

# Housing and health

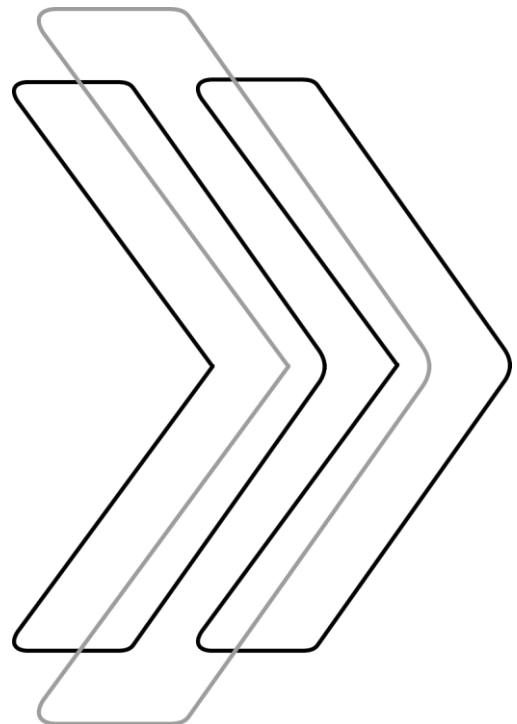
## Opportunities for sustainability and transformation partnerships

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# Foreword

*As our sustainability and transformation partnership (STP) in Kent and Medway develops we know that we have to work with our partners to make our vision a reality. That means making the most of what other sectors offer in terms of directly influencing health and on reducing demands on NHS and wider public services. The housing sector will be an important partner in that including in supporting efficient discharge from hospitals and in helping people stay independent in the community. But housing is more important than that. This guide is a useful one-stop shop and reminder of how critical good housing is to a healthy community.*

*It won't answer all your questions about housing, but it will help you stop and think, 'Have we made the most of our partnerships with housing locally? How much more could we do?' It includes links to a wide range of resources that will help your STP with a range of issues from discharge from hospital, to mental health and the use of surplus NHS estates. It also argues, rightly, that STPs and emerging integrated care systems need to increasingly take a life-course approach to health and housing and to broaden our focus beyond seeing housing partners as helping us with short-term issues only.*

*It is also challenging to STPs, and to NHS England and NHS Improvement. If we are to really unlock the potential of housing for health, then we need more than the evidence. We need to really take the opportunities on offer locally and we need leadership, support and the incentives from the centre to make it happen faster and more systematically than at present. This publication makes excellent suggestions on how to make that happen.*

Ravi Baghirathan

Project Director, Kent and Medway Sustainability and Transformation Partnership

# 1 Introduction

NHS organisations and local government are working together with other partners to improve health and care for their local populations through sustainability and transformation partnerships (STPs), devolution and integrated care systems (ICSs) (NHS England 2018). STPs and emerging ICSs will not be successful in the short term in preventing people's need for care, or reducing demand for services unless they engage and work more closely with local partners, including local government, the local housing sector and others including the voluntary and community sector. In some areas this is already happening, but it is not happening at the scale and depth needed. In the long term, STPs and ICSs will need to work more closely and constructively with the housing sector to prevent ill health if they are to successfully transform population health.

The evidence that good-quality housing is critical to health is well established (Public Health England 2017). Further, a well-housed population helps to reduce and delay demand for NHS services and allow patients to go home when they are clinically fit to do so. Furthermore, it is estimated that the cost of poor housing to NHS is £1.4 billion per year (BRE 2015). So, it is clearly in the interests of the NHS to work more closely with housing partners as STPs develop.

Where health and housing have come together, the focus has often been around keeping people independent and at home, and on supporting discharge from hospital. This is important but STPs and ICSs need to take advantage of the contribution housing can make to the health and social care sectors to maximise the health of local populations across the life-course. Most STPs are not yet currently doing enough to address the wider social and economic determinants of health of which good housing is a fundamental component. This is in the interests of their populations, and in the interest of the NHS as it moves towards providing place-based care.

This short report is intended to help those leading and contributing to STPs and emerging ICSs to make 'the most of housing' as they deliver and continue to develop. Behind this lies our belief that housing is one of the core local services that STPs and ICSs need to engage with at a strategic level as they develop population health systems. In particular this report sets out:

- why housing is important for STPs and emerging ICSs
- how well housing is currently represented in STPs
- three priorities: supporting discharge, the use of NHS estates and mental health
- going further: the broader importance of housing to health across the life-course
- recommendations for action: maximising opportunities in the short and long term.

We make a number of recommendations for local STPs, which are relevant to emerging ICSs too. These are focused on what can be done, in the short term, to deliver sustainability and, in the long term, to support transformation. But STPs need to be challenged and supported from the centre to make the most of the contribution that housing can make to health. Our recommendations on sustainability and transformation are therefore driven by what needs to be done locally and by national health and housing system leaders. This detail is set out in Section 5.

