Housing support and care: Integrated solutions for integrated challenges City of Westminster and The Royal Borough of Kensington and Chelsea

Joint Strategic Needs Assessment (JSNA)

August 2016

www.jsna.info

An introduction to JSNAs

The purpose of JSNAs is to improve the health and wellbeing of the local community and reduce inequalities for all ages by informing all relevant parties about the health and social care needs of the local population and how these may be addressed. They are assessments of the current and future health and social care needs of the local population, with the core aim of developing local evidence-based priorities for commissioning and strategies. The needs identified may be met by the local authorities, CCGs, NHS providers or others.

JSNAs are a continuous process of strategic assessment and planning and are an integral part of CCG and local authority commissioning and planning cycles. Their agreed priorities are used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities and CCGs, exercised through the Health and Wellbeing Boards. Health and Wellbeing Boards are able to decide when to update or refresh JSNAs or undertake a fresh process to ensure that they are able to inform local commissioning plans.

This report

This JSNA considers integrated approaches which might better support the provision of housing support and care for residents of The Royal Borough of Kensington and Chelsea and The City of Westminster. It explores the way in which Local Authority departments and services might collaborate more closely with each other and with NHS partners to improve customer journeys and cost benefit ratios, thereby preventing unnecessary deterioration in health and wellbeing, delaying inevitable deterioration and mitigating the impact of deterioration when it occurs.

JSNAs consider borough based data alongside that from other boroughs. The Public Health department, which leads the production of JSNA reports, services three boroughs. As this report explores challenges which are shared by all three, and as one of the key departments responsible for service delivery serves the same three boroughs, the material draws on data and activity across all three. This adds depth to the report, facilitating greater understanding of the challenges.

It is clear that there is much activity already in place in both boroughs which seeks to address the challenges of providing housing support and care. This report makes a series of recommendations which seek to build on this activity, to provide levers for extending existing good practice and existing partnerships and to try new approaches in close collaboration. These recommendations build on the findings of pre-existing local research and reports, and draw on national, regional and local evidence. They have been drafted in collaboration with key stakeholders. The intention is to stimulate where necessary a conversation centred

around integrated efforts, to ensure that the right services are delivered in the right place at the right time, with a focus on improving outcomes for those most in need.

Equalities statement

JSNAs must consider the health, wellbeing and social care needs for the local area, addressing the whole local population from pre-conception to end of life. The "local area" is that of the two boroughs, and the population living in or accessing services within the area, and those people residing out of the area for whom West London CCG and Central London CCG and the local services have responsibility. The "whole local population" includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs etc.).

The focus of the JSNA is the housing support and care needs of residents who are vulnerable due to poor health and wellbeing and/or poor housing conditions.

There is a high correlation between many of the protected characteristics and deprivation, and between deprivation and poor housing conditions. The recommendations of the JSNA can therefore be expected to make a positive contribution to reducing health inequalities.

Authors and contributors

This JSNA has been co-produced by Adult Social Care, the two Housing departments and Public Health. The report was written by Anna Waterman with Irene Fernow and Jessica Nyman.

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1 Executive Summary

1.1 Introduction

There is a strong evidence base for the links between housing, health and wellbeing: good quality and appropriate housing is crucial to enabling people to stay healthy and well, and less likely to need more costly health and social care interventions. Poor quality housing and homes which do not lend themselves to effective delivery of care packages can give rise to health and social care needs, exacerbate existing needs and lead to early loss of independence.

While many residents live in homes which support their health and wellbeing, there are resident's cross-tenure who do not and residents who need supportive housing. The services which councils provide to address this are an important part of the package available to support residents in maintaining their independence. It is these on which this JSNA focuses, placing the resident at the centre.

1.2 Approach

This report focuses specifically on the shared challenges which can only be addressed through collaborative working, not on those which can be resolved largely within single departments.

It draws on local research and reports, compares local data with meaningful benchmarks, and evidence from a number of sources. It seeks to build on existing good practice locally and to learn from practice elsewhere.

Throughout, stakeholder engagement has been central to this JSNA. Public Health has held a co-ordinating role, brokering cross-departmental and cross-agency discussion on the shared challenges identified, and offering analysis of data, evidence and the economic case for investment upstream. The engagement and intelligence offered by a range of stakeholders across the system, through workshops, team meetings, third sector forums and one to one discussions, has ensured that the report is rooted in the local landscape and is able to offer recommendations which are applicable across both boroughs while allowing scope for appropriate tailoring and targeting to address the particularities of each one.

1.3 Aims

This JSNA has five overarching objectives:

- To present an overview of the impact of poor housing on residents' health and wellbeing;
- To articulate key strategic drivers and the constraints Local Authorities face in addressing the support needs of residents;
- To explore the economic case for integrated approaches and working 'upstream';
- To identify key issues which require integrated strategic planning by health, housing and Adult Social Care;
- To identify potential measures which might enable the local authorities to utilize their assets more effectively and enable residents to maintain their independence for as long as possible through providing the appropriate mix of support at the right time.

1.4 Main findings

There is a significant challenge facing the Local Authorities. The boroughs cover one of the most densely populated areas in the country and demand for accommodation is very high, as reflected in house prices. There is limited housing which is affordable by households on low incomes / benefits, and demand for social and affordable housing outstrips supply, leading to long waiting times for social housing. In addition, a large proportion of properties in the private rented sector are in poor condition.

Another challenge is the size and age of the stock available: the great majority is flats, the number of family sized homes is limited and space for further development also limited. As a result, people requiring larger properties or ones which meet the four accessibility features have limited opportunity. All of these characteristics can exacerbate pre-existing health and well-being issues and/or our ability to address them, through the timely delivery of care and/or re-housing.

The housing departments each have strategies in place to address the challenges and there is much activity underway, however the characteristics of housing in the two boroughs limits the capacity of the system to respond to demand.

A significant percentage of the working age population has a disability and/or mental illness, and enablement and capacity building is essential to reduce demand on services. The management of chronic disease is paramount; maintaining quality of life and providing joined up, high quality services are crucial.

New legislation such as The Care Act 2014 and direction such as the NHS 5 Year Forward View have shifted the focus of health, housing and social care closer to prevention as demand needs to be managed effectively. Indeed, the evidence overwhelmingly shows cost effectiveness of prevention and early intervention far outweighs that of support packages further down the line and that, without significant investment in prevention and early intervention, all three councils face escalating costs.

Evidence also demonstrates that effective prevention requires robust partnership work across council departments, with NHS partners and with other front line agencies. An increase in joint commissioning, potentially pooling budgets beyond the existing and planned arrangements between NHS and ASC to incorporate other agencies, such as housing and other council departments, may be the only realistic way forward.

1.5 Foundation stones

The recommendations highlight seven common interwoven threads which offer important messages for how systems might be better structured. They are referred to in this report as foundation stones on which cost effective personalised prevention and early invention might rest.

- Joint commissioning and pooled budgets: Recognising the links between housing, health and social care, and the restrictions on how specific budgets can be used, commissioners need to increase the use of pooled budgets as a way of unblocking solutions and facilitating closer collaboration. This might enable greater weighting towards 'upstream' prevention and earlier intervention.

- IT data sharing protocols and information governance: Collaborative work to facilitate and enable information exchange between organisations, supported by robust information governance protocols and initiatives to facilitate patients' confidence in appropriate disclosure, is required if cost effective personalised prevention and early intervention are to be realised.

- Asset based approaches[1] (for individuals and for communities): This report advocates the development of strategies which explicitly seek to strengthen community resilience and practices which utilise residents' own strengths.

[1] Communities that are more connected need fewer public services, create dynamic places to live, and improve outcomes for residents.

- Smooth customer journeys supported by referral rights and referral pathways: work building on existing best practice is required to ensure that, regardless of where a resident makes first contact, the offer is consistent and secures optimal impact.
- Quality services and facilities, appropriately tailored and targeted: This report seeks to highlight services which secure positive outcomes for some of our most vulnerable residents and which might play a greater role in facilitating cost effective provision than may previously have been recognised.
- Workforce development: Ensuring that staff teams are skilled-up, confident and supported to address the challenge is essential if positive outcomes are to be achieved.
- Local intelligence: This foundation stone refers to securing greater understanding of the local landscape. Two specific areas highlighted are Fuel Poverty and those in severe and multiple disadvantage.

1.6 Recommendations

This JSNA seeks to identify integrated solutions to shared problems in areas of provision which rely on partnership working. These fall into five themes:

- Strengthening prevention and early intervention
- Delivering personalised housing support and care
- Strengthening collaborative approaches to supporting carers
- Improving the offer for those in severe and multiple disadvantage
- Improving housing options in later life

The recommendations are not exclusively addressed for Housing departments, for Adult Social Care or indeed other departments or agencies. They will need to be addressed in partnership by the relevant teams or departments and the lead may be different for each borough and for each recommendation. Section 7 presents the full set of recommendations with a steer as to what success might look like. It also proposes which department or organisation might take a lead on each.

While there is much commonality across the boroughs, residents' experiences, the scale of the challenges and the way in which they are manifested, all vary. Any implementation plans which stem from this report will need to consider the most appropriate, borough based response to each recommendation.

Strengthening prevention and early intervention

Recommendation 1: Increase the number of homes in the boroughs which offer residents easy access and manoeuvrability.

Recommendation 2: Develop a strategic approach to improving housing conditions, cross tenure, to facilitate efforts to maintain residents' health and wellbeing.

Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community.

Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation.

Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services, which promote independence and self-reliance and are tailored and targeted to secure best impact.

Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' (MECC) approach.

Delivering personalised housing support and care

Recommendation 7: Establish data sharing appropriate protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents.

Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care.

Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape.

Strengthening collaborative approaches to supporting carers

Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support.

Improving the offer for those in severe and multiple disadvantage

Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health, housing and social care solutions to those in severe and multiple disadvantage.

Improving housing options in later life

Recommendation 12: Councils must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and promote and facilitate their take-up.

1.7 Implementation

This JSNA will be discussed at the Health and Wellbeing Boards for each borough in September 2016. Discussion will be framed to ensure that the particular resonance of the recommendations for each borough is identified and a roadmap for delivery agreed which secures buy-in on the front line.

2 Introduction

This JSNA considers the housing support and care provided to residents of the Royal Borough of Kensington and Chelsea and the City of Westminster. It explores the way in which Local Authority departments and services might collaborate more closely with each other and with NHS partners to improve customer journeys and cost benefit ratios, thereby preventing unnecessary deterioration in health and wellbeing, delaying inevitable deterioration and mitigating the impact of deterioration when it occurs.

The JSNA is being published at a time of great change, with current spending projections suggesting significant financial pressures on services for the next 20 years[2]. There is a growing desire and recognition across the UK for devolved power and in 2015 a health and care devolution agreement for London was signed[3] which would allow a place based approach, offering opportunities to do things differently, and there are suggestions that London should seek further devolved powers to help address the housing crisis[4]. Place based approaches, which seek to achieve better outcomes at a lower cost[5], are considered by some to be integral to public sector reform, bringing a greater number of partners together to work collaboratively[6] and offering an opportunity to address the broader drivers of poor health, including housing[7]. This context provides an important backdrop to the JSNA.

