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Making creative use of NHS estate

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Introduction

The Government has said that it wishes to see publicly owned land released for housing development as a way of stimulating growth. One Housing Group, a leading developer of supported housing and provider of care and support services for a range of user groups, welcomes this policy. However, One Housing Group believes that it is important that any housing that is developed on NHS estate:

- helps the NHS to deliver better outcomes at lower cost
- provides housing that promotes greater independence for older people and vulnerable adults
- commands the support of local people as a good use of land and resources
- releases money back to the NHS to fund services.

Moving towards greater integration between health, housing and social care will involve a new operational model, a new cost model and, crucially, new responses to what the client wants. This will involve measuring and demonstrating the contribution of housing and housing related services in delivering better outcomes at lower cost, particularly in the areas of older people's care, mental health, complex needs and learning difficulties. It should be possible to use the resources that are available and to use NHS reforms to support this form of approach.

On 30 January, One Housing Group held a round-table discussion at the King's Fund to bring together key people in the sector. The event was attended by -

Baroness Julia Neuberger DBE	Chair, One Housing Group
Kevin Beirne	One Housing Group
Professor Steve Field	Chair, NHS Future Forum
David Gubb	Department of Health
Tina Hothersall	Homes and Communities Agency
Richard Humphries	King's Fund
David Orr	National Housing Federation
Ian McPherson OBE	Mental Health Providers' Forum
Peter Molyneux	SW London and St George's NHS MH Trust
John Payne	Extra Care Charitable Trust
Sylvie Pierce	Earth Regeneration
Jeremy Porteus	Housing LIN
Gareth Pountain	One Housing Group
Wendy Wallace	Camden and Islington NHS MH FT

Participants discussed:

- how investment decisions and financial flows can be aligned to support the wider QIPP agenda
- how we best demonstrate the contribution of housing and housing related services to integrated / accountable care models
- the ways in which creative use can be made of NHS estate to deliver housing and support for older people, people with mental health problems, complex needs and learning difficulties
- how surplus NHS estate can be used to deliver a revenue stream to the services people want

What follows is a summary of that discussion. It is divided into five sections:

1. Summary and recommendations
2. Creating value rather than disposing of estate
3. Developing the business case
4. Contributing to integration
5. Next steps.

1.0 SUMMARY AND RECOMMENDATIONS

Creating value rather than disposing of estate

1.1 The Government has said that it wishes to see publicly-owned land released for housing development as a way of stimulating growth. However, we need to leverage land to provide the housing necessary to reduce demand for institutional care. Co-operation is needed on new models of care that are underpinned by the creation of appropriate housing that will reduce cost and improve the patient experience.

1.2 Much of the NHS land that has currently been identified for disposal will be released for housing development. More value could be created either by developing the accommodation necessary to provide for an ageing population, to support speedy discharge and step-down to recovery, or for those with support needs or to deliver a revenue stream that can be routed back into service delivery.

1.3 A site could be used for housing for sale and housing with support where the commercial return provides the cross subsidy to replace grant subsidy and delivers a significant return for the NHS. Provided that this can be structured correctly, many housing associations would be in a position to deliver an accelerated process by making use of scheme specific development finance with no call on the public purse. They will be in a position to offer the same return as a private developer but instead of leaking value to private sector shareholders they can deliver value to the public.

1.4 If we are going to be successful in changing thinking and considering land disposal as a lever in delivering service transformation, this needs to be built in at a much earlier stage of the process than currently is the case. At the point of conception there needs to be a clear service plan that delivers the QIPP agenda, the willingness to sell the idea to the public pre-planning and the buildings necessary to deliver the services at the required cost.

Developing the business case

1.5 Given the financial pressure that the NHS is under, it is unsurprising that there is an increasing interest in whether it can realise income from its surplus estate. However, the discussion should not just be about disposal – it should be about delivering a return for the public. So, it is worth asking how they best generate value and enable the public to receive the services they want.NHS Foundation Trusts have considerable freedom when it comes to owning property and sub-contracting to third parties. Certainly many are looking to expand their property portfolios (especially in London) and to own assets that can be used to deliver healthcare.