## 2 Why is housing important to STPs?

Sustainability and transformation plans (now partnerships) were announced in NHS planning guidance (NHS England 2015). They are intended to cover three main areas: developing new models of care and improving quality; improving health and wellbeing of their population; and improving efficiency of their services. At the same time and, as a means to deliver these ambitions, they are intended to improve integration of the NHS with social care with other local partners and sectors such as local government. A high priority for STPs in practice has been to reduce demand for hospital care through using other community resources.

In this document we focus on the relationship between health and housing. The 'housing sector' in England (see box below) is large, has been changing over time and faces challenges. For clarity, we do not include in this document a consideration of the role of institutions such as care homes, prisons or the armed forces.

In the past, the connection between health and housing has often focused on the role that housing organisations, such as housing associations, can play in supporting discharge of older people from hospital where it is relatively straightforward to quantify benefits in terms of the efficiency and outcomes measures that NHS organisations are routinely held to account for. But there is also a wealth of evidence that shows how important good housing is to health across the life-course (Marmot *et al* 2010).

The potential impact of housing on improving health and the resulting benefits for the NHS – in terms of moderating demands and financial savings – are so large that STPs have to do more to engage with the housing sector. Economic modelling has estimated that reducing excess cold in homes to an acceptable level would save the NHS £848 million per annum and reducing all falls in the home could save the service £435 million (BRE 2015, Table 2).

### **The housing sector in England**

The housing sector includes developers, private and social landlords who provide homes for rent (for example, housing associations and local authorities), planning authorities and other bodies that regulate building and the quality of homes, and a wide range of other national and local stakeholders. The Ministry of Housing, Communities and Local Government sets the overall strategy for housing and responds to issues such as homelessness. There were 23.5 million homes in England in 2015. This includes a mix of owner-occupied, privately rented and socially-rented homes. Of these:

- 62 per cent were owner-occupied
- 20 per cent were privately rented
- 17 per cent were social rented.

The housing sector has changed over time. The quality of housing has improved, with the number of homes not meeting the statutory 'decent' standard (to be in reasonable repair, have modern facilities, and provide thermal comfort) falling from 35 per cent to 20 per cent between 2006 and 2014 and fewer social housing homes not meeting it (14 per cent) than any other sector.

There are serious problems with under-supply and affordability. This is reflected in homelessness figures (71,500 households were homeless and in temporary accommodation at 31 March 2016) and in the support needed to keep people in homes (the government spent £20.9 billion in England on Housing Benefit in 2015/16).

Government priorities for housing include increasing private supply, public sector land disposal (including surplus NHS land for NHS key workers and other housing), planning reforms, shared ownership and some new specialist homes for older people and those with disabilities.

Source: National Audit Office 2017b



Beyond the short-term financial payback, there are long-term consequences for people's health, and therefore on demand for NHS services, of poor housing. These consequences are both direct and indirect. For example, fuel poverty and homelessness have important consequences for health (National Institute of Health and Care Excellence 2015). It is estimated that around 10 per cent of excess winter deaths are attributable to fuel poverty (Hills 2012), and homelessness, which raises health risks and associated costs, is growing. Even when homeless families can be re-housed, many local authorities have to place homeless families in private accommodation which is often of a poor standard (Public Accounts Committee 2017) compared to many housing association homes which are more likely to be of a 'decent standard' (Buck *et al* 2016).

There is a well-recognised shortage of housing, which needs to be addressed. But it is not just the number of homes that is important; in the longer term we know that good-quality housing is also likely to lead to better health through its indirect impact on other factors including improved outcomes in the early years, better employment prospects and strong community resilience and wellbeing, which are all associated with good health (Buck and Gregory 2013).

These are all issues that deeply affect population health. We challenge STPs to be more ambitious as they work to develop a stronger focus on population health, with a focus on maximising the contribution of housing to health across the life-course. But first, how is housing currently represented in STPs?

### The current representation of housing in STPs

Figure 1 sets out the main themes in all 44 sustainability and transformation plans. The housing sector has a contribution to make to all these themes – from strengthening prevention to improving mental health and tackling productivity (for example, by improving discharge from hospital) – and to 'the enablers', including appropriate data-sharing and the use and repurposing of surplus NHS estates.

**Figure 1** Main themes of STPs



Source: The King's Fund 2017

A King's Fund review (Ham *et al* 2017) highlighted some examples of STPs that include plans to work with the housing sector. For example:

- Cornwall and the Isles of Scilly aims to prevent homelessness, to improve access to affordable, good-quality housing and to reduce fuel poverty
- Bedfordshire, Luton and Milton Keynes plans to develop local centres where both housing and health services are co-located.