It is clear that there is much activity already in place in each borough which seeks to address the challenges of providing housing support and care. This report makes a series of recommendations which seek to build on this activity, to provide levers for extending existing good practice and existing partnerships and to try new approaches in close collaboration. These recommendations build on the findings of pre-existing local research and reports, and draw on national, regional and local evidence. They have been drafted in collaboration with key stakeholders. The intention is to stimulate where necessary a different kind of conversation centred around integrated efforts, to ensure that the right services are delivered in the right place at the right time, with a focus on improving outcomes for those most in need.

[2] The King's Fund 2012, Future Trends. http://www.kingsfund.org.uk/time-to-think-differently/trends
[3] Prtners to the agreement include: London Councils, PHE London regions, NHS England London Region, the GLA and London CCGs.
[4] London Assembly, 2016: At Home with Renting: Improving security for London's private renters https://www.london.gov.uk/sites/default/files/at_home_with_renting_march_2016.pdf
[5] The King's Fund, 2010: Place-based approaches and the NHS. Lessons from Total Place.
[6] http://www.local.gov.uk/c/document_library/get_file?uuid=8541bff1-fab7-413b-b2ef-d02ce743fcdb&groupId=10180
[7] http://www.nlgn.org.uk/public/2016/get-well-soon-reimagining-place-based-health/

2.1 Knowledge gaps and research questions

This JSNA has five overarching objectives:

1. To present an overview of the impact of poor housing on residents' health and wellbeing;
2. To articulate the strategic drivers, the constraints Local Authorities face in addressing the support needs of residents;
3. To explore the economic case for integrated approaches and working 'upstream';
4. To identify key issues which require integrated strategic planning by health, housing and Adult Social Care;
5. To identify potential measures which might enable the local authorities to utilize their assets more effectively and enable residents to maintain their independence for as long as possible through providing the appropriate mix of support at the right time.

2.2 Scope

Given the scale and complexity of the challenge facing Local Authorities in relation to housing, a number of pieces of work have been undertaken or are underway to identify how best different housing solutions might be utilized.

This JSNA does not seek to duplicate this work, and analysis of need for particular types of housing is therefore outside scope. A brief outline of these reviews is included as appendix one.

The primary focus of this report is the way in which Local Authority departments and services might collaborate more closely with each other and with NHS partners to improve cost benefit ratios, preventing unnecessary deterioration in health and wellbeing, delaying inevitable deterioration and mitigating the impact of deterioration when it occurs.

2.3 Stakeholder engagement

This report has sought to take a 360^{O} view of housing and care in each of the three boroughs. In order to achieve this, extensive engagement was undertaken with a broad range of stakeholders both to determine the scope of the JSNA and to identify the conclusions and recommendations. This engagement took the form of face to face interviews, group meetings and stakeholder workshops with council and NHS staff, and the third sector. Some of these were designed around the breadth of the scope, others considered specific issues in greater depth.

A brief outline of the larger engagement initiatives can be found as appendix two. A more detailed account of stakeholder engagement can be made available upon request.

3 The local landscape

3.1 Housing and health: the evidence[8]

Good quality and appropriate housing are crucial to enabling people to stay healthy and well, and less likely to need more costly health and social care interventions. Poor quality or inappropriate housing or accommodation can give rise to health and social care needs, exacerbate existing needs and can lead to early loss of independence: addressing housing thereby supports delivery of health and care outcomes[9].

There is a strong evidence base for the impact that inappropriate and poor quality housing has on health and wellbeing. In some instances this can lead to a quicker deterioration in residents' health[10], for example as a result of a fall, an inability to maintain personal hygiene or keep the home sufficiently warm. Risk factors for hospital admission and deterioration include cold and associated damp and mould as a precipitant for cardiovascular, respiratory, rheumatoid disease and mental illness for example, and exposure to hazards. The biggest and most costly housing hazards impacting on NHS costs include damp and mould, excess cold, falls, collision and entrapment hazards and fire or hot surfaces, as well as lead poisoning.

Similarly, once a care need exists, inadequate housing, inability to adapt the home for the persons need or mobility restrictions risk further deterioration as well as premature placement in a residential setting, which could have been avoided with adequate housing provisions. The services councils provide to address these issues are an important part of the package available to support residents in maintaining their independence.

3.2 The housing stock

i. Size

The boroughs cover one of the most densely populated areas in the country. A fundamental challenge for Local Authorities is the poor match between the accommodation available across the three borough and the needs of residents, be these housing based needs, or care needs.

[8] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England Post 2010

[9] Housing, health and care integration toolkit, Foundations, December 2013

[10] http://www.just-fair.co.uk/#!United-Nations-Austerity-policies-breach-the-UK%E2%80%99s-international-human-rights-obligations/qbw0c/577384fa0cf231749dc9f955

Westminster and Kensington and Chelsea both have a high proportion of one and two bedroom properties (75% and72% respectively). Hammersmith and Fulham is on a par with inner London (66%). For England, the equivalent figure is significantly lower, at 54%[11]. Of the 72,477 socially rented households in the three boroughs in April 2011, 16.9% were considered to be overcrowded, having fewer bedrooms than recommended by the bedroom standard and over 70% of those were family households containing an estimated 17,500 children (2011 Census). The average waiting time for a 2 bed property in LBHF is currently 23 months, in RBKC 50 months and in Westminster 120 months. For a 4 bed property these waiting times increase to 43 months[12] in LBHF, 79 months in RBKC[13] and in WCC 300 months[14]. Averages can be misleading, however, as households with different priority will wait different amounts of time.

Children living in poor or overcrowded housing are more likely to have respiratory problems, be at risk of infections, and experience long-term ill health and disability. They are also more likely to experience mental health problems such as anxiety and depression. It can also affect nutrition and development, educational attainment and future life opportunities[*]*.*

Working with partners, each of the Councils has delivered a number of successful projects aimed at mitigating the impact of overcrowding, including case workers offering a range of support and minor space saving adaptations. It is important for the children in overcrowded homes to have access to open spaces and good quality safe outdoor play experiences. There are many good quality parks, open spaces and playgrounds in each of the local authority areas and there has been significant investment in playgrounds and parks in recent years. It is important that this legacy is maintained and that children and families can continue to access safe open spaces and playgrounds within their communities.

The mismatch between stock and need is exacerbated by under-occupancy, i.e. family sized accommodation housing single primarily older person households. While some residents simply value having the additional space, evidence suggests that among those aged over 60, 58% would move to more suitable accommodation but that there is reluctance due to a lack of suitable alternatives or fear of an unfamiliar environment, as well as a desire to retain the asset to pass

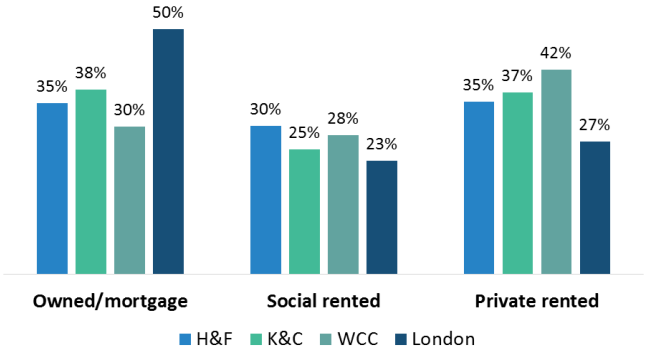
[11] file:///Q:/1512RBKC_SHMA%20(1).pdf
[12] https://www.lbhf.gov.uk/housing/applying-council-housing
[*] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England Post 2010.
[13] Internally requested figures – up to date as of June 2016.
[14] https://www.westminster.gov.uk/temporary-accommodation

on[15]. However, under-occupancy is present alongside overcrowding[16] and there is an incentive for Local Authorities to encourage under occupiers to move into more suitable accommodation in a way which frees up larger properties for use as social and/or intermediate housing (see section 6.5).

ii. Affordability

All three boroughs are among the least affordable boroughs in London to buy a property, and private sector rents are high. All three boroughs have a lower than London proportion of residents who are owner occupiers and a higher proportion in the rented sectors, particularly the private rented sector. Due to the high value of properties, rents are higher than the housing benefit maximum allowance.

Figure 2: Tenure of residents of all age by borough, 2011



Source: Census, 2011[17]

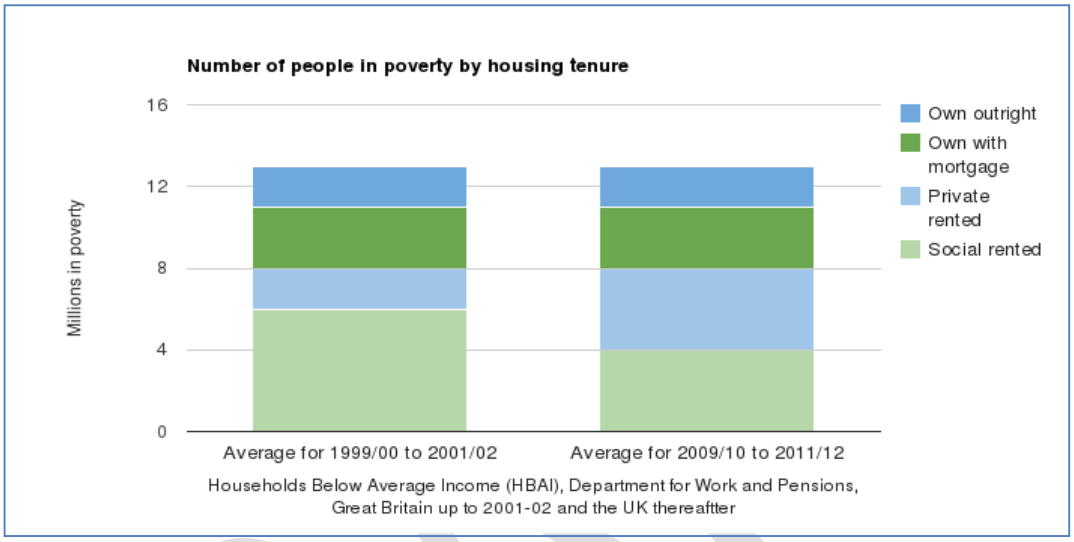
All three boroughs have a higher proportion of stock in the social rented sector than the London average of 24.1%: 31.1% in Hammersmith and Fulham, 24.6% in Kensington and Chelsea and 25.9% in Westminster[18], however demand still far outstrips supply. High land costs make it hard for local authorities and registered providers to develop new supported housing schemes and new sub-market or affordable housing. As a result, there are long waiting lists and the three boroughs are increasingly dependent on temporary housing, currently housing approximately 6,500 households in temporary accommodation, which carries a heavy financial burden. The high value of properties is largely prohibitive for councils seeking to discharge homelessness applicants into the private rented sector and to procure temporary accommodation properties in-borough. Temporary accommodation can have a negative impact on health and wellbeing for a variety of reasons[19]. Properties are sourced for temporary accommodation

[15] Wood, C. *The top of the ladder.* DEMOS, 2013
[16] The impact of overcrowding on children particularly is discussed in the Child Poverty JSNA (2014).
[17] Strategic Housing Market Assessment for Hammersmith & Fulham 2014/15, Kensington & Chelsea Dec 2015 and Westminster Housing Market Analysis: Final Report Dec 2014, by Wessex Economics.
[18] 2011 Census: Tenure, local authorities in England and Wales, Table KS402EW
[19] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England Post 2010, page 79.

from the lowest cost end of the market and the Councils enforce rigorous standards. However, the nature of temporary accommodation means that the properties are leased and the leases are not always renewed (when landlords wish to have their properties returned), which causes uncertainty.

