HOUSING LIN POLICY BRIEFING

Long Term Conditions and the Wider Policy Context

This briefing paper has been put together to set out the policy direction for the management of long term conditions; what this means for service commissioners and providers of housing and housing related support services. It brings together some key messages on self care, health and well-being and prevention arising from recent policy directives on long-term conditions and others that impact people with long term conditions.

This paper also seeks to encourage providers to provide examples to the Housing LIN for publication on our website and dissemination through local meetings and to stimulate debate and encourage further service development.

All three government departments (Office of the Deputy Prime Minister, Department of Health and Department of Work and Pensions) with responsibility for services for vulnerable people have published national policy documents this year. This briefing considers the following:

- Supporting People with long term conditions to self care – best practice guidance published by Department of Health (DH) in February 2006
- The DH White Paper Our Health, Our Care, Our Say: a new direction for community services – published by DH in January 2006
- A Sure Start to Later Life: Ending Inequalities for Older People – a report by the Social Exclusion Unit published jointly by the Office of the Deputy Prime Minister (ODPM), Department of Work and Pensions (DWP) and the DH in January 2006

1. Introduction

The idea of individuals taking responsibility for their own health and well-being has been on the agenda alongside prevention for a considerable time. However service delivery through the NHS and social care has been patchy and often overshadowed by concerns around access to acute care in hospitals and services for the most vulnerable.

The focus for self care within the NHS has been the Expert Patients Programme (EPP) launched in April 2002 and based on research in the United States which shows that patients with long term health conditions are often best placed to know

what they need to manage their own condition. The programme has been very successful and one of the targets in the recent White Paper is to make it available in all areas by 2008.

In primary care, local delivery plans include targets for health and well-being in the long term conditions and older people's targets. Many PCT's have used this to tackle health inequalities, promote smoking cessation and recognise that health is closely related to poverty, educational achievement and lifestyle. The White Paper makes clear that PCT's will not have future plans approved unless they can demonstrate a strategy for shifting resources from acute services into the community.

Local Authority Community Plans developed through Local Strategic Partnerships and looking across local systems to include the range of local government, health services and voluntary and private sector often include targets to reduce social exclusion and promote health and well-being. Examples include smoking cessation, physical activity and improved diet. The White Paper sees local partnerships using Sustainable Communities Strategies to set priorities for Local Area Agreements (LAA's) and Local Strategic Partnerships (LSP's) commissionining services to deliver them. (LAA arrangements and the implications for housing with care will be featured separately in a future Housing LIN Briefing).

Alongside of this local authorities have worked with the voluntary sector to develop a range of low level preventative services, many of them aimed at older people. Examples include falls assessments and prevention, home maintenance, luncheon clubs and health promotion.

One of the key messages from across Government is for the agendas and drivers outlined above to be brought together through 'whole system' planning and commissioning.

2. Some Useful Facts and Figures

Long Term Conditions can be defined as follows:

- are enduring
- are not curable and require ongoing care
- will get progressively worse

This definition covers a range of physical and mental health conditions.

DH estimates that there are 17.5million people with Long Term Conditions and included in this number are 8million with multiple Long Term Conditions

Historically care has been reactive, unplanned and episodic and reliant on hospitals and acute care.

DH figures show the following:

- 5% LTC inpatients = 42% of all acute bed days
- LTCs account for 80% of GP attendances
- Only 50% medicines taken as prescribed

Individuals with long term conditions are major users of social care and many

also receive housing related support services

The DH White Paper sets out how telecare will be used as a systematic approach to support people in their own homes alongside community matrons and the primary and social care system to reduce emergency bed days and support patients to manage their conditions in the community

National Targets in the DH Planning and Priorities framework for PCT's include:

- April 2008 - reduce Emergency Occupied Bed Days by 5%
- April 2008 - identify the cohort of Very High Intensity Users - est. 240k nationally
- April 2008 – all Very High Intensity users have care plans and are case managed
- April 2007 – complete appointment of Community Matrons - 3,000 nationally

3. The Policy Context

a) Supporting People with Long Term conditions to Self Care

This is a guide to developing local strategies and good practice, drawing on a body of evidence about what works well. It explains how health and social care services can support self care providing options for people to choose from. These elements include;

- information – to enable people to assess their own condition, know what is 'normal' for them and know when, where and how to get help and advice
- self monitoring devices – monitoring people's conditions in their own home using sensors and helping people to remain independent in their own home through the provision of aids and adaptations and repairs.
- skills education and training – disease specific education and self management skills such as the Expert Patients programme (EPP). The target is that this should be available to people with long term conditions by 2008
- support networks – recognising the role of community and voluntary sector groups and encouraging their involvement

Self care is important because when people are supported to self care a range of outputs are delivered, firstly for the patient – improved health and well-being, secondly for service providers – reduced need for emergency health and social care services.