But despite the fact that three out of every four of the 44 plans mentions housing (Buck 2017), only a few were far ahead in their planning and analysis (Care & Repair 2017). Nottingham and Nottinghamshire is widely acknowledged as having the most developed plan as regards housing (Nottingham City Council 2016), where it is a core theme, across the life-course.

### **Nottingham and Nottinghamshire sustainability and transformation plan – proposals relating to housing and the home**

- The plan recognises that people are living longer and that many, especially those living with multiple conditions, may be vulnerable due to their housing.
- Where possible services that do not need to be delivered in a hospital setting will be delivered in different ways, for example, through the use of assistive technology to deliver care in the community and in people's homes.
- An STP advisory group allows the voluntary and community sector, including home care providers and care homes, to contribute to the plan.
- More people will be offered the 'warm homes on prescription' scheme so that they can more easily afford to heat their home.
- The plan aspires to better support from housing providers to ensure that accommodation for people being discharged from hospital is safe to return to.

It is clear that most STPs have a lot further to go to realise the potential of housing to health. Below we make recommendations for STPs to consider to bridge the gap between acknowledging the important role that housing can play, and acting on it and realising it.

### 3 Three priorities: supporting discharge from hospital, strategic use of NHS estates and mental health

There are many ways in which high-quality housing can support STPs in delivering better population health. We illustrate possible approaches in three themes.

- In the short term, housing can support local areas in enabling timely discharge from hospital.
- Longer-term strategic use of NHS estates can potentially free up land to provide housing.
- For people with mental health problems, good-quality supported housing can support independent living in the community.

#### Supporting discharge from hospital

Ongoing concerns over delayed discharges creates the burning platform for a serious look at how housing organisations with high-quality spare capacity and support can help. Being part of the response to delayed discharges (and reducing long length of stay) could be a key step towards a stronger strategic relationship between health and housing that is currently missing. The right home environment can also allow people to stay in their home for as long as they want and can support them in managing their health and care needs (National Housing Federation 2017).

NHS England guidance for clinical commissioning groups (CCGs) (NHS England undated a) highlights a range of well-evidenced practice on how housing and health 'can work together to prevent and reduce hospital admissions, length of stay, delayed discharge, readmission rates and ultimately improve outcomes, particularly by promoting equality (for groups

protected under the Equality Act 2010) and reducing health inequalities in accessing services through integration’.

Many housing providers are working well already with their NHS partners on this. But one challenge locally for the NHS where those relationships are not already strong, is who to approach and engage among the wide range of local housing providers. The offer from housing needs to be clearer and, where there are multiple housing providers, more consistent so that it is easier for the NHS to engage with them.

### The use of NHS estates

The review of NHS estates and property carried out by Sir Robert Naylor (Department of Health 2017) identified two key opportunities for housing and health. The first is that local estate strategies should be linked to sustainability and transformation plans and are therefore key to delivering the Forward View. The second is that where land is sold by the NHS it could be developed to provide homes for NHS staff, therefore potentially helping with staff recruitment in areas with high housing costs. Housing associations have been asked to submit suggestions as to how this might be achieved. The review also suggested that the NHS could set up its own bespoke housing association.

As an example of how the NHS is responding Frimley Health NHS Foundation Trust has commissioned Thames Valley Housing to develop 86 key worker apartments on land which was previously unproductive. The freehold passed to Thames Valley Housing and 34 market sale homes cross-subsidised the affordable homes. The trust retains priority in nominating residents (Inside Housing 2017).

However, more broadly, the New Economics Foundation has looked at NHS sites that have been sold under the government’s public land sale programme (Wheatley and Beswick 2018). Its analysis shows that across the homes to be built on NHS land in England, four out of five will be unaffordable to a nurse on an average salary and only one in 10 of the homes built on sold-off NHS land will be for genuinely affordable social rent. In London, the average expected sale price is £561,589 – 18 times the annual salary of a nurse and, across all sites, no homes for sale will be affordable to NHS key workers, including nurses and midwives. Two London NHS trusts are reported to be exploring the possibility of developing land for residential use on a large scale (Clover 2018). This is a very sensitive area of policy and local initiatives need

to clearly demonstrate their social/health value and engage openly with any concerns that they are driven only by short-term profits.

There are opportunities to reduce health inequalities and to make efficiency savings through using the existing NHS estate but significant barriers remain. There is a clear risk that NHS organisations will look only to maximise the financial benefit of surplus estate and also focus on housing for NHS staff. The New Economics Foundation analysis shows that, more generally, the affordability of housing developed on surplus NHS estate puts it out of the reach of many who require access to high-quality housing. In our view, the wider 'social value' (to include the indirect effects on health of a greater supply of decent, affordable housing for local populations) of estates development should form part of the business case at the earliest stages and it will be important that STPs find ways to quantify the available benefits.