1.6 Demographic change and the increasing size of the ageing population present real challenge for public services. We must take the opportunity to unlock the potential in the individual. Using NHS estate to produce specialist housing for older people could release mainstream housing for family use, deliver better customer experience and support people with long term conditions as well as making better use of assets. Retirement housing delivers higher density buildings in a way that makes very good use of land.

1.7 There are compelling arguments for both the increased investment in housing and the reconfiguration of services in mental health and learning disabilities to include a stronger housing element. There are a number of ways in which housing and housing related support services contribute to improved outcomes at lower cost. For people with mental health problems and people with complex needs this has meant a focus on four areas:

1. risk reduction
2. prevention and demand management
3. early discharge from acute settings to step-down facilities
4. ending of out-of-borough placements.

There is no shortage of models; it's really a question of how to get them built.

Contribution to integration

1.8 It is important that we are clear what integration is intended to achieve – and to establish that our reasons for wanting integration are subject to change over time. It is not possible to continue with hundreds of NHS organisations with little understanding of how good each of them is. If we are going to move forward we need to look at need in the round, stratify risk correctly, understand the contribution that community services can make and how new technology can be used to support higher levels of self-care.

1.9 One of the problems is that we think that good comes from competition whereas it actually comes from co-operation. Integration of health, housing and social care has been on the agenda for a long time but it is difficult to implement. Added to this different languages are spoken and terminologies used between all the partners and sectors. However, a lot of innovative work has taken place where there are shared interests. Many of the NHS's "wicked problems" could be solved by the right combination of altruism and pragmatism.

1.10 Expertise is needed to navigate systems and processes within the NHS and across social care and housing (and local authorities). In recent years commissioners have managed the strategic link with housing. However, Foundation Trusts have a real incentive to integrate services and move away from saying whether they want to use their land themselves towards asking whether value is being delivered for the public from the site. Trusts recognise that they can develop shared value across the care pathway by forming new relationships with primary care, with community organisations and voluntary sector providers.

1.11 Key to this is understanding how to navigate the financial flows in housing. Creative thinking between the public and private sectors to support capital input to re-provision and refurbishment is required. There is a recognition that care needs to move into the home and community settings. However,

community care has not always been perceived by the public as a good alternative to institutional forms of provision. There is a need to accept this and then think about how to bring all parties together and move forward with a new approach. Housing associations are well placed to offer health care organisations new ways of using their existing estate and to deliver better outcomes at lower cost.

2.0 CREATING VALUE RATHER THAN DISPOSING OF ESTATE

2.1 The NHS has numerous sites - we all walk past them every day. Of course, not all of them are available for use as many have already been leveraged against other schemes. However, it is worth asking how they best generate value and enable the public to receive the services they want.

2.2 There are well established ways in which the NHS disposes of land that it believes are surplus to requirements. This does, to some extent, depend on the value of the site. Once the site has been declared surplus it is placed on the register for 40 days during which time other public bodies can express an interest. If no expression of interest is made then the site can be declared surplus. Traditional land disposals have tended to be done badly. There are a number of reasons for this:

- Firstly, the declaration of a site as surplus can create an impairment and so this acts as a disincentive
- The NHS is bad at defining what it wishes to see on any site and bad at structuring the appropriate deals
- There is a need to coordinate activity across the whole of the public sector to look at how public benefit can be generated.

2.3 Nonetheless, NHS Foundation Trusts have considerable freedoms when it comes to owning property and sub-contracting to third parties. Certainly many are looking to expand their property portfolios (especially in London) and to own assets that can be used to deliver healthcare or used more effectively. They are also looking to develop their own control of the care pathway by forming new relationships with primary care, with community organisations and voluntary sector providers.

2.4 Inventive joint working is needed between the public and private sectors to support capital input to reprovision and refurbishment. Housing organisations will be well placed to offer healthcare organisations new ways of using their existing estate to:

- deliver the facilities that local residents require
- deliver change through a social enterprise driven long-term investment model
- create a public asset that strengthens the balance sheet and contributes to deficit reduction; and
- deliver a model that uses the public estate in both a more commercial and creative way.