Figure 3 below shows the number of people in the UK living in poverty, by housing tenure, highlighting that owner-occupiers account for 5 million of these.

Figure 3: Number of people in poverty by housing tenure



Source: DWP

A key consequence of increased life expectancy is that people will have to manage their retirement income and assets over a longer period than past generations[20]. Increased life expectancy, in combination with increased living costs and a tighter fiscal climate, is also leading to an increase in the number of older residents in the private sector living in family sized accommodation which they cannot afford adequately to maintain, a situation compounded by a lack of appropriate and suitably priced property to facilitate downsizing.[21][22]

The combined impact of welfare reform and the Housing and Planning Act is likely to lead to a net loss in affordable housing locally, at least in the short term, and so greater reliance on the private sector for temporary accommodation and/or more permanent private rented offers.

iii. Quality and improvements

[20] Consumer Demand for Retirement Borrowing, Louise Overton and Lorna Fox O'Mahony, November 2015.
[21] https://www.jrf.org.uk/press/home-cash-plan-help-income-poor-older-people-stay-their-own-homes
[22] Overton and Fox O'Mahony, Consumer-demand-for-retirement-borrowing, 2015

The condition and structure of housing and its amenities can significantly impact on health and well-being. Poor ventilation, energy efficiency, insulation, damp, condensation, and inefficient heating / excess heat can all have an impact on health and lead to and exacerbate long term medical conditions. The high proportion of housing stock comprised of flats, older properties and properties in conservation areas make many homes 'difficult to treat' with traditional methods such as cavity wall and loft insulation.

All three boroughs have a high proportion of flats, which represent 91% of dwellings in Westminster, 85% in Kensington and Chelsea and 74% in Hammersmith and Fulham. This high proportion of flats presents challenges in ensuring appropriate access and safety, without which older people and those with life limiting illness and/or disabilities, who as figure 1 shows below represent 19% of the population, can be left feeling isolated and/or unable to leave their home unaided, as reported by voluntary/community sector stakeholders.

Figure 1: Long term health problem or disability by age

	LBHF	RBKC	WCC	Three boroughs	London
Younger than 65 years, no limiting long term illness	83%	81%	80%	81%	81%
Aged over 65 or with limiting long term illness	17%	19%	20%	19%	**19%**
• ***Younger than 65 with limiting long term illness***	*8%*	*7%*	*9%*	8%	*8%*
• ***Older than 65 years***	*9%*	*12%*	*11%*	11%	*11%*
Total	100%	100%	100%	100%	100%

Source: Census 2011

Recent analysis of the English Household Survey carried out by Future Climate shows that flats are less energy efficient than is commonly assumed and highlights that private sector blocks of flats and converted homes are being insulated at a significantly slower rate than houses[23]. There are a number of legal, practical and social barriers to improvements of common parts which can impede ability to carry out relevant adaptations and improvements[24].

Local Action

Westminster City Council is collaborating with key stakeholders, including Oxford University, Future Climate, TLT Solicitors[1] and the Association for Energy Conservation (ACE) to increase the evidence base around flats and fuel poverty, and identify and champion appropriate legal reform to better enable improvements[1].

[23] http://futureclimate.org.uk/wp-content/uploads/2015/06/Futureproofing-Flats-Event-Report-Final.pdf

[24] Wendy Wilson, Social Policy Section Disabled adaptations in leasehold flats & common areas, Standard Note: SN/SP/3133, 27 March 2012

The proportion of all homes subject to planning restrictions / conservation orders, which can prevent action to improve the quality and/or appropriateness of the stock, is high in all three boroughs: around 50% in Hammersmith and Fulham[25], in Kensington and Chelsea 70%[26] and in Westminster 76%[27].

Vulnerable occupiers, such as older people and those with poor health and/or disability, are particularly at risk and also have the greatest exposure to a cold home environment due to the lengthy periods that they spend indoors. Older people are likely to be disproportionately represented in worst stock[28].

iv. Local responses

Efforts are being made to address these issues in each of the three boroughs. Westminster Council has an ambitious programme of housing renewal which will deliver new homes. These will be a mixture of new social housing units, affordable rented products and private properties. Planning powers will be used to require developers to deliver 30% affordable homes, 35% in the largest developments. The masterplans will also focus on improving the public realm including green space, play areas and facilities for young people. There will be significant capital investment in the Council-owned housing stock, managed by CityWest Homes, and this is being informed by considerations relating to health and wellbeing.

The Kensington and Chelsea Tenant Management Organisation has been working closely with the Council to develop an investment strategy to improve the quality of housing stock and thereby improve quality of life for its tenants. This will build on insulation works already undertaken to reduce energy consumption and address fuel poverty. Like WCC, RBKC is looking at potential regeneration opportunities, seeking to ensure that the housing stock available more closely mirrors the composition of households and developing neighbourhoods that enhance residents' sense of well-being. RBKC also commissions supported housing schemes for single parents at risk of homelessness. These aim to support families in transition to permanent housing through the provision of support and advice services that include resettlement and employment and training support. A Tenancy Sustainment Team supports families in temporary accommodation.

The housing strategies for each borough discuss each of the issues above in greater depth and set out borough priorities. They are outlined in section 3.4 below.

[25] https://www.lbhf.gov.uk/planning/urban-design-and-conservation/conservation-areas
[26] https://www.rbkc.gov.uk/Planning/conservationareas/conservationsearch.asp
[27] http://transact.westminster.gov.uk/docstores/publications_store/environment/heca_report_march_2015.pdf
[28] Westminster SHSOP review needs proper reference

Headlines

There is a significant challenge facing the local authorities, which cover one of the most densely populated areas in the country. Demand for social and affordable housing outstrips supply, leading to long waiting times for social housing. In addition, a large proportion of properties in the private rented sector are in poor condition.

The Housing departments each have strategies in place to address the challenges and there is much activity underway, however the characteristics of housing across the boroughs limit the capacity of the system to respond to demand.

3.3 Fiscal climate

Local Authorities are facing significant financial challenges at a time when demand for housing, health and social care services is growing. NHS, Housing Services and Adult Social Care are under increasing pressure, through a combination of reduced budgets, an aging population, Housing and Welfare Reform and a requirement to implement significant reforms under the Care Act. Across North West London, it is estimated that if we continue to operate as we do now then by 2021 there will be a financial gap of between £500 million and £1.1bn in our health and care system[29].

It is widely recognised that to meet this gap, investment is needed in preventing poor health and wellbeing. However, finite resources render it difficult to shift resources upstream when demand on services among those with immediate needs is great. The nationally driven tightening of eligibility criteria for Adult Social Care recognises this demand but can mean that services are only able to provide care to residents once their wellbeing has decreased, rather than helping to prevent deterioration.

To respond effectively to the fiscal climate, commissioners need to increase the use of pooled budgets as a way of enabling closer health, housing and care collaboration with services weighted towards 'upstream' prevention and earlier intervention, and care in the community.

3.4 Strategic context and policy drivers

It is a period of uncertainty for the housing sector as significant changes to housing and welfare are underway through the Housing and Planning Act (2016) and the Welfare Reform and Work Act (2016) and changes to homelessness legislation are proposed. Although the full implications of these is unknown, affordable housing supply could decrease, at least in the short term, as homelessness presentations could go up.

[29] Kensington & Chelsea Joint Health and Wellbeing Strategy 2016-2021: Consultation Draft

Housing and Planning Act 2016[30]

The Housing and Planning Act 2016 contains a range of provisions on new homes, landlords and property agents, abandoned premises, social housing, planning, compulsory purchase, and public land (duty to dispose). It is a means of supporting delivery of the challenging targets for the London Mayor and central government to deliver large numbers of new properties across the country.

The Starter Homes provision that 20% of new supply on development sites should be Starter Homes, combined with the requirement on local authorities to make an annual payment to government based on the number of higher value voids that are likely to become vacant, could result in a decline in conventional affordable housing supply (i.e. social and intermediate housing) at least in the short term.

Welfare Reform and Work Act 2016

This legislation introduced reduced spending to lower the benefits bill and deficit. Amongst other things, the Act lowers the existing household benefit cap from £26,000 to £23,000 per annum (London) and freezes Local Housing Allowance rates for 4 years (supported housing is exempt). While the estimated number of residents leaving the boroughs as a direct result of previous welfare cuts has been lower than initially anticipated, possibly due to a combination of discretionary housing benefit payments and households making savings, the additional reductions are likely to increase the number of households presenting as homeless from the private sector, necessitating increased use of temporary accommodation.

The Act also introduces a requirement on registered providers of social housing in England to reduce social housing rents by 1% a year for 4 years. While this will benefit social tenants, the cost to the provider is to be covered through sales of assets which, in areas such as Westminster, Kensington and Chelsea and Hammersmith and Fulham should be expected to lead to a reduction in the amount of socially rented stock available within borough boundaries.

Anticipated housing legislation

The Government is considering changing homelessness legislation and a private members bill relating to this has been introduced to Parliament. This could place new legal duties on councils to prevent homelessness and to provide housing for a greater number of people when they are homeless.

[30] http://www.local.gov.uk/documents/10180/5533246/051316+LGA+Briefing+-+Housing+and+Planning+Bill+-+summary+at+Royal+Assent.pdf/669c7385-376a-45ea-b83b-2764c56a1d00

The Care Act 2014

The Care Act primarily affects Adult Social Care, but is a duty on the entire local authority and specifically states that Housing and Adult Social Care must work together to prevent, delay or reduce individuals' needs for care and support. This is an important tool to address a common challenge for local service providers, that the Adult Social Care and Housing eligibility criteria are different, which can result in a number of vulnerable individuals falling into the gaps. It also states that local authorities should work with partners to identify unmet need and co-ordinate shared approaches to preventing or reducing such needs, developing joint commissioning arrangements to achieve health and wellbeing outcomes across the traditional service boundaries of housing, health, care and support.

There is a focus in the Act on enabling customers to live as independently as possible in the community including where appropriate in supported living schemes. There are, however, a number of people who may be vulnerable but are not eligible for adult care and support under the Care Act. This can result in multiple visits to different front line services, making delivery of positive outcomes challenging. Over time their needs commonly deteriorate and can result in anti-social behaviour, emergency admissions and greater reliance on public services. The most vulnerable among this group of residents are increasingly recognised as having 'severe and multiple disadvantage' and their needs are explored in section 6.4 of this report.

Better Care Fund

The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. It is a key delivery mechanism for promoting independent living in the community, enabling elderly or unwell people to stay out of hospital and recover their independence as quickly as possible. The Better Care Fund project locally includes the Community Independence Service (see appendix three), as well as other jointly funded initiatives.

The NHS Five Year Forward View (2014)

This document sets out a strategic vision and direction of travel for the NHS over the next five years including setting priorities and outcomes. It outlines the context in which the NHS and health and care services operate including variable quality of care, high levels of preventable illness and complex and deep-rooted health inequalities. Although it doesn't specifically discuss the role of housing, it sets a new direction for the NHS and makes clear that achieving 'a radical upgrade in prevention' will require new partnerships with organisations outside the NHS. It states that there is a broad consensus on what a "better future" for the NHS looks like, which includes:

- New partnerships with local communities, local authorities and employers
- A radical upgrade in prevention and public health
- Transformation to break down the barriers in how care is provided
- Opportunities to implement a range of service and delivery models – as opposed to a "one size fits all" policy.