## Mental health

*The five year forward view for mental health* (Mental Health Taskforce 2016) places priority on supporting people at home – reducing the need for avoidable admissions to hospital, and ensuring rapid, effective discharge when people do need to be admitted. In many areas the rate of bed occupancy in acute mental health providers is far higher than the Royal College of Psychiatrists' recommended level of 85 per cent with some respondents to a 2015 survey reporting occupancy rates of up to 138 per cent (Royal College of Psychiatrists 2015). Lack of available beds leads to costly out-of-area placements which are associated with an increased risk of suicide.

The Commission on Acute Adult Psychiatric Care found that issues with bed occupancy and supply were strongly influenced by delayed discharged due, in large part, to availability of housing. This means people are inappropriately in hospital, incurring high costs and also experiencing greater levels of restriction than are appropriate. The Royal College of Psychiatrists' Commission suggests that land identified for disposal could be used to develop supported accommodation to provide step-down placements for people with mental health problems being discharged from hospital (Royal College of Psychiatrists 2015).

In some areas housing associations are developing mental health care pathways that support people to leave secure mental health inpatient services and moving into community living. For example, One Housing Group provides step-down care with a view to people eventually living in their own homes

## **Housing and health**

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with ongoing support at Tile House in King's Cross, which provides 15 high-quality self-contained supported housing units for people with complex mental health needs. This model saved the NHS £443,964 per year (Crocker 2014).

STPs need to consider the important role that housing can play in transforming and modernising mental health services to promote further independence and quality of life, and ensure equal priority given to this group as physical health (parity of esteem).

## 4 The broader need to focus across the life-course

Focusing on the three areas above would be a good start for STPs in engaging with housing, partly because they are of direct current policy concern. But this should not be where STPs stop. Good housing supports health across the life-course, from childhood through working life and in to older age. We set out examples below, using key stages of the life-course, of issues that STPs and ICSs should consider as they mature further into population health systems.

### Early years and children

Housing is particularly important in ensuring a healthy start in life and is a key factor in the generation of health inequalities. Children are particularly affected by living in poor-quality housing and unintentional injuries in the home are a leading cause of morbidity and mortality.

Children are more likely to live in overcrowded housing than working-age adults and pensioners (Department for Communities and Local Government 2015). This relates particularly to children living in low income families. Evidence suggests that children living in cold, overcrowded or unsafe housing are more likely to be bullied, to not see friends, to have a longstanding health problem, disability or infirmity and be below average in key academic areas as a direct consequence of living in poor-quality housing (NatCen Social Research 2013, Figure 5). Children living in cold homes are twice as likely to develop respiratory problems as those in warm homes and there are clear effects of fuel poverty on the mental health of adolescents (Marmot Review Team 2011).

Poor-quality and overcrowded housing is associated with increased prevalence of injuries in children (RoSPA undated a) but all children are at higher risk of unintended injury in the home than adults. More than two million children under the age of 15 are taken to accident and emergency units every year following an accident in or around the home at a cost to the NHS of approximately £146 million a year (Audit Commission and Healthcare



Commission 2007, cited in National Institute for Health and Care Excellence 2010). Surviving severe injuries can lead to significant pain and have a negative impact on the social and psychological wellbeing of children (National Institute for Health and Care Excellence 2010, chapter 2).

The number of children living in temporary accommodation has increased by 73 per cent since 2010 to 120,170 (National Audit Office 2017a) with severe consequences for their health. The number of families with children placed in bed-and-breakfast type accommodation increased from 740 in 2010 to 2,660 in 2017. This is in spite of a commitment in 2002 that no family with children would have to live in a B&B except in an emergency and for no longer than six weeks (House of Commons Library 2018).

Homelessness and temporary accommodation during pregnancy are associated with an increased risk of preterm birth, low birth weight, poor mental health in infants and children, and developmental delay (Stein and Gelberg 2000; Richards *et al* 2011, cited in NSPCC undated).

While STPs will not be able to affect many of these issues in the short term, they are in a position to build local momentum for longer-term action. In particular, there is a major opportunity for STPs and their constituent partners to scale up and prevent unintentional domestic injuries, help avoid respiratory conditions in children and young people, ensure health services target homeless families in temporary accommodation.

## Working-age adults

Housing affects the health of working-age people, including through the affordability of local housing, rising rates of homelessness, the quality and availability of supported housing locally and unintended injuries in the home.

The availability of affordable housing, ie, housing that costs no more than a set proportion of a household's income (Shelter puts this at 35 per cent (Shelter 2015)) has a huge impact on the health and wellbeing people of working age. There is also a well-documented impact of bad housing on health and wellbeing: prevalence of asthma is associated with air quality and dampness, while overcrowding and cold have been shown to be associated with physical illnesses including heart disease and hypothermia (Wright *et al* 2004, cited in NatCen Social Research 2013). Overcrowding increases rates of infectious diseases and is linked with poor mental health.