2.5 Much of the public sector land that has currently been identified for disposal will be released for housing development. The priority for the Homes and Communities Agency– and many private and social housing developers will

be one of additionality. It is worth asking whether there is more value that could be created either by developing the accommodation necessary to provide for an ageing population, accommodation to support speedy discharge and step-down to recovery, accommodation for those with support needs or to deliver a revenue stream that can be routed back into service delivery.

2.6 A site could used for housing for sale and housing with support where the commercial return provides the cross subsidy to replace grant funding and delivers a significant return for the NHS. Provided that this can be structured correctly many housing associations can deliver an accelerated process by making use of scheme specific development finance with no call on the public purse.

2.7 The NHS does not have a good track record of handling its property portfolio. Too often the NHS has forgotten that it is the steward of public assets when dealing with its estate. There is a clear need to free up organisations who own sites to work creatively and to work with their communities – to be brave and bold. Property and land are part of a community's history and this is often ignored. It is not surprising that there can be hostility, suspicion and resistance from communities when change is proposed. Add to this the many rules, regulations and processes and the result is often watered down schemes and not enough freedom to progress with anything more creative.

2.8 So, while there are issues around maximising receipts, there is also a need to consider and do what is best for the NHS locally. It will be critical to create new buildings for specialist purposes because this need is not always addressed in the general housing stock. This is possibly an easier conversation to have locally as opposed to engaging with Prop Co at a national level as mutual interest, pragmatic solutions and the practicalities might be more clear locally.

2.9 If we are going to change thinking and consider land disposal as a lever in delivering service transformation, this needs to be built in at a much earlier stage of the process than currently is the case. At the point of conception there needs to be a clear service plan that delivers the QIPP agenda. There needs to be the willingness to sell the idea to the public pre-planning and some thinking on not just how to dispose of land, but also how to use it.

2.10 Housing associations buy land in the same market as do private housing companies. In contrast to private investors where profits go, for example, out of the country to foreign investors, housing associations are likely to have discussions with local authorities about providing a proportion of the development at an affordable rent. Housing associations can offer to provide the same high value housing scheme but would put all profits into the scheme. This would increase the social benefit of schemes with all profits going back to support, say, health benefits.

3.0 Developing the business case

3.1 The huge pressures that the NHS is currently facing to deliver savings will affect any approach. Although an integrated approach had been used in some places over the past 10 years or so, there are very few exemplars in

the England of thinking this through and matching the needs of clients and providers.

3.2 There are a number of ways in which housing and housing-related support services have contributed to improved outcomes at lower cost. For older people, people with mental health problems and those with complex needs this has meant a focus on four areas:

1. risk reduction
2. prevention and demand management
3. early discharge from acute settings to step-down facilities
4. ending of out-of-borough placements.

3.3 Although the economic evidence base is limited, there is a strong argument for the positive contribution of housing and housing-related support services to health. Examples include:

- Housing organisations delivering level one and two IAPT services and predictive modelling
- The National Audit Office has estimated up to £50m could be saved annually by more consistent use of crisis intervention services
- Capgemini study of the benefits of the Supporting People (SP) funding programme estimated that £1.6bn in housing-related support services generated £3.41bn to the public purse, including to health and social care by avoiding more costly acute services.
- The Care Services Efficiency Delivery Team (CSED) showed that investment in preventative support by housing organisations leads to better outcomes for service users than the likely alternative;
- National Mental Health Development Unit (NMHDU) estimated that consistent inclusion of housing and related support services in the psychosis care pathway would deliver £50m saving p.a.

3.4 Volition, a collaboration between the PCT, Leeds Partnership NHS Foundation Trust, Leeds City Council and local housing support providers via a voluntary and community sector body, sought to reduce the number of delayed discharges from acute psychiatric wards due to waits for housing in Leeds. The new pathway is based on earlier identification of housing needs by Leeds Partnership Foundation Trust staff, improved access to housing advice and support on the wards and the development of a single point of access for all the organisations that provide housing-related support for people with mental health needs. To date the initiative has led to:

- service users on acute wards having improved access to an increased range of housing options on discharge
- regular communication and review of capacity and demand across the whole system by housing and mental health services has now been established
- no delayed discharges due to housing issues over six months[1].