NHS Planning Guidance – Delivering the Five Year Forward View (Sustainability and Transformation Plans) (2015)

The planning guidance asks all health and care systems (within self-defined geographies) to create comprehensive local blueprints for implementing and delivering the priorities of the Five Year Forward View, planning by place[31], rather than planning by institution. Local places are asked to develop a shared vision which will support integration and service transformation. The Kings Fund's Place Based Systems of Care recommends that existing structures such as Health and Wellbeing Boards should be vehicle for leading the delivery of integrated and "place-based" care. It recommends services provide patient-centred, integrated and preventative care which is not only clinically informed but also informed by the partners delivering services that affect the wider determinants of wellbeing, specifically referencing housing.

North West London Sustainability and Transformation Plan

This document sets out the case for change, ambitions for the future in each of the eight boroughs covered and how efforts will be focused on locally identified priorities to address health and wellbeing, care and quality and finance and productivity. Among other characteristics, the document highlights the high proportion of residents living in poverty and overcrowded households, that nearly half of the population aged over 65 lives alone, carrying the risk of social isolation, and the high proportion of Adult Social Care users wanting more social contact. The draft priorities include a local one for the three boroughs which reads 'Ensure that no residents … are living in accommodation/homes that are making them sick'.

[31] The King's Fund, 2010: Place-based approaches and the NHS. Lessons from Total Place.

3.5 Local responses

ASC Business Plans

The three business plans set out Adult Social Care's approach to care and support, delivering person-centred high quality, integrated care provided in people's homes and communities. The emphasis is on targeted prevention and support for vulnerable people to ensure they remain independent and healthy for as long as possible, delaying progression onto more intensive forms of care and ensuring appropriate care and support is available to patients as soon as they are medically fit for discharge from hospital. Key services, which provide care to support residents with tasks they cannot do themselves whilst enabling them to live as independently as possible, are the Community Independence Service, home care, telecare and meals on wheels. The Business Plans acknowledge that the suitability and safety of housing is key to enabling someone to be cared for in their home and of strategic importance to Adult Social Care and Health.

Local Prevention Offer

Prevention is critical to the vision of the Care Act: that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. In response to this, the Adult Social Care team has developed a local prevention offer which applies to all adults, from those with no established need to those who need a lot of care and support in order to prevent or delay need and deterioration of condition. The councils recognise that, although ASC plays a critical part, the responsibility for prevention is wider and approaches need to be integrated and aligned across the councils' departments and with other local partners. It identifies secondary and tertiary prevention as ASC's focus, in order to ensure that all services have a re-abling approach and encourage the customer to be as independent as possible. Being in suitable living accommodation, such as on the ground floor or in sheltered accommodation with outreach floating support, for example, can enable someone to continue safely to live independently. In relation to the development of preventative services we also take into consideration the 'Fs of Frailty'. This is seen as a good way to know when ASC can make an early intervention to prevent further needs as there is evidence that many of the conditions that can lead to frailty are amenable to preventative measures. These include: memory loss (**f**ailing memory), social isolation (loss of **f**riends and **f**amily), malnutrition (unhealthy **f**ood intake), **f**alls and living in cold damp homes (**f**uel poverty). These are each recurrent themes in this report.

Housing strategies

The councils' Housing departments have a strategy committing them to meeting the housing needs of the population, including the most vulnerable residents who are eligible for care and support from the council.

Kensington and Chelsea Housing Strategy 2013-17

The main Housing Strategy, which is due to expire in 2017, prioritises regeneration and development of new homes, including larger homes, a better range of high quality sheltered housing to older people and the development and sustainment of specialist accommodation that can support vulnerable people across a range of complex needs. The strategy emphases the need to prevent homelessness, improve the private rented sector and highlights the benefits of community development and states the need to target resources at those who can effectively be supported to become more independent[32].

Modernising Older People's Housing and Accommodation with Care Services Strategy 2013 (Joint strategy, Housing and Adult Social Care)

This strategy recognises the importance of improving the housing stock to accommodate the aging population and that many of the homes occupied by older people at the time of writing are not fit for purpose. The strategy commits Kensington and Chelsea's Adult Social Care and Housing departments to work collaboratively to meet the needs of the local population and enable older residents to remain independent for longer.

Westminster Housing Strategy

Westminster's 'Housing Strategy: Direction of Travel' statement sets out how the Council will continue to work with private sector landlords to address poor conditions, lobby for a fairer share of energy efficiency funding, invest £12m in its stock to tackle cold and damp and to work with 450 council tenants most at risk of poor health. It also commits to a review of services for vulnerable adults and of its portfolio of sheltered housing. Maximising the delivery of new affordable housing is also a key theme of the strategy as is improving outcomes for homeless households by making them an offer of good quality private housing rather than them waiting for years in temporary accommodation.

32 www.rbkc.gov.uk/pdf/Royal%20Borough%20of%20Kensington%20and%20Chelsea%20Housing%20Strategy%20Summary%20Leaflet.pdf

Joint Health and Wellbeing Strategies (JHWS)

The JHWS for the three boroughs are each being refreshed for publication in Autumn 2016. All three make reference to the fact that 60% of health and wellbeing is attributable to the social determinants of health, housing being a major contributor. The visions place emphasis on person-centred and integrated prevention and early intervention and on supporting communities to stay healthy and independent in the community with choice and control over their lives.

The visions also commit to radically upgrading prevention and early intervention, mainstreaming prevention into everything that we do across the life course, and working across organisational and sector boundaries to achieve this. Housing is mentioned specifically as a key partner in each strategy.

Headlines

New legislation such as The Care Act 2014 and direction such as the NHS 5 Year Forward View has shifted the focus of health, housing and social care closer to prevention as demand needs to be managed effectively.

Housing and Welfare reform is anticipated to lead to an increase in demand on already oversubscribed social housing with alternative suitable housing options limited.

The strong drivers to support residents to remain in their own home coupled with a challenging fiscal climate, render it imperative for Local Authorities to invest to best effect. This requires collaboration and integration.

Regional and local policy initiatives seek to meet this challenge, through increased focus on prevention and early intervention, best use of existing resources and levers.

4 Population need: supply and demand

4.1 Older People

Older people are the greatest users of health and social care services and are also the most complex to treat, often needing support with multiple conditions. The proportion of people aged 65+ living in the three boroughs is comparable with London (11.1%), although Kensington and Chelsea has a slightly higher proportion (12%) and Hammersmith and Fulham lower (9%).

Improved life expectancy and the ageing of the baby boom generation are expected to result in an increase in the number of older people in London aged 65+ by 16% and aged 85+ by 35% over the next decade. Local figures are harder to predict and can be over-estimated, however the modelling indicates an increase of 12% in Hammersmith and Fulham, 14% in Westminster, and 23% in Kensington and Chelsea among those aged 65+[33]. These percentages are translated into numbers below.

Figure 4: Expected increase in the older population over the coming 20 year period

H&F	2014	2024	2034
65-74	9,824	10,322	13,231
75-84	5,523	6,837	7,439
85+	2,230	3,117	4,512
Total 65+	**17,577**	**20,277**	**25,182**

K&C	2014	2024	2034
65-74	12,333	12,935	16,043
75-84	6,375	9,341	9,874
85+	2,749	4,145	6,645
Total 65+	**21,458**	**26,421**	**32,562**

West	2014	2024	2034
65-74	13,922	15,294	19,253
75-84	8,617	10,155	11,258
85+	3,370	4,767	6,541
Total 65+	**25,909**	**30,216**	**37,052**

Source: Census 2011

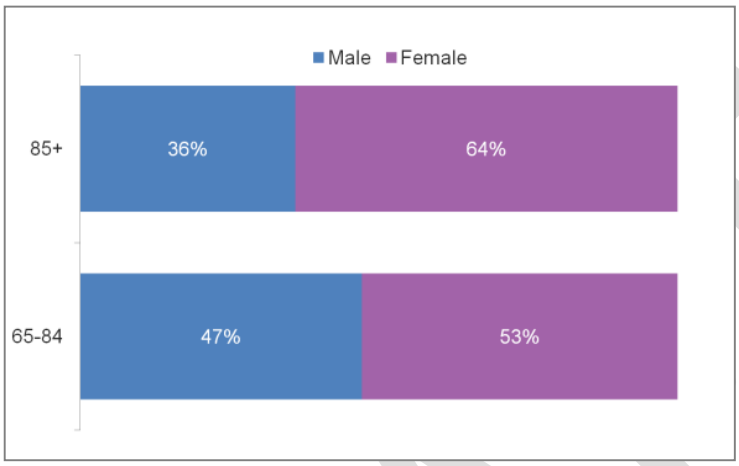
As discussed in section 3.2ii, a key consequence of increased life expectancy is that people will have to manage their retirement income and assets over a longer period than past generations.

[33] Tri-Borough Public Health Report, 2013-14

i. Gender

There are more women than men in the population of residents aged over 65 years, as is common in London and across England, and this becomes more pronounced with age. This is important for delivery of care, be this in the community or in some form of residential care.

Figure 5: Breakdown of residents aged over 65 years, by sex

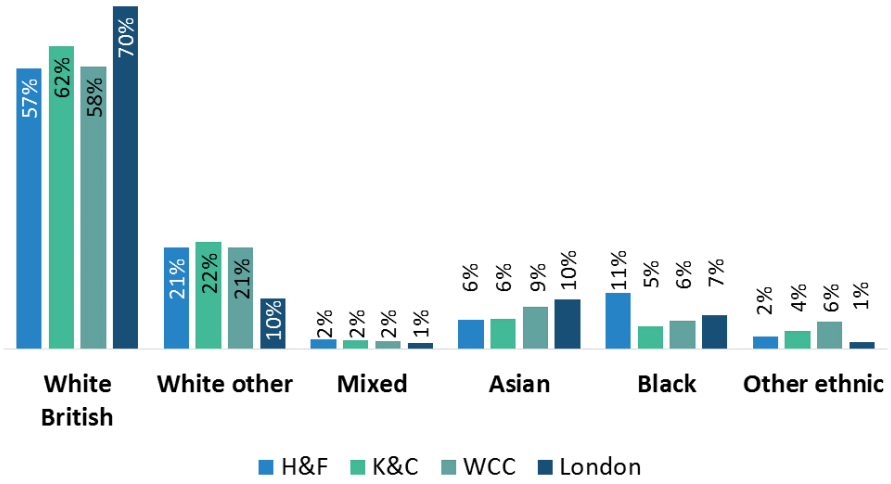


Source: Census 2011

Data from ASC shows that men are under represented among their client base. 64% of older (65+ years) clients receiving homecare are women: there are twice as many older women than older men receiving homecare. There are similar trends in nursing/ residential care for older people and for direct payments. There are a number of potential reasons for this, including that women generally live longer than men and might provide unpaid care for their partners, delaying the need for Local Authority provision, and that men may be less likely to access services. Gender is an important consideration for service planning.

ii. Ethnicity

Figure 6: Percentage of residents aged 65 years and over in the three boroughs by ethnic group, 2011



Source: Census 2011

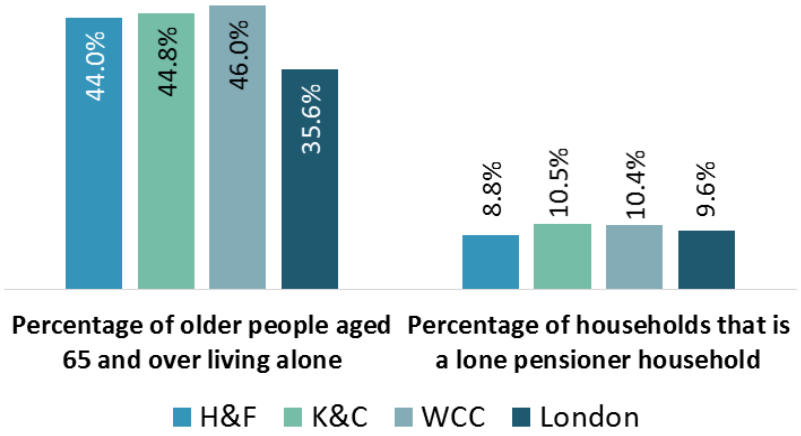
The proportion of clients of BAME origin can be expected to increase as the population ages. This will have implications for service delivery given that, in both LBHF and RBKC, 3% of the population currently state they are not able to speak English well[34].

iii. Older people living alone

In Kensington and Chelsea, 46.5% of older people live in single-person households, compared with 45.3% in Westminster and 37.4% in Hammersmith and Fulham[35]. One in 10 households (10.5%) in Kensington and Chelsea is a lone pensioner household, compared to 10.4% in Westminster and 8.8% in Hammersmith. These figures are close to the London average (9.6%) but lower than that for England (12.4%)[36].