NHS costs could be reduced by £2 billion per year if poor-quality homes with health hazards (such as cold, damp and falls hazards) were brought up to standard (BRE 2015). Poor-quality housing is a widespread problem, in 2014 one in five homes in England were classified as 'non-decent' (Department for Communities and Local Government 2015). Generally, the quality of housing in housing association homes is higher, they are more energy efficient and in a better state of repair than other rented housing (Buck *et al* 2016), but supply is limited.

Around 30 per cent of households in supported housing are led by a working age adult (the remaining 70 per cent comprise older people) (Communities and Local Government Select Committee 2017). Supported housing provides care and support services alongside general housing management and is intended to enable people to live safely and healthily in their communities. The key working-age client groups are people with physical or learning disabilities (around 9 per cent of all units); individuals and families at risk of homelessness (9 per cent); people with mental health problems (5 per cent); and women and children at risk of domestic abuse (Communities and Local Government Select Committee 2017). A 2010 study estimated that supported housing for these groups saves around £1,000 per person per year in public funding (Frontier Economics 2010) and a study of a care and support scheme in Bradford found that caring appropriately for just six people had saved more than £280,000 most of which would have been spent on lengthy hospital stays (National Housing Federation 2015).

The health impact of homelessness can be extremely high: the average age of a homeless person at death is 47 years (Crisis 2011). The numbers of homeless people are relatively small but are increasing at a significant rate: since 2011 the number of rough sleepers in England has increased by 134 per cent and the number of homeless households in temporary accommodation has increased from 49,000 in 2011 to 77,000 in 2017 (Public Accounts Committee 2017). Homelessness has a direct impact on NHS costs and activity. A Department of Health study found that homeless people were 3.2 times more likely to be an inpatient admission than the general population, with costs on average 1.5 times higher (Department of Health 2010). This implies a cost of £64 million per year over and above the costs for the same number of the general population. Inpatient admissions and visits to accident and emergency departments represent a fraction of the total costs to the health service (Department of Health 2010). In two case studies outlined in a government review the costs of drug and detox treatment and mental health support were reduced from £16,000 to £27,000 and from £32,000 to £3,000

when those individuals were moved into accommodation with co-ordinated support (*Making every adult matter* report, cited in Ministry of Housing, Communities and Local Government 2012).

Finally, accidents in the home are a health risk for adults as well as children. Around 2.7 million people are treated in hospital for injuries following accidents in the home at an average cost of around £2,700 per person and around 4,000 die following home accidents (RoSPA undated b).

There is a range of initiatives that STPs can support to improve housing and health of people of working age, including working with the voluntary sector. Examples from around the country include the following.

- The Healthy Homes programme in Knowsley targeted areas of poor-quality housing, knocking on 32,000 doors over two years and referring residents via a tablet to 17 different agencies, including income maximisation and employment advice and energy efficiency services (Gowland 2015).
- A pilot study of The Housing First Feasibility Study in Liverpool which uses private rented or social rented flats to house formerly homeless people with high needs in their own, settled homes demonstrated a 15 per cent drop in reports about very bad physical health, a 34 per cent drop in reports of bad or very bad mental health and a 50 per cent increase in contact with family since becoming a tenant (Blood *et al* 2017).
- In the biggest initiative of its type outside London, the newly established Greater Manchester Homes Partnership is offering rough sleepers accommodation with a wide range of support to help them access health, training and employment services and to sustain their tenancies (Greater Manchester Combined Authority 2017).
- Bournemouth Churches Housing Association has seconded staff into hospitals to support homeless people on their discharge from hospital. Based on 2015 figures estimated savings to the NHS were £55,200 per year (National Housing Federation 2017).

## Older age

85 per cent of people aged over 85 live at home (Laing and Buisson 2017) while 29 per cent of people aged 85 and older live in substandard housing (Department for Communities and Local Government 2016).

Older people are particularly vulnerable to accidents in the home and the impact of these can be most severe in this group. Falls are estimated to cost the NHS more than £2.3 billion per year (National Institute of Health and Care Excellence 2013) and bring with them a loss of independence, pain, injury and mortality – falls are the most common cause of deaths related to injury in people over the age of 75 (NHS Choices 2015).

Older people are particularly prone to hypothermia, which is the main contributing factor in cause of death for more than 400 people in the over-65 age group each year (RoSPA undated b).

Keeping older patients (those aged 65 and above) who no longer need acute care in hospital rather than discharging them home is estimated to cost the NHS in England £820 million annually (National Audit Office 2016). The main drivers for this increase are the number of days spent waiting for a package of home care or for a nursing home placement (National Audit Office 2016). This is why we highlight timely discharge as one of the areas where STPs can make most progress in the short term in Section 2.