[1] Accommodation Pathway Project Update Leeds Partnerships NHS FT, NHS Leeds, Leeds City Council, Volition March 2010

3.5 One Housing Group developed Ponders End, a purpose-built development that provides high-quality supported housing with 24-hour support for 12 people with complex mental health histories who are returning from expensive out-of-area placements or long-stay wards. The self-contained flats are situated in a specially designed building offering customers an opportunity to develop their independent living skills while providing additional safety and wellbeing functions with communal facilities to support group work and social inclusion activities. The success of the service in supporting and moving on people who had previously lived in hospital or care homes has been praised as a model for replication by other providers and local authorities.

3.6 So, there are some compelling arguments for the increased investment in housing and the reconfiguration of care pathways to include a stronger housing element. Much of this has been demonstrated in recent years through innovation and demonstration projects. However it has not transferred into mainstream practice and the application of such evidence is patchy, haphazard and unpredictable[2],[3]. When good ideas succeed it is more often due to the creativity, determination and hard work of particular individuals than to any explicit strategies that may be developed for supporting the development and spread of their innovation and ideas[4].

3.7 The blocks to the development of new ideas and to the mainstreaming of such initiatives have been summarised as follows:

- There are different ways of assessing risk in an institutional setting as opposed to a community setting and this leads to clinicians being reluctant to discharge patients
- There is a lack of understanding or appreciation of the skills and competencies that exist across sectoral and professional boundaries which inhibits the development of community pathways that involve a range of providers
- Too often serious incidents occur as a result of poorly-managed transfers of care
- Even if care can be transferred from one setting to another the finances cannot follow the care.

3.8 Where health providers have worked with community housing providers to improve outcomes they have found attitudes to risk and a need to develop a shared understanding of skills to be an important component. Midland Heart and 2Gether have developed more integrated packages of care based on the recovery approach. They recognise that this requires them to form new relationships with agencies that have different skills to develop shared value. In particular, to bring into the pathway a range of skills including housing options advice, floating support, life skilling and housing with the necessary support to enable a speedy move into the community.

3.9 Both organisations have invested a significant amount of time to ensure that relationships were built between staff groups at different levels of the

[2] Hazlett et al ((2008) An Exploratory Study of Knowledge Flows: A case Study of Public Sector Procurement. Total Quality Management 19(1-2) : 57-66.
[3] Eccles et al (2005) Changing the Behaviour of Healthcare Professionals: The Use of Theory in Promoting the Uptake of Research Findings". Journal of Clinical Epidemiology 58: 107-112.
[4] Scott C et al (2009) Integrated Health Systems and Integrated Knowledge : Creating Space for Putting Knowledge into Action. Healthcare Quarterly Vol.13.

organisation, to understand their respective strengths and develop an understanding of the need to manage risk differently in different settings. When London Cyrenians were developing a step-down project in Kensington and Chelsea they worked with local residents to ensure that they were informed of the risks and how best to manage them[5].

3.10 For people with Long Term Conditions (LTCs), conventional models of care assume that people are ill, go to hospital, and then go home again. A more proactive approach would be to consider how to support people with LTCs in their homes rather than supporting the home, hospital, home cycle. The Extra Care Charitable Trust has established wellbeing services that are nurse led. Enriched Opportunities, a service to support people with dementia, and the Locksmith Scheme to unlock the skills and talents of older people, are all part of an approach to dementia care that has reduced demand for institutional care.

3.11 There is a significant mainstream agenda for health and housing services resulting from many factors including an ageing population. So much of what is currently provided is based on the model that assumes that care is provided in hospitals and that the sustainability of health care organisations is based on them providing care in hospital. All too often community-based models of care have fallen short of expectations. There is a need to accept this and then think about how to bring all parties together, take a customer-focused approach and move forward with new models of service.

3.12 There is an argument for a "sixth case" to the five-case business planning model that prioritises the proposal's 'additionality' or added value for the NHS and the local community. This could be accompanied by a set of standards or requirements for how local communities and local organisations would like to see local land used. This will enable organisations to act genuinely as guardians of public assets and to take account of other issues such as inequality. Whatever processes we put in place greater value is likely to be created through co-operation and imaginative ways of delivering it.