[34] JSNA Highlights Reports 2013/14
[35] Source: ONS, 2011 Census Table DC4404EW
[36] ONS, 2011 Census, Table KS105EW

Figure 7: Percentage of residents aged 65 years and over living alone in each of the three boroughs and London, 2011

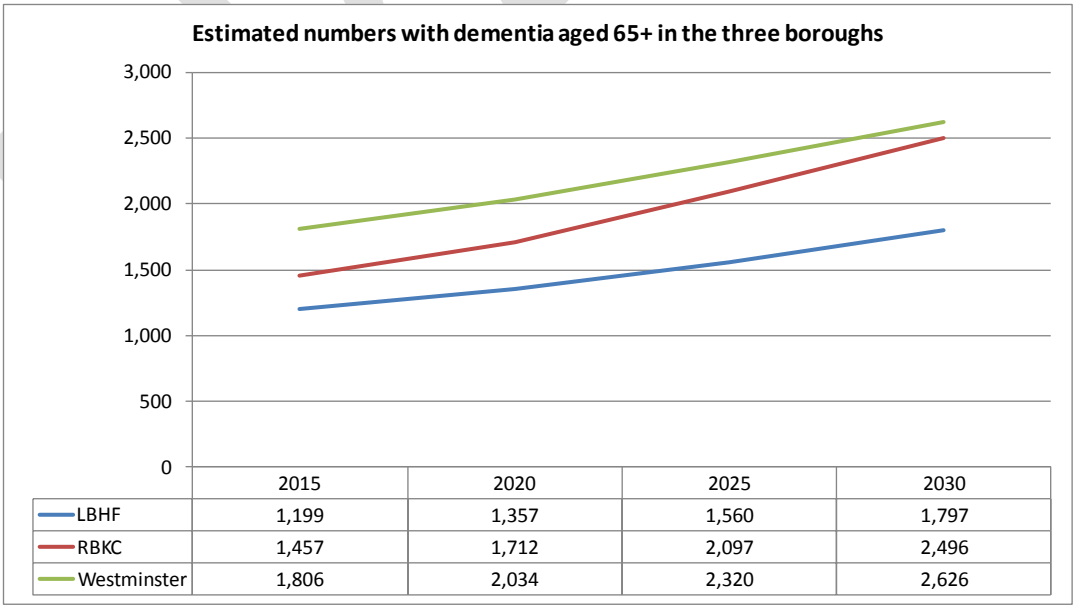


Source: Census 2011

iv. Dementia

The Dementia JSNA showed that the numbers of people living with dementia in the three boroughs is projected to increase by about 55% in the next 15 years, due to the greater number of older people age 80+. Around two thirds of those in care homes locally have a diagnosis of dementia.

Figure 8: Estimated numbers with dementia aged 65 years and older by borough



	2015	2020	2025	2030
LBHF	1,199	1,357	1,560	1,797
RBKC	1,457	1,712	2,097	2,496
Westminster	1,806	2,034	2,320	2,626

Source: GLA Population Projections http://data.london.gov.uk/dataset/gla-population-projections-custom-age-tables (accessed 1 July 2015, as referenced in the Dementia JSNA)

One of the themes of the Dementia JSNA is that whilst it is important to maintain independence, there needs to be an appropriate escalation of care when needed.

Also, that there may be a need for increased training for paid and unpaid carers, residential care staff, and other appropriate professionals. Sections 6.1.6 Making Every Contact Count (MECC) and section 6.2 Personalised Housing Support and Care explore the themes around maximising opportunity and the importance of providing the right support at the right time.

The Dementia JSNA finds that Housing, Environment and Planning strategies do not specifically mention dementia or carers of people with dementia and recommends that the increasing numbers and needs of people with dementia and their carers are taken into account in wider local authority and health strategies, especially housing.

v. People aged over 65 on a low income

As shown in figure 9 overleaf, currently 28% of older people living in Hammersmith and Fulham, 22% in Kensington and Chelsea and 25% in Westminster are living in deprivation. If the percentage of older people living in poverty remains the same, this population is expected to grow over the next twenty years from 6,700 to 9,600 (42% increase) in Hammersmith and Fulham, from 6,400 to 8,900 in Kensington and Chelsea (40% increase) and from 9,400 to 13,600 (44% increase) in Westminster by 2030, due to population aging. The numbers for deprivation are important as they indicate need and the future burden on local authority housing and care.

Figure 9: Older people living in poverty across the three boroughs

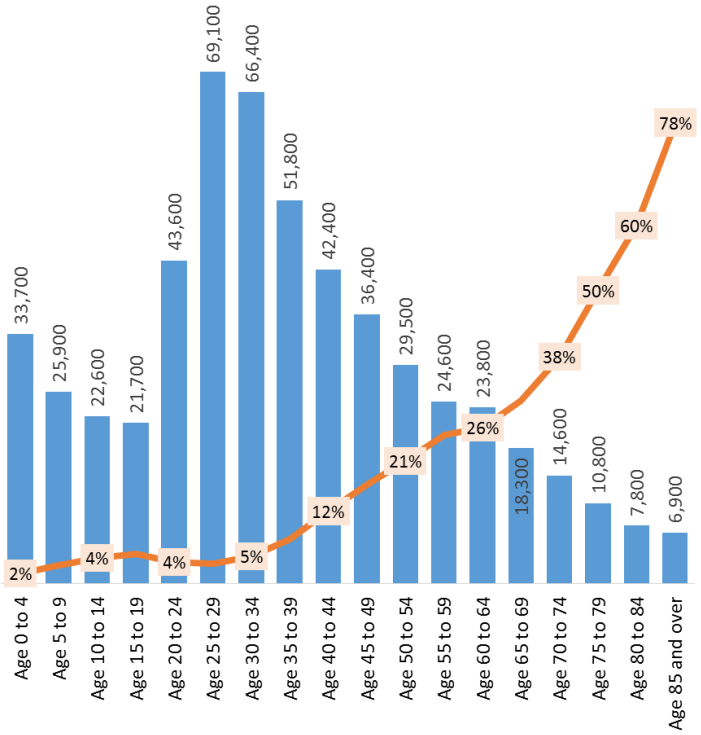
	Percentage of older people in poverty	Number of older people		Number of older people in poverty			Proportion of lower super output areas in most deprived 10% nationally	Rank
	2015	2015	2030	2015	2030	% change	2015	2015
LBHF	28%	24,507	34,804	6,700	9,600	42%	19%	38
RBKC	22%	29,627	41,415	6,400	8,900	40%	23%	26
WCC	25%	37,873	54,624	9,400	13,600	44%	23%	28
London Average	24%	1,329,292	1,867,204	313,700	440,600	40%		

Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); GLA 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model

4.2 Physical disabilities

Across the three boroughs, around 42,000 people aged 15-64 and 27,000 people aged 65+ reported having a long-term illness or disability, the larger proportion being women (Census 2011). As life expectancy increases, so do the rates of chronic disease and with them the cost of health and social care - effective management of chronic diseases (such as cardio-vascular disease (CVD), diabetes and respiratory disease) can help residents stay independent for longer.

Figure 10: Number and percentage of residents reporting a long term illness or disability in Hammersmith & Fulham, Kensington and Chelsea, Westminster and London, by age, 2011



Source: Census 2011

Although the likelihood of having a disability increases with age, the large number of working age residents in the local area means the 45-64 year old age group has the largest number of people reporting a long-term illness or disability. This has implications for future demand, although it is not a straightforward picture due to population churn. There is a high correlation between disability and deprivation and historically it is the more deprived sections of the population who show less mobility, suggesting that the large proportion may be eligible for social housing earlier than might otherwise be the case. However, welfare reform might change this picture as more deprived population groups are forced to move out of the area.

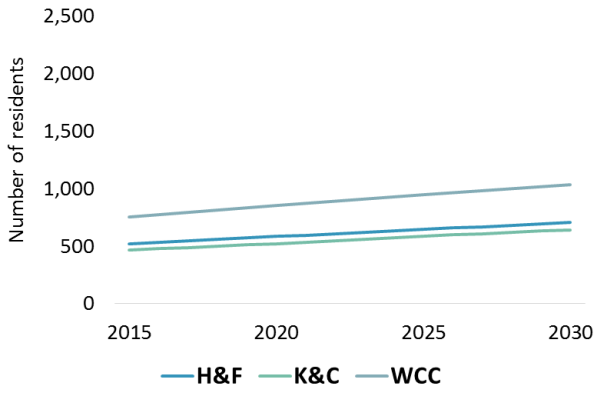
Many people with long term conditions develop disabilities or mental health problems, which may require social care support, including the provision of care for their families and children.

National data[37] suggests that around 2,000 people (Hammersmith & Fulham and Kensington and Chelsea) and 3,000 people (Westminster) aged 18-64 may suffer from a severe disability, with highest numbers in the older age groups[38].

4.3 People with learning disabilities

The Learning Disabilities JSNA shows that there were 1014 people aged 18-64 with a learning disability known to our local authorities in 2013-14. Estimates suggest a prevalence rate of autism in adults with learning disabilities of between 20-30%, which is the equivalent of 69-104 adults in LBHF, 44-65 adults in RBKC and 90-135 adults in WCC. Of the 884 adult carers who responded to the 2014/15 carers' survey, 4% reported having a learning disability in LBHF and RBKC and 6% in WCC.

Figure 11 Estimated number of residents with learning disability in Hammersmith & Fulham, Kensington and Chelsea and Westminster, 2015-2030



Source: Local analysis by the Public Health Intelligence Team using population segmentation from the London Health Commission, and population projections from the GLA (SHLAA 2014)

Of critical importance is the number of older people with learning disabilities requiring social care services. Better survival rates amongst the population are likely to have an impact on resources where carers become elderly and unable to provide continued support, and people with learning disabilities develop more complex needs such as dementia. In 2013/14, 14% of people with learning disabilities receiving a service from Adult Social Care were aged 65 or over.