For more information on long term conditions see
www.dh.gov.uk/HealthandSocialCareTopics/LongTermConditions

b) Department of Health White Paper, Our health, our care, our say: a new direction for community services

The DH White Paper includes a chapter on **Enabling health independence and well-being.** The chapter makes the link between preventing ill-health and supporting people to play a role in local communities with regeneration and building sustainable communities. One of the delivery mechanisms will be a network of one stop shops containing health, social care, housing leisure, education and voluntary and social opportunities.

One of the case studies in this chapter is Westbury Fields extra care village for older people which has150 flats and a 60 bed care home all on one site in Bristol.

Chapter five of the paper entitled **Support for people with longer term needs** looks at care and support for people with ongoing needs. There are estimated to be 15 million people in England with long-term health needs and this will grow by over a million each decade as a result of the ageing population. In future health and social care will focus on supporting these people to understand and take control of their conditions. Helping people to take control will include The Expert Patient Programme (EPP) which helps people manage chronic conditions. By 2008 the expectation is that everyone with a long-term condition will receive information about their condition and access to peer support and other self care support networks.

The policy direction is to move the treatment and support for long term conditions out of hospital into the community. Examples include the following references to telecare;

- the TELeHEART programme in America for veterans with high risk of cardiovascular disease
- house alarms linked to a call centre staffed by a nurse
- telecare as part of intermediate care
- telemedicine including spirometric and cardiac readings from the home to detect acute episodes early and minimise or eliminate the need for hospital admission
- in-home touch screen and video link for patients to self monitor and provide information to health professionals
- bed sensors that detect if people have returned to bed safely during the night

The White Paper sets out plans for three demonstration sites with a resident population of at least 1 million and from a variety of geographical contexts. These demonstration sites will be challenged to achieve significant gains in quality of life and reductions in acute hospital use. Each of them will work with a number of NHS, social care, private and voluntary sector partners, including NHS Connecting for Health and NHS Direct. The projects will provide an opportunity to pilot a shared health and social care record. The aim is to commence the demonstration projects by the end of 2006 and share early findings by the end of 2008.

Copies of the White Paper are available at www.dh.gov.uk/PublicationsandStatistics under policy and guidance.
Information on telecare is available at www.dh.gov.uk/changeagentteam

c) Social Exclusion Unit Report

A Sure Start to Later Life is a joint report published by the Social Exclusion Unit (SEU), Department of Health (DH) and the Department of Work and Pensions (DWP).

It aims to adopt the Sure Start approach developed for children and reshape it for older people's services. It is based on aspirations of independence, dignity and choice. It sets out basic standards of health, wealth and housing, alongside improved quality of life, right to participate, meaningful relationships, inclusive communities, strong leadership and equality.

Older people at risk of exclusion are characterised by low income, living alone and suffering from depression. There is a strong link between increasing age and exclusion.

One of the key elements of Sure Start is a single accessible gateway, the aim being to bring together a range of services that can empower older people and improve their quality of life. A pilot programme called Link Age Plus will test out the Sure Start approach for older people, starting in spring 2006. This model is also part of the DH Partnerships for Older People Projects (POPP's) and Local Area Agreements (LAA's). The Sure Start approach will encourage better integration between housing and other services such as health and social care.

The report goes on to say that health and social care services should be preventative and be more responsive to individual needs. The report uses the Joseph Rowntree Foundation description of preventative services as 'that bit of help' and considers the case for small amounts of investment at much earlier stages. The need for preventative services was a key theme in the SEU consultation with older people, including the opportunity to take part in active ageing.

The report includes a chapter on housing and housing related support services and recognises that many older people would benefit from low level support such as home safety, energy efficiency, new technology such as telecare, low level housing support such as gardening, changing light bulbs and hanging curtains, or a disabled facilities grant to fund adaptations. The report highlights the work of Home Improvement Agencies (HIA's)

A copy of the full report is available at: www.socialexclusion.gov.uk

4. Examples of Practice

Set out below are a number of examples of good practice, taken from a range of housing and housing care and support services, helping individuals to manage their health and well-being.

i) *Links with health promotion in Extra Care Housing*

The Extra Care Charitable Trust runs as many as 1,500 activity groups and information events within its housing schemes. The project has been supported by a Section 64 health improvement grant from DH. The project is now in its third and final year and was developed following a survey in one scheme which identified that

75% of residents had not accessed their GP or the NHS for health screening. A pilot screening programme identified 122 previously undetected conditions amongst a population of just 136.

The focus of the well-being programme is preventative health screening and health promotion, scoring on 10 key indicators;

- diet
- mobility
- bladder/bowel function
- heart and circulation
- breathing
- hearing and sight
- skin
- fitness
- psychological
- sleep

Referrals to GP's and other specialists are made as necessary. Between April 2005 and June 2005 advisors made a total of 331 referrals. The service is free and confidential. Between December 2004 and June 2005 advisors dealt with over 2,000 concerns. Evaluation of first assessment scores and follow up scores show an improvement across all the indicators.