4.0 Contribution to integration

4.1 In order to meet the financial challenges they face, whilst improving quality, health and social care commissioners are looking for more integrated models of care. Clinical commissioning groups and local authorities will want to align their decisions to ensure that there is no cost-shunting and that they are both making the best use of their joint resources[6]. Such co-operation is essential if we are to build and finance housing based models of provision that rely less on in-patient and residential settings and more on caring for people at home and in the community[7].

4.2 Increasingly, health and social care commissioning will be based on outcomes with providers being accountable for delivery. Integrated care models encourage primary care and other clinicians to take responsibility for designing, delivering and, ultimately, for managing the budget for integrated clinical services. Providers are developing supply/value chains that deliver the

[5] Molyneux P (2010) Health and Housing : World's apart ? NHF : London
[6] Ostrom E et al (2010) Social Capital : Conceptual Explorations. Indiana University Press.
[7] Appleby J (2010) Improving NHS Productivity : More With the Same Not More of the Same. King's Fund : London.

desired solutions across the whole of a particular pathway or an overall package of care, which include housing providers and providers of care and support from other parts of the not for profit sector. For this to work a number of things need to be present:

- A desire to improve quality through innovation to increase productivity and prevent need for care
- Work with agencies that people trust, allowing them to navigate the world
- Clarity on how reductions in cost will be released and measured
- Clarity around desired outcomes for all commissioners
- Development of new ways of providing services.

4.3 Whether it is to meet the needs of an ageing population or those with complex needs, these requirements can only be met if the full breadth of needs are acknowledged and agencies work together to meet them. Without such co-operation it will be difficult to give priority to new models of care that rely less on in-patient and residential settings and more on caring for people at home and in the community[8] and will genuinely reform the NHS and change the cost model.

4.4 There has been a great deal of innovative work around the hospital closure programme. Where land is to be released it is necessary to identify areas of mutual interest and focus on people with complex needs within a larger strategic development. The only place within the new architecture where these discussions can take place is the HWBs. HWBs would benefit from housing and other providers as members, coupled with the necessary governance arrangements to enable providers to participate safely without creating conflicts of interest. This is likely to require HWBs to have an independent chair to enable them to mediate between different sectoral interests.

4.5 There is a need to take a spatial planning approach that reflects changing demography and the necessary standards of building to meet their needs. At present cost drives the approach with developers needing to keep costs down, providers needing to ensure that services are provided and that the owner maximises return. The Government has signalled that models such as Extra Care should be incorporated into the additional 100,000 houses the Government wants to see. Retirement housing can be built to higher densities and can make very good use of land.

[8] Appleby J (2010) Improving NHS Productivity : More With the Same Not More of the Same. King's Fund : London.

NEXT STEPS

In summary, what we are proposing will not be easy to achieve. However, there is definitely a business case here for managers of NHS Trusts to focus on providing medical care within a hospital ward rather than services to long-term care patients. Patients also benefit as they can be cared for in a 'homely' environment rather than a hospital. It seems there is a missed opportunity here.

There are a number of mechanisms that could enable this vision to be realised:

- Relatively small amounts of money can be used as carrots to encourage people to get round the table and work in a collaborative manner. The Homes and Communities Agency could play a key enabling role and their investment could make the difference between viability and non-viability of schemes in many circumstances.
- The NHS Commissioning Board should consider issues of depravation and relate this to inequalities and integration. At a local level, each Health and Wellbeing Board (HWB) needs to have a housing representative and an independent Chair to mediate between sectoral interests.
- Organisations that own sites need to be freed up to work creatively and to work with their communities. Property and land are part of a community's history and the narrative needs to be told to communities in a way that avoids the suspicion and resistance that can meet proposed change.
- There is a need to be clear about what "good" looks like for the community and then to work with the appropriate range of people to deliver "good". The emphasis should be on cooperation rather than competition and to see disposals as a lever to change which enables organisations to act genuinely as the stewards of public assets. The Homes and Communities Agency has a role to play in rewarding creativity.
- More work is needed on pulling together the evidence that supports an integrated approach to health, social care and housing. Good practice examples need to be costed and extrapolated across the economy. There is an argument for a sixth case to the five-case business planning model that prioritises the proposal's 'additionality' for the NHS and the local community.

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