4.4 Severe and enduring mental illness (SMI)

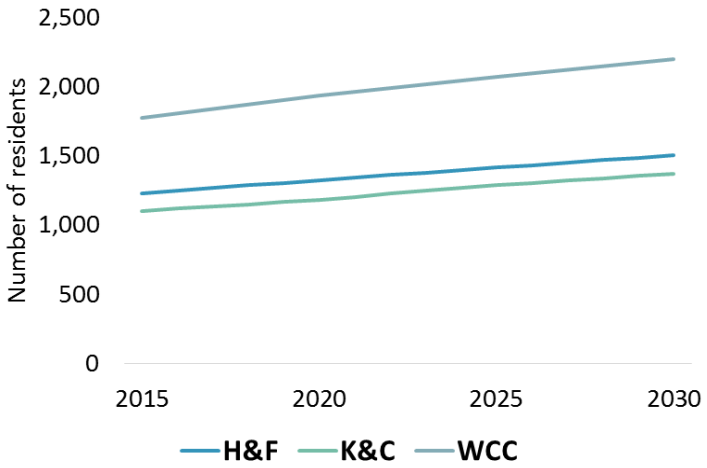
The population with mental illness who may be eligible for supported accommodation have severe and enduring mental health problems such as bipolar disorder and schizophrenia.

[37] Source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI), national data from the Health Survey for England, 2001, applied to population estimates from the Office for National Statistics, 2014

[38] Numbers may differ to national trends, given the unusual socio-economic and demographic profile locally.

Rates of severe mental illness as recorded by GP practices are extremely high, with all three boroughs being in the top fifteen in the country, due in part perhaps to good GP identification and recording. West London CCG has the highest SMI prevalence in the country, Central London the fourth highest, and Hammersmith and Fulham the twelfth highest, out of 212 CCGs. The CCGs have similar numbers of people with SMI registered in each borough: 2,500 in LBHF, 3,200 in RBKC and 3,306 in WCC. Demand for mental health services looks set to rise in line with the population increase.

Figure 12 Estimated number of residents with severe and enduring mental illness in Hammersmith & Fulham, Kensington and Chelsea and Westminster, 2015-2030



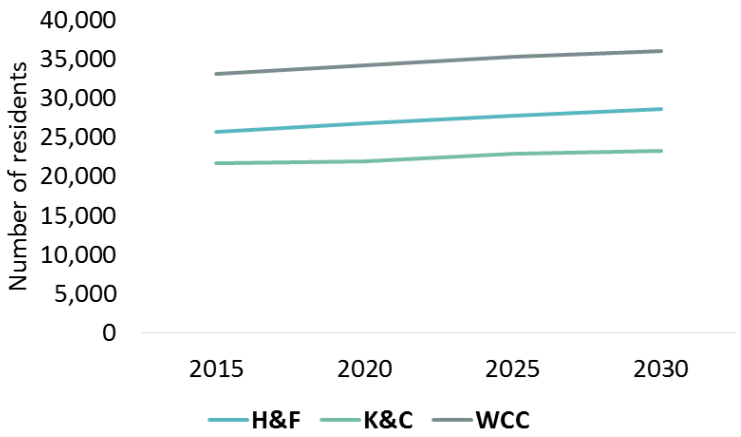
Source: Local analysis by the Public Health Intelligence Team using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014)

Housing related support for people with severe mental illness ranges from floating support to low, medium and high supported housing. Residential and hospital placements are utilised to meet people's needs, support recovery goals and enable move-on where appropriate. Intensive services include NHS acute (inpatient) and Psychiatric Intensive Care Units, independent hospital provision and specialist placements for complex care. Residential and nursing placements are usually out of the local area.

4.5 Common Mental Illness (CMI)

Common mental illness covers the range of mental illnesses which can be treated through primary care services, such as anxiety and depression. Rates of common mental illness are likely to be similar to London, but numbers are substantial in absolute terms. Nationally, around 40% of years of life lost from a disability are from mental ill-health and a similar figure can be expected locally.

Figure 13: Estimated number of adults aged 16 years and over with a common mental illness in Hammersmith & Fulham, Kensington and Chelsea and Westminster, 2015-2030



Source: National estimates from 'Adult psychiatric morbidity in England, 2007: Results of a household survey' (Health and Social Care Information Centre, 2009) applied to population projections from the Greater London Authority (GLA SHLAA 2014)

Headlines

All three Local Authorities can expect an increase in the proportion of their populations who have housing and care needs. Simultaneously the fiscal climate has led to a tightening of the Adult Social Care eligibility criteria and reduction in budget for non-statutory prevention services.

A significant percentage of the working age population have a disability and/or mental health illness and enablement and capacity building is essential to reduce demand on services. The management and treatment of chronic disease is paramount, and maintaining quality of life and providing joined up, high quality services are crucial.

Service planning needs to take account of increasing deprivation among the older population, increasing ethnic diversity and of gender.

The proportion of older people living alone has implications for service planning, given the link between this, social isolation and premature deterioration of health and wellbeing.

4.6 Local assets

There are assets available to Local Authorities seeking to improve the match between their stock and their population. These include a range of services which address the challenges vulnerable residents face, the majority of which are commissioned by Local Authority departments and NHS partners. They are provided by statutory sector agencies, voluntary/community sector organisation and other third sector or private bodies and include the Residential Environmental Health Service, Adult Social Care's Home care service, RSL, council and ALMO estate teams, the Community Independence Service, Floating Support services and carers' services. Additional preventative services and more information about each one can be found as appendix three.

5 The economic case for prevention, early intervention and personalised support

Introduction

The preceding sections have established that, given the ageing population and people living for longer in ill-health, there will be an increasing need for the provision of health and social care among our population. This chapter seeks to offer analysis of the economic evidence for how best to address this need within available resources.

5.1 The cost of care

£15.5 billion nationally is spent by local authorities on Adult Social Care each year. For most older people with low to medium level need, enabling them to remain in their own homes has been shown to yield the best outcomes in terms of keeping people out of hospital and preventing escalation of care[39]. The gross weekly costs of nursing or residential care for clients in the three boroughs range from £458-950.

Councils provide re-ablement, provision of equipment and home adaptations as a means of preventing and/or delaying the need for increasingly intensive and costly care (such as home care, followed by institutional care in residential and nursing homes). Facilitating care at home also relies on the care giver to be able to detect changes in care need and to respond adequately and in a timely manner. For people with very high need, the costs of staying at home may be higher than costs of a home placement[40].

The Nuffield trust has been working on ways to combine health and social care data to predict the need for social care in order to focus re-ablement efforts. They showed that only 20% of people aged 85 or older moved into the intense social care category, emphasising the need for a targeted approach. However, the social care data available in the model was not accurate enough to support this, highlighting the need for high quality and joined up data. With such data in place modelling tools could further maximise value for money[41].

[39] Your home or a home? Community Care *magazine 26 November 2009. Accessed July 2016.* http://www.communitycare.co.uk/2009/11/20/care-homes-v-care-at-home-council-spending-patterns-reveal-the-cost-equation-is-not-clear-cut/

[40] *Health and Social Care Cost information centre, Personal Social services Expenditure and Unit costs, England 2012-13.* Page 24

[41] http://www.nuffieldtrust.org.uk/sites/files/nuffield/Predicting-social-care-costs-Feb11-REPORT.pdf

Given the emphasis on keeping residents out of residential and nursing homes, Extra Care seems to be a cost effective alternative, being deemed to cost half of the alternative provision that would have otherwise applied[42]. However, more evidence needs to accrue to confirm the cost benefit of Extra Care and much depends on service models.

The health, social and economic value of informal care is huge. In 2000, 65% of the value of long-term care and support was provided by unpaid care, 25% from the state and 10% funded privately. If carers' support had to be replaced with provision from statutory services, it would cost the NHS, social services and other statutory bodies around £34 billion a year nationally, or around £140 million a year in Hammersmith and Fulham, £135 million a year in Kensington and Chelsea and £150 million a year in Westminster[43]. It is therefore of great importance to support carers, roughly 20% of whom provide in excess of 50 hours care a week and around 50% of whom have a co-morbidity themselves.

The majority of people who take up formal care services do so following discharge from hospital. In the three boroughs, the three most common types of hospital admissions for those discharged to a care home (which account for one third of all admissions) are fractures (mostly due to falls), urinary tract infections and stroke, which have a major effect on mobility and functioning. Some could be avoided or delayed through a more preventative approach.

5.2 Integrated provision

Adaptations to the home and use of technology go a long way in reducing the need for escalation of social care in those with low and medium levels of need. However, adaptations are not enough and need to go hand in hand with other services such as occupational therapy, carers and medical professionals, and rely on joined up systems across agencies. Telecare is deemed to save £2,000 on average per installation but it also relies on supporting services functioning collaboratively.

5.3 The importance of data

The lack of data and data linkage is a major disadvantage to front line professionals seeking to provide smooth customer journeys and integrated care. It is also a major barrier to quantifying return on investment locally. For example, a project with CCG investment to remedy poor quality housing can only demonstrate return on

[42] Improving housing with care choices for older people. An evaluation of Extra care housing. http://www.pssru.ac.uk/pdf/dp2774.pdf
[43] http://jsna.info/document/carers-evidence-pack

investment using nationally recognised modelling tools (which suggest a probable saving of £1 million locally): it is unable to provide savings figures specifically for the CCG. Logic chains, collection of relevant data and careful informed evaluation will help close this evidence gap. Without them, existing data does not allow for this kind of detailed cost benefit analysis at present.

5.4 Homes and neighbourhoods: their role in prevention

The Care Act places a duty on local authorities to prevent, delay or reduce the need for care and support through provision or arrangement of services, facilities and resources. This duty extends to all residents, regardless of their present care needs. Prevention starts as early as childhood there are two major aspects which relate directly to housing:

i. Preventing the creation of care needs (through hazards and damp and cold homes, for example) and the deterioration of health and wellbeing through an enabling housing environment (ground level bathroom facilities, wheel chair accessibility) for example.

ii. The built environment surrounding the property and public realm.

5.3.1 Creating the right buildings to prevent care need

Poor quality housing has been calculated as costing the NHS at least £600 million a year nationally (roughly over £1 million locally) with a cost to wider society of more than £1.5 billion.

New homes

The least costly way to proactively delay or avoid need is through building new homes to the Lifetime Home standard, enabling people to stay in their own homes for longer, reducing the need for adaptations and giving greater choice to disabled people who are currently unable to live independently due to lack of suitable housing (e.g. wheel chair access to and within the house).

Cost benefit analyses on retro-fitting downstairs bathrooms compared with incorporating a lifetime home standard at build stage shows that the cost of retro-fitting would be in the region of £2000 while incorporating it up front would lower it to around £300[44]. Therefore it is important to not miss further opportunities to create lifetime homes despite the low number of new dwellings overall.