Developing relationships locally and tailoring arrangements for each local area are key to improving care for older people. STPs can help to do this by promoting co-ordinated care across organisational boundaries including developing provision and partnerships that avoid acute admissions for older people as far as is possible. There are solutions to these issues that STPs could look to. Examples include the following.

- An impact assessment of two housing-led programmes run by Birmingham City Council, Decent Homes and Supporting People, found that for a total outlay of £12 million the council achieved £24 million savings a year. Improvements relating to cold homes and to reducing falls among older people were the initiatives that brought the quickest returns (Buck and Gregory 2013).
- Birmingham and Solihull STP recognises extra care housing for older people as part of their transformation plan, as does the plan produced by Cornwall and the Isles of Scilly (Housing LIN 2017).
- Extra care housing, which provides support for frail older people on site, has been found to lead to improved outcomes and to financial savings to both the NHS and to social care. For example, an academic evaluation of one extra care housing scheme found 19 per cent of residents deemed to be 'pre-frail' at baseline were classed as 'resilient' 18 months later; a 14

per cent reduction in depression over 18 months; and a reduction of 38 per cent in NHS costs over 12 months (Holland *et al* 2016).

- Finally, for the 15 per cent of the over 85s living in care homes, enhanced care, for example the provision of primary care services on site and multidisciplinary team support, can achieve reductions in hospital admissions. NHS England provides guidance on enhanced health in care homes targets for both NHS and local authority commissioners as well as providers, care homes and people in homes and their families (NHS England 2016).
- For more examples and case studies see the resource from the Chartered Institute of Environmental Health (Chartered Institute of Environmental Health undated).

## 5 Overcoming barriers and opportunities in both the short term and long term

Our prime finding from the review work above is obvious but needs repeating: health and housing colleagues need to recognise the value that each brings to each other in the short, and especially long, term. Our belief is that housing is one of the core local services that STPs and ICSs need to engage with at a strategic level as they develop population health systems.

Just as in all partnerships across sectors, successful STPs involving health and housing require trust, mutual understanding and investment of time and effort. At the very time when health and housing need most to come together, they can find it harder to do so when resources across sectors are under pressure. STPs are the key local opportunity to make the best of those resources together, and to work jointly to the ultimate benefits of the health of local populations. The answers must be local, but the centre can help, in making it easier for local health and housing partners to find these answers and take the opportunities outlined in this paper.

We set out below what those things are, and recommendations to help. These are summarised in Table 1.

Table 1: Strengthening housing’s place in STPs and emerging integrated care systems: recommendations

|            | National  | Local  |
|------------|---|--|
| Short term | <ul style="list-style-type: none"> <li>NHS England should support sharing of practice from the centre, developing – but mainly sharing – existing material on housing and health in a way that STPs will find helpful. This may be through a ‘Health and Housing Alliance’.</li> <li>Within existing spending plans, NHS England and NHS Improvement should tie the release of STP funds (especially capital) to the realisation of local NHS estate surpluses, to include both financial and social value (eg, meeting housing need).</li> </ul> | <ul style="list-style-type: none"> <li>STP workstreams should designate a lead on housing whose role is to co-ordinate and share knowledge on housing and health from within the STP footprint and beyond.</li> <li>STPs should implement the new memorandum of understanding on improving health and care through the home (Public Health England 2018) and assess themselves against its indicators for success.</li> <li>The National Housing Federation, working with other housing agencies and NHS England, should develop a register of standardised high-quality spare housing capacity to support discharge.</li> </ul> |
| Long term  | <ul style="list-style-type: none"> <li>In order to stimulate transformation, and housing’s place within it, NHS and STP financial systems need to be more closely aligned with prevention. This includes developing capitation-based budgets.</li> </ul>  | <ul style="list-style-type: none"> <li>STPs should apply the learning from NHS England’s Healthy New Towns programme.</li> <li>As STPs develop further into population health systems, it is essential that they work with other partners including housing to deliver improvement at macro and micro levels.</li> </ul>   |

## The short-term – seizing opportunities presented by STPs and ICSS

In the short term, STPs involving the housing sector may help to address sustainability problems in the NHS and social care.

While there is a need to invest time in understanding the potential opportunities, the housing sector can help with the pressures facing health and social care services and can help them deliver their short-term goals, while building on this for longer-term transformation.

### ***Better co-ordination between the local health system and local housing sector (local)***

Although in some areas local authority and other housing providers are large organisations, in many areas the number of small housing organisations, and the wide variety in their 'offer', is a big barrier to NHS engagement from commissioners, providers and STP leads. Beyond supporting their existing residents, national housing leaders could develop a series of 'standard offers' in the form of a menu and local register for different client groups that would form a default basis for housing associations and other providers to work from when providing step down options to hospitals.