A diverse range of groups and social activities have developed supported by over 400 residents who have volunteered to train and become well-being ambassadors. There are over 1,500 different groups and activities including an introduction to herbal medicine, falls prevention, diet and exercise, yoga, Tai Chi, poetry, painting, skittles and more. These too have health benefits. A study of people aged 65 plus who enjoy Tai Chi are 47% less likely than those not taking part to slip or fall due to their improved strength and balance

Further information is available at www.extracare.org.uk

ii) *Telecare and falls prevention*

A wide range of devices are now available – users know that if they fall help will arrive, for many people this increases their confidence which in turn reduces falls.

The majority of accident prevention programmes for older people focus on falls prevention. These include exercise initiatives to increase strength and stability, involvement with nursing teams, specialist falls co-ordinators and the use of community alarms and telecare to support people at risk and individuals who have had one or more falls.

In Barnsley one of the Health Action Zone (HAZ) projects is collecting evidence to assess the acceptability and effectiveness of telecare. Work includes focus groups and the provision of telecare to 30 older people.

Further information on telecare is available at www.cat.csip.org.uk and www.dh.gov.uk/changeagentteam

iii) *Home Improvement Agencies and hospital discharge*

Care and Repair England have published *On the Mend* a guide for commissioners showing how home improvement agencies can contribute to hospital discharge through the provision of adaptations and by ensuring that the homes people return to from hospital are fit for them to live in.

Established in 1994 the Hackney Anchor Staying Put service provides a holistic approach to hospital discharge. The service is available to older people in hospital and unable to return home unless essential work is carried out to their home. It is also available to people who are in danger of hospital admission unless such work is carried out. Work ranges from handrails installed by a handyperson through to major adaptations and renovations. The service also provides benefit checks and will liaise with a variety of agencies on behalf of clients.

The Sefton Home from Hospital service was established on a small scale in 1996. Like the Hackney project it helps older people in hospital as well as those in danger of hospital admission because of the need for adaptations and/or repairs to their property.

In Warwick the Daily Living Support Service combines the provision of short term (6 weeks maximum) practical support services such as shopping and cleaning with advice on equipment and small adaptations carried out by the handyperson service. Clients also receive a benefits check and can be referred to the core HIA service for repairs and major adaptations.

Leeds Hospital Discharge team focuses on fast track installation of minor adaptations. The service operates across tenure and age. The agency uses independent contracts working to agreed schedules of rates. If major adaptations and repairs are required the contractor refers individuals back to the core service.

In addition to hospital discharge HIA's are involved in improving housing stock and brining it up to Decent Homes standards, helping people live independently, falls prevention and home security and safety.

Further information can be found at: www.careandrepair-england.org.uk and www.cel.co.uk/foundations

The SEU report includes a case study of an active age centre in Somerset which is part of the DH POPP's programme. There are 50 active age centres in village halls and sheltered housing schemes, providing information and advice, access to the internet, falls prevention services and access to volunteering. The notion is one of active citizenship with older people organising and delivering support to their peers.

iv) *Extra Care Housing and Intermediate Care services*

Arch Hill Court Extra Care and The Woodlands Intermediate Care Service is managed by Wyre Forest Housing Association. It was jointly commissioned by Worcestershire County Council, the local districts, PCTs and social services as part of the planning and development of new Extra Care Housing in the county.

The programme based on the suitability of remodelling and redesignating existing sheltered housing schemes. Social services provide 24hour emergency domiciliary care, including to the 6 flats at Woodlands. In addition, at the Woodlands there is on-site therapy and nursing care services to provide rehabilitative and transitional care to prevent admissions and readmissions into hospital and to facilitate hospital discharge arrangements.

5. Further examples or reports

A number of examples in the Government publications are LIN case studies. There are also references to factsheets and the LIN toolkit, including:

- Case Study 19 – Durham Integrated Teams – a practical guide featured in the DH White Paper
- Case Study 5 – A mixed tenure retirement community – Westbury Fields Bristol featured in the DH White Paper
- Assessing health Risks and Health Inequalities in Housing – A LIN Toolkit
- Health for Life: Health Promotion in Extra Care Housing. An overview of the 'community hub' approach to health promotion activity for older people in Macclesfield and Congleton.

In addition the recent report from Care and Repair *Small things matter – the key role of handyperson services* (sponsored by the LIN) shows how the work of HIA's and handyperson services have contributed to improved hospital discharges. www.changeagentteam.org.uk/housing

Also a number of the Partnerships for Older People Projects (POPP's) include self care. Further details can be found at: www.dh.gov.uk and www.cat.csip.org.uk

If your organisation is delivering services that contribute to the delivery of better care and support for people with long term health conditions please let us know by contacting housinglin@cat.csip.org.uk