The case for all new housing to incorporate measures to enable life-long occupancy should include standards to withstand and mitigate the effects of climate change. As

[44] www.nihousingcouncil.org/CMSPages/GetFile.aspx?guid=95e1f58e-1f51-4cfc-823b-921ce882db8f

explored in 6.1.2, cold homes are linked to an increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. House building designs are evolving in recognition of climate change. A 'passive house' design enables passive heating of the house (for example by sunlight, residual heat from technical equipment and from those who enter the house) and prevents unnecessary heat loss. The design provides a 75% reduction in space heating requirements compared to traditional buildings, a warm and constant climate and reduces CO2 emissions[45]. An additional capital investment of 15% for passive houses would decrease in larger developments through economy of scale and is offset by savings in the long term. Suggestions for incentivising the construction of passive homes may be nothing more complicated than offering a government-backed low interest loan in line with the UKs Green deal philosophy whereby retrofit measures are financed 100% upfront[46].

Existing buildings

The Building Research Establishment calculated that the first year of treatment costs to the NHS of people living in the poorest 15% of the housing stock in England is around £1.4 billion. The cost of hospital, community and social care in the 12 months after admission due to a fall is deemed to be four times higher than the admission itself[47], including a 37% increase in social care costs. Falls patients, despite accounting for just over 1% of the over-65 population used 4% of the entire annual inpatient acute hospital spending in the year post fall and 4% of the entire local Adult Social Care budget in Devon[48].

Of the 75% of people aged over 55 in the UK who are owner-occupiers, many struggle to keep up with the costs of home improvements or maintenance. More than 20% of households with a person over 65 years of age failed to meet the Decent Homes standard in 2012, of which nearly 80% were owner occupiers. They failed most commonly on falls risk and excess cold[49].

The evidence presented in the DECC fuel poverty strategy suggests that tackling cold homes offers by far the best value for money[50]. Recent research suggests that the total

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45 http://www.seai.ie/Renewables/Renewable_Energy_for_the_Homeowner/SEI_Passive_House_A4.pdf Accessed 29/7/16

46 (http://www.bere.co.uk/sites/default/files/research/16PHT_Nick%20Newman%20submission.pdf)

47 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/exploring-system-wide-costs-of-falls-in-torbay-kingsfund-aug13.pdf

48 Ibid

49 Off the radar. Housing disrepair and health impact in later life. Report by Care & Repair England 2016

50 Cutting the cost of keeping warm. DECC strategy 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408644/cutting_the_cost_of_keeping_warm.pdf

benefits are 1.5 to 2 times the magnitude of retrofitting insulation when health gains, energy and emission savings are considered[51].

In addition to countering fuel poverty, cold and damp adaptations can be carried out to make a house suitable. National estimates scaled down to borough level, assuming that boroughs are similar to national figures, shows that proactively tackling the top 10 housing hazards definitely pays back in terms of local NHS costs and is likely to be much more favourable financially if social care costs are included. Payback is achieved in the shortest period of time for fixing stairs and levelling to prevent falls, removing collision and entrapment hazards and reducing excess cold.

Introducing adaptations to the house that facilitate coping at home not only enable the cared for person to stay at home, it has also been shown to reduce the actual amount of care needed, enabling the person to undertake tasks independently (curb-free shower compared with bath for example). Adaptations also present an opportunity to protect informal carers. On average, adaptations provided through the DFG grant are thought to delay relocation to a care home by 4 years[52].

The savings to local authorities through the Disabled Facilities Grant (DFG) are significant. Compared to a residential placement, which costs around £30,000 per annum, a DFG costs on average £7,000, as a one off intervention. To maximise the DFG, now within the Better Care Fund, it needs to be aligned with other services to offer a holistic and joined up approach. This can be achieved by bringing 'independence services' under one roof within a single team of occupational therapists, case managers, technical officers and other stakeholders. Local authorities have considerable flexibility in spending the DFG. For example, choosing not to means-test people has helped to avoid delays with adaptations in Ealing. Pre-emptive home modifications at relatively low cost have been shown to reduce falls that require medical treatment by 26%, bringing potential savings of £500m each year to NHS and ASC[53]. There may be financial benefits to providing a standard package of aids and adaptations to prevent crisis and hospital admission upon request, rather than first requiring assessment[54].

Many issues make the current national system for adaptations sub-optimal. The assistance people receive depends on the tenure of their home rather than need, and on the financial contributions people are expected to make. Implementation of the

[51] Chapman, Howden-Chapman, Viggers et al 2209 J Epidemiological Community Health, Apr 63(4): 271-7
[52] http://www.foundations.uk.com/media/4210/foundations-dfg-foi-report-nov-2015.pdf
[53] http://www.communitycare.co.uk/2016/02/23/adaptations-already-cut-social-care-costs-heres-increase-impact
[54] http://www.scie-socialcareonline.org.uk/the-cost-benefit-to-the-nhs-arising-from-preventative-housing-interventions/r/a11G000000DeS8yIAF; http://laterlife.ageing-better.org.uk

national system also varies by authority, compromising equity. The majority of adaptations focus on existing problems, reacting rather than anticipating need. Yet the provision of adaptations at the point of crisis is less efficient than provision which plans ahead and might have averted the crisis. In times of budget constraints, the danger is that preventative approaches give way to the demands of reactive provision, which in turn means higher costs are incurred when people become eligible for help. A more strategic joint approach between housing, health and social care, which focuses on prevention and early intervention and is desirable, facilitated by joint commissioning[55].

One of the ways to join up agencies is to link DFG data and social care data via NHS numbers, something that is not currently happening in the three boroughs. Only Hammersmith and Fulham currently makes DFG data available to ASC, and this is not linked. The Whole Systems Integrated Care programme currently seeks to link ASC with health data, as stipulated by the Better Care Fund. Extension of this programme to incorporate wider determinants data, such as housing data, would greatly enhance capacity for care to be delivered cost effectively.

5.3.2 Creating the right built environment to prevent care need

There are many factors that influence the health of a person, but the single most cost effective focus for achieving preserved functionality, good health and mobility is physical activity. Physical activity preserves muscle and bone strength and balance into old age and thus prevents falls and frailty. Falls are multi-factorial and preventable; yet around 30% of people over 65 fall each year, 10% of those resulting in a fracture[56]. Combined hospital and social care costs, for patients with a hip fracture, amount to more than £6 million a day nationally: over two years, each hip fracture costs local authorities an estimated £3,879 for social care[57]. In 2014 there were 119 admissions in LBHF, 98 in RBKC and 121 in WCC resulting in a total of over 1.3 million pounds spent in the three boroughs on hip fractures alone.

Physical activity has also been shown to be effective in preventing and treating dementia, one of the major predictors of care need[58] and being active five times a week significantly reduces stroke risk.

[55] http://www.foundations.uk.com/media/4210/foundations-dfg-foi-report-nov-2015.pdf
[56] Foundation, B.H., *Economic costs of Inactivity. Evidence briefing.* British Heart Foundation National Centre (BHFNC) for Physical Activity and Health, Loughborough University, 2013.
[57] Local HES data 2014
[58] J. Eric Ahlskog, Y.E.G., Neill R. Graff-Radford, Ronald C. Petersen, *Physical Exercise as a Preventive or Disease-Modifying Treatment of Dementia and Brain Aging.* Mayo Clin Proc, 2011. **86**(9): p.8.

There is a strong business case for greater physical activity: a brief intervention for physical activity yields cost savings per quality adjusted life year of between £750 and £3,150.11[59]. In the three boroughs savings of over £5 million could be achieved if 100% of the resident population achieved just the minimum recommended levels of physical activity: 30 minutes of moderate activity, spread over the day. Further, this is likely to be an underestimate as it does not take into account costs associated with mental illness or dementia.

The Kings Fund recommends focussing on two themes with the highest yield in order to increase activity:

i. The reduction of car travel through improving cycling and walking provision and the urban realm, and
ii. Improving access to green spaces.

Getting just one more person to walk a day could recoup £768 a year in terms of health benefits, productivity gains and reductions in air pollution and congestion[60]. Having access to safe green spaces, walkable facilities such as shops and communal areas, proximity to public transport, street furniture such as benches and safety of the area all contribute to preventing deconditioning and social isolation[61]. In addition to facilitating individuals' independence and connections with the community, there are also benefits for broader community resilience[62].

The importance of dementia-friendly neighbourhoods cannot be overstated. The Dementia JSNA highlighted that the mainstay of management is to provide supportive care and an environment which allows people with dementia to function at their maximum capacity.

Many older people find that once they are outside the labour market, their environment presents an obstacle to a fulfilling old age in terms of social integration and support and accessing resources. Suggested remedies include a focus on public transport with shelters and seats at bus stops and toilets at transport hubs; streets,

59 http://webarchive.nationalarchives.gov.uk/20150116154742/http:/www.foodwm.org.uk/resources/Microsoft_Word_-_Cost_Effectiveness_Evidence_for_Physical_Activity_Programmes_-_Document_4.pdf

60 Improving Publics Health. Active safe and Travel. Kings Fund. Accessed July 2016. http://www.kingsfund.org.uk/projects/improving-publics-health/active-and-safe-travel

61 Healthy aging and the built environment. Centres of Disease Control. Accessed July 2016. https://www.cdc.gov/healthyplaces/healthtopics/healthyaging.htm

62 Lawlor, E. The pedestrian pound. The business case for better streets and places. https://www.livingstreets.org.uk/media/1391/pedestrianpound_fullreport_web.pdf

footpaths and cycle routes that are clean, well lit and safe; adequate road-crossing points and affordable housing that meets the needs and aspirations of older people[63].

The cost effectiveness for Local Authorities of investment in the built environment is well-evidenced, associated with health and wellbeing at the community level, as well as improving satisfaction with 'place', increased social cohesion and interaction, increasing volunteering, creative 'play' among children and increased educational performance. Up to £23 is recouped for every £1 spent on increased walking and cycling facilities, parks and public gardens[64]. Improving open spaces can yield cost benefit ratios in the region of 2.7, meaning that any investment in open spaces such as local parks would be almost tripled in return. Similarly, improvement of the public realm is associated with a ratio of 1.4, and this does not include the wider benefits of increased physical activity and community resilience, as these are hard to quantify and likely to be locality-specific[65].

In a climate of shrinking resource and increasing reliance on community assets, the utilisation of planning requirements and the Community Infrastructure Levy for investment in the public realm are important tools for promoting health and wellbeing.

Key messages

Lack of data and data linkage is a major disadvantage to quantifying return on investment locally.

Integrated provision across front line services is critical to securing return on investment in those services and in provision such as telecare.

Evidence suggests that large scale savings can be achieved with a number of measures relating to housing, such as forward thinking planning to create life time, affordable, future proofed new housing stock and improvement of old housing stock.

Interventions to prevent deterioration of health and wellbeing extend as much to the built environment as to the buildings themselves.

[63] Kendig H, Phillipson C. Communities: New Approaches to Challenging Health and Social inequalities. Accessed July 2016. http://www.britac.ac.uk/sites/default/files/Hal%20Kendig%20and%20Chris%20Phillipson%20-%20Building%20Age-Friendly%20Communities%20-%20New%20Approaches%20to%20Challenging.pdf

[64] Marsh K, Bertranou E, Samanta K (2011). *Cost-benefit Analysis and Social Impact Bond Feasibility Analysis for the Birmingham Be Active Scheme*. London: Matrix Evidence. Available at: www.socialfinance.org.uk/sites/default/files/matrix_be_active_final_report_0.pdf Accessed 29/7/16

[65] Valuing the Benefits of Regeneration. Economics paper 7. Volume 1. Final Report. Accessed July 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6382/1795633.pdf

6 Priorities for strategic, cost effective provision

The material explored in the former chapters suggests five key lines of enquiry in which integration between housing, Adult Social Care and health planning and delivery needs to be improved to enable cost effective interventions.