The voluntary and community sector faces similar problems when seeking to work with STPs; there is clear value to health in a better and stronger connection, but that is hard to achieve (New Philanthropy Capital 2018). Some of the mechanisms that attempt to help with that, for example an organisation similar to the Health and Wellbeing Alliance (NHS England undated b), which was set up and funded jointly by the Department of Health and Social Care, Public Health England and NHS England, would be worth exploring around housing and health.

**Recommendation:** The National Housing Federation, working with other housing agencies and NHS England, should develop a register and menu of standardised high-quality spare capacity to support discharge (local).

**Recommendation:** Health and housing sector system leaders should explore whether a 'Housing and Health Alliance' model may be appropriate to strengthen policy and practice links between them to support stronger local working.

### ***Putting into practice what is already known (national and local)***

There is lots of innovative practice going on, some of which is mentioned above. Housing organisations provide care and support in partnership with the NHS and social care. Housing is much more than a roof and a bed. Support for people with mental health needs, for people involved in substance misuse, to maintain older people's independence and for people with health behaviour



change needs are all good examples of the benefits housing services can offer. There is also great work being done by housing organisations to help with lesser-known but highly complex mental and physical health issues, such as hoarding, and of mental skills training for young people at risk of homelessness.

Examples of where this work comes together well include the following.

- New resources to improve health through the home, [www.gov.uk/government/news/new-resources-to-improve-health-through-the-home](http://www.gov.uk/government/news/new-resources-to-improve-health-through-the-home)
- NHS England commissioning guide, [www.england.nhs.uk/commissioning/health-housing/](http://www.england.nhs.uk/commissioning/health-housing/)
- National Housing Federation website, [www.housing.org.uk/](http://www.housing.org.uk/)
- Housing, NHS Alliance, [www.nhsalliance.org/housing-for-health/](http://www.nhsalliance.org/housing-for-health/)
- Housing LIN website, [www.housinglin.org.uk/](http://www.housinglin.org.uk/)
- Pathway Healthcare for Homeless People website, [www.pathway.org.uk/faculty/](http://www.pathway.org.uk/faculty/)
- 'Housing', The King's Fund website, [www.kingsfund.org.uk/topics/housing](http://www.kingsfund.org.uk/topics/housing)
- *Improving health and care through the home: a national memorandum of understanding* (Public Health England 2018).

Some of this work is captured and shared, but it is not easy for STP leads to see it, share it and act on it. One reason for that is it is collated in different places as above, each useful in its own way, but hard to access to someone with little time.

What matters is also how this evidence translates locally, and who those involved in STP workstreams speak to locally in the housing sector. That knowledge will be in STP footprints somewhere, in providers that work with the housing sector, in commissioners with expertise, providers that work closely with the housing sector, or in health and wellbeing boards, many of which have housing as a focus.

**Recommendation:** STP workstreams should designate a lead on housing whose role is to co-ordinate and share knowledge on housing and health from within the footprint and from beyond (local).

**Recommendation:** NHS England should support this approach by developing – but mainly by sharing – existing material on housing and health in a way that STPs will find helpful. This may be through a Health and Housing Alliance (national).

**Recommendation:** To support the above, STPs should implement the new national memorandum on improving health and care through the home (Public Health England 2018) which is directly relevant to STPs and assess themselves against its indicators of success (local).

### ***Business cases and the release of NHS estate for financial and social value***

To develop their plans and partnerships further, STPs will require funding (especially capital) to transform the NHS estate and move towards more community-orientated services. NHS England and NHS Improvement will decide on the basis of STP's business plans which areas will be prioritised for support.

This gives the centre a strong lever over STPs: the 2018-19 planning guidance (NHS England 2018) stated that the approval of additional STP capital will be contingent on the STP having 'a compelling estates and capital plan... Further information on the next steps regarding STP capital will be communicated separately.'

This is an opportunity for the centre to send STPs a strong signal that additional capital will be dependent on the appropriate use and disposal of surplus NHS estate and that important criteria should be that local systems need to contribute to the value of national capital by that the value is linked to the wider social value associated with housing to the local economy and population. For example, STPs that prioritise housing (and in particular social and affordable housing) as part of their contribution to capital funding should be rewarded and recognised in the assurance framework for STP capital decisions.

**Recommendation:** As STPs approach the centre for support for transformation, NHS England and NHS Improvement should tie the release of funds (especially capital) to the realisation of local NHS estates surpluses, to include both financial and social value (eg, to meeting housing need).

## The longer term – towards transformation

The real gains from closer working between the health and housing sectors will be in the longer term and will contribute to transformation. This will require system and policy changes, as well as efforts by STPs and housing partners. Some of these can be 'built in' to the existing changes required to move towards the realisation of STPs, ICSs and a stronger focus on prevention and population health, as suggested in our recommendations.

