are the same, but different. Those differences should be celebrated, and utilised, for the benefit of local communities and patients living in them. It seems quite clear to many and certainly to those in our session that the NHS will struggle to make the necessary changes to the way it operates without engaging in true partnership working - and there are willing partners out there.

Hilary Blackwell and Kyle Holling
Trowers & Hamlins

List of participants

Trowers & Hamlins	Hilary Blackwell (Chair) - Partner
Longhurst Group	Mark Askey - Director of Care and Support
Midland Heart	Danny Booth - Commissioning Support Manager
Staffordshire STP	Phil Brenner - Estates Lead
Department of Health	Richard Dickson - Provider Engagement Programme Lead, Commercial Directorate
Accord Group	Maxine Espley - Executive Director Health Social Care & Support
Worcestershire Health and Care NHS Trust	Mark Fenton - STP Strategic Estates Lead
George Eliot Hospital NHS Trust	Joanna Guy - Head of Business Development
ExtraCare Charitable Trust	Angela Harding - Executive Director Operations
Trident Reach the People Charity	Amy Hewett - Head of Homeless Services
Trowers & Hamlins	Kyle Holling - Partner
Gloucestershire Hospitals NHS Foundation Trust	Neil Jackson - Director of Estates and Facilities
The Royal Wolverhampton NHS Trust	David Loughton - Chief Executive
Black Country Housing Group	Abigail Robson - Board Chair
Bromford Group	Andy Rhoades - Head of Land
Accord Group	Alan Yates - Director of Regeneration

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