### ***Better payment systems and aligned financial incentives (national)***

The NHS's payment systems, in the acute sector widely based on Payment by Results (PbR), reward the NHS for treating patients when they are in need of care, as opposed to supporting the improvement of health and wellbeing. While housing providers may benefit from PbR in the longer term, a move towards capitation-based payments for health care providers, which are more aligned with STPs and integrated care, would give local systems an incentive to transform care, and to work more closely with housing and other partners to maintain and support health and wellbeing in the community.

The National Audit Office's report reinforces this, but also points out the inconsistency in approach between NHS England and NHS Improvement, '...commissioners have been given conflicting messages on the current payment system, with NHS England giving commissioners a clear steer to explore other payment systems to help manage demand, while NHS Improvement has encouraged trusts to use Payment by Results to maximise their income' (National Audit Office 2018, p 44).

And as the National Audit Office emphasises, 'While developing preventative services was a strong feature of all the plans we examined, most partnerships we visited noted that they had made insufficient progress so far. Their need to make short-term immediate savings meant they were often overlooking investment in preventative services' (National Audit Office 2018, p 45).

NHS Improvement and NHS England have signaled a relaxation of requirements for PbR and some areas are starting to extend use of block contracts in acute care and move towards capitated budgets. There is flexibility and movement in the right direction, but the housing sector needs to be included in the discussion at this early and still emerging phase.

**Recommendation:** In order to stimulate transformation, and housing's place within it, NHS and STP financial systems need to be more closely aligned for prevention. This includes developing capitation-based budgets.

### ***Learning the lessons of Healthy New Towns (local)***

The NHS England Healthy New Towns programme is an important innovation, seeking to develop and mainstream best practice in planning places for healthy futures. The focus of the programme is five-fold: integrated care based on multidisciplinary teamworking; services delivered in community settings wherever clinically appropriate; technologically enabled care; place-based partnership-working between health and non-health agencies; and thriving community life promoting health and wellbeing in the population.

The 10 demonstrator sites represent a cross-section of new housing developments in England. Sites have finalised their delivery plans and have been setting up partnerships, involving planning and wider local authorities, housing developers, clinical commissioning groups, and health and care providers. Their objectives are to develop best practice, case studies and guidance to help ensure all new housing developments embed certain principles, promoting health and wellbeing and securing high-quality health and care services.

NHS England has commissioned a package of work summarising and generalising the learning from the Healthy New Towns programme. Given their relevance the lessons from the Healthy New Towns should be part of any STPs future work on housing and health.

**Recommendation:** STPs should apply the learning from NHS England's Healthy New Towns programme.

### ***From integration of the health and care system, to population health systems (local?)***

Integration of health, and with social care is now a widely accepted goal for the health and care system. Initially integration focused within organisations, then between them. STPs continue this journey but go beyond that. To do justice to transformation, STPs need to become, or be leading lights in the development of, population health systems.

The NHS and its partners can look to other countries for inspiration. Learning from population-health systems in a range of countries shows that success comes through operating on both levels below (Alderwick *et al* 2015).

- At the macro level, population-health systems use a population-level lens to plan programmes and interventions across a range of different services and sectors. Key features include: population-level data (to understand need across populations and track health outcomes); population-based budgets (either real or virtual) to align financial incentives with improving population health; and involvement of a range of partners and services to deliver improvements.
- At the micro level, they deliver various interventions (including housing support, education programmes, employment advice and smoking cessation services) to improve the health of individuals. Key features include: integrated health records to co-ordinate services; scaled-up primary care systems; close working across organisations and systems to offer a wide range of interventions; and close working with individuals to support and empower them to manage their own health.

For example, in the US at the macro level health care systems are using health care budgets directly in 'housing as health care' experiments including rent subsidies and providing new housing for high-cost patients, in the knowledge that this will pay-off to the health system (Doran *et al* 2013).

If STPs are to develop successfully into population health systems they will need to learn from how population health systems work elsewhere, including how they are working much more directly with other sectors such as housing.

**Recommendation:** As STPs develop further into population health systems it is essential that they work with other partners including housing to deliver improvement at macro and micro level.

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Before joining the Fund, David worked at the Department of Health as deputy director for health inequalities. He managed the Labour government's PSA target on health inequalities and the independent Marmot Review of inequalities in health. While in the Department he worked on many policy areas – including on diabetes, long-term conditions, dental health, waiting times, the pharmaceutical industry, childhood obesity and choice and competition – as an economic and strategy adviser. He has also worked at Guy's Hospital, King's College London and the Centre for Health Economics in York where his focus was on the economics of public health and behaviours and incentives.

**Sarah Gregory** works in the Policy team at the King's Fund conducts research and policy analysis across a range of topics. She has a particular interest in comparative health policy and sits on the steering committee for the European Health Policy Group.

Sarah joined The King's Fund from the BBC where she worked for 10 years as a social affairs analyst for BBC News and then as a producer in both news and current affairs.