6.1 Strengthening prevention and early intervention

Introduction

Between Housing, Adult Social Care and Health, there are a number of opportunities to prevent and delay deterioration in health and wellbeing, and to reduce the support and care needs of residents. This section explores how ASC, Housing and NHS partners might facilitate best use of resources, working in partnership to improve the home environment, facilitate self-reliance and support the range of front line services to intervene earlier, thereby preventing and/or delaying deterioration.

Nationally:

- Over 20% all older householders live in a home that fails to meet the Decent Homes standard.
- 780,000 householders aged 55+ live in fuel poverty.
- 1.3m householders aged 55+ live in a home with at least one Category 1 hazard.
- The cost of poor housing to the NHS (first treatment costs) is £624m - costs dominated by excess cold hazards and those associated with falls
- One fifth of homes occupied by those aged 65+ years has none of the four accessibility features (level access, flush threshold, WC at entrance level, sufficiently wide doors and circulation space).

BRE/PHE 2013, p.5

6.1.1 Accessibility

Chapter 3 outlines the scale of the challenge facing the three councils related to both the ageing population and the increasing proportion of the working age population who have life limiting illnesses and/or disabilities.

It is estimated that by 2030, the number of residents in the three boroughs using a mobility aid will increase by 50%, from 18,000 to 27,000 residents (Health Survey for England 2013, Social care[66]). Section 3.2 presents the significant deficit in the three boroughs of properties which meet accessibility criteria and can cater for this growth, in both the private

[66] Older people were asked whether they made use of a range of mobility aids, including elbow crutches, electric wheelchair, manual wheelchair, mobility scooter, walking stick, zimmer frame or other walking frame, or other mobility aid.

sector and social housing. Unless the deficit is addressed, the council will find it increasingly difficult to find appropriate placements for its resident population, despite the fact that some of those in need of accessible homes will be owner occupiers able to commission adaptations to their own properties. Regardless of tenure, residents who are in accommodation which is no longer appropriate for their needs are at risk of earlier deterioration of their health and wellbeing, resulting in earlier loss of independence and reliance on the public purse. Provision for clients with particular accessibility issues is a key element of the preventative agenda[67].

Local good practice

RBKC has an accessible housing register with a dedicated medical team which provides people with hands-on support, enabling them to be matched to properties much more effectively.

Given our reliance on temporary accommodation, it is important to highlight that there are very few properties available to the council for this tenure which are able to accommodate accessibility requirements, presenting a significant barrier.

Accessible and adaptive dwellings

The Lifetime Homes standard was a set of sixteen design criteria intended to make homes more easily adaptable for lifetime use at minimal cost. Until recently it was a mandatory requirement for new build properties under the London Plan (2011). The Government rationalised technical standards for new housing in 2015, applied through national Building Regulations rather than through planning policies. As a result the Lifetime Home Standards were replaced by Building Regulations (Part M4(2) (accessible and adaptable dwellings) and Part M4(3) (wheelchair user dwellings)) to ensure dwellings are accessible and adaptive. Local planning authorities have the option to require that the optional Building Regulations are met in new housing developments provided there is evidence to justify the need for them. The Minor Alterations to the London Plan (2015) updated the policy approach in response to revocation of Lifetime Homes and introduction of the optional Building Regulations. The London Plan policy is, therefore, that 90% of all new homes should be built to meet Building Regulation M4(2) and 10% should be built to meet M4(3).

The London Plan will certainly facilitate an increase in the number of properties which are accessible and adaptable, however of the homes we will inhabit in 2050, around 80 per cent are already standing today[68]. It is easier to meet the standard with

[67] Feedback from user groups and voluntary sector organizations challenge a commonly held assumption that people with disabilities desire ground floor units, suggesting instead that for some this heightens feelings of vulnerability.

[68] HOME TRUTHS: A Low-Carbon Strategy to Reduce UK Household Emissions by 80% by 2050 by Brenda Boardman, University of Oxford's Environmental Change Institute

new build than it is when you are providing housing within existing buildings (conversions or changes of use). Careful consideration should therefore be given to maximize opportunities for build of homes which meet the wheelchair accessible standard, above and beyond the GLA policy of 10%.

Representatives of voluntary sector organisations engaged in this JSNA highlighted that too often it is assumed that people with disabilities wish to be on the ground floor; for some this will lead to a greater sense of vulnerability.

Adaptations

While some provision has to be designed appropriately from scratch, much can be achieved to ensure units' fixtures and fittings are appropriate for an ageing population and/or a greater proportion of working age population living with life limiting illness and/or disabilities. External sources of funding, such as the Disabled Facilities Grants (DFGs) and accident prevention grants, offer opportunities for adaptations that can increase the suitability of people's homes to meet their needs. While these are available cross tenure, there are very few installations in the private rented sector because you need permission from the landlord which may not be forthcoming, particularly for more invasive works. Also for some works, the process can take a lengthy period of time, beyond the resident's tenancy agreement.

Local practice

During the course of producing this JSNA, discussion held with CityWest Homes led to them reviewing standards, specifications and options around improving accessibility across its managed stock. This includes, for example, investigating how housing might assist in slowing the progression and impact of dementia.

However, stakeholder feedback in two boroughs suggested that these grants can be under-utilised, in part due to the staffing resource required to process each intervention. Similarly, feedback from the respective Housing departments highlights that securing approval for adaptations to be made takes too long, with planning restriction cited as a key barrier. In each borough, the DFG is administered by the residential environmental health service, with input from social care managers and/or health professionals. The customer journey from identification of requirement for modification, to assessment through to delivery might benefit from review to ensure that councils are able to expedite the process in the interests of cost efficiency (see section four highlighting the cost effectiveness of residential health intervention).

Recommendation 1: Increase the number of homes in the boroughs which offer residents easy access and manoeuvrability, ensuring:

a) Strong emphasis on refurbishing existing homes to deliver a greater proportion of readily adaptable homes more quickly.

b) Expedient customer journeys for aids and adaptations, from identification of requirement to delivery which offer the best use of available resource.

6.1.2 Housing conditions

Healthy homes

Westminster's Strategic Housing Services for Older People highlights that repairs and access to adaptations are critical in enabling residents to remain in their choice of housing.

The Councils' residential environmental health services (see appendix three) are central to the improvement of housing conditions, including help with adaptations to improve independence and energy efficiency measures. This work has particular resonance in the private sector, which is characterized by the poorest quality homes, preventing unnecessary deterioration of health and wellbeing and the associated preventable reliance on more intensive local authority provision.

There are legislative powers which support the role of REHS teams, notably the Housing Health and Safety Rating System (HHSRS) and Houses in Multiple Occupation (HMO) standards. The Housing Health and Safety Rating System (HHSRS) enable risks from hazards to health and safety in dwellings to be assessed and removed or minimized. Introduced under the Housing Act 2004, it provides local authorities with enforcement duties (Category 1 hazards) and powers (Category 2 hazards)[69]. Excess cold is one of the highest scoring and most prevalent hazards.

Local action

Public health has invested over £1m across the three councils' residential environmental health services to undertake proactive work to achieve the following outcomes in conjunction with ASC, GP practices and voluntary organizations:

- Improved housing conditions for vulnerable households.
- Integrated and streamlined care pathways among agencies supporting those 'at risk'.
- Greater engagement of community groups in reporting and addressing housing conditions.
- Integrated 'whole person' approach among those supporting vulnerable households.

[69] The Sector Skills Council for the places in which we live and work, Essential Information For Landlords and Agents HHSRS (Housing Health & Safety Rating System) file:///Q:/Essential_Information_for_Landlords_and_Agents_-_HHSRS_-_Asset_Skills_2006.pdf

Dealing with excess cold hazards can contribute to a reduction in:

- Death and ill health associated with excess cold
- Costs to the NHS for treating the above diseases
- Fuel poverty and CO2 emissions[70].

There are particular problems posed by the amount of older energy inefficient housing stock in England and Wales, particularly homes with solid walls in the private sector housing stock, many of which are hard to treat.

Local 'handyman' services offer simple and very low cost interventions to assist older people and those with disabilities with heating / plumbing / electrics / energy efficiency and minor adaptations. They can significantly enhance effectiveness of health and social care provision. As the population ages, there will be greater demand for such services, which allow residents to remain independent in their own homes for longer, experiencing greater levels of comfort and security.

Fuel poverty

A household is said to be in fuel poverty when its members cannot afford to keep adequately warm at reasonable cost, given their income; when a household's required fuel costs are above the median level; and when, if they were to spend what is required to warm the home, the household would be left with a residual income below the official poverty line. Cold homes are linked to an increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. Fuel poverty is caused by a convergence of three key factors:

- low income, which is often linked to absolute poverty
- high fuel prices, including the use of relatively expensive fuel sources (such as electricity as opposed to gas), aggravated by higher tariffs for low-volume energy users and/or use of pre-payment meters
- poor energy efficiency of a home, e.g. through low levels of insulation and old or inefficient heating systems

Figures from the Department of Energy and Climate Change (DECC), show that fuel poverty numbers across the three boroughs are comparable to the England mean rate of 10.4%, but somewhat higher than the average for London of 9.8%. Notably there has been a stagnation in fuel poverty numbers across England between 2013 and 2014, whereas the figure for London has increased by 0.8% and risen faster in Hammersmith & Fulham (3.3%) Kensington and Chelsea (3.6%), and Westminster (3%).

[70] CIEH guidance on enforcement of excess cold hazards in England, July 2011 file:///Q:/CIEH_guidance_on_enforcement_of_excess_cold_hazards_in_England_-_July_2011_(amended_May_2014).pdf

Figure 15: Fuel poor households

LA Name	Estimated no. of Fuel Poor Households 2013	Proportion of households fuel poor (%) 2013	Estimated no. of Fuel Poor Households 2014	Proportion of households fuel poor (%) 2013	% change
LBHF	8,500	10.3%	10,978	13.6%	+3.3%
RBKC	8,565	10.7%	11,274	14.3%	+3.6%
WCC	10,655	9.9%	13,672	12.9%	+3%
London	32,6114	9,8%	348,215	10.6%	+0.8%
England	2.35 m	10,4%	2.38 m	10.4%	0%

Source: https://www.gov.uk/government/collections/fuel-poverty-statistics

The total number of excess winter deaths recorded for England and Wales in 2014/15 was 43,900 (the highest since 1999/00), with the majority of deaths amongst people aged 75 and over. Respiratory diseases were the underlying cause of death in more than a third of all excess winter deaths in 2014/15. Local authority data for excess winter deaths is not available for 2014/15 until November 2016, but a significant increase is expected on the previous year 2013/14. Following a dip in 2013/14, the number of excess winter deaths in London has more than doubled since.

Figure 16: Excess winter deaths

Excess Winter Deaths	2012/13	2013/14	2014/15
Hammersmith and Fulham	70	30	Tbc (Nov)
Kensington and Chelsea	50	30	Tbc (Nov)
Westminster	70	30	Tbc (Nov)
London	2,750	1,700	4,000
Nationally	31,200	17,460	36,300

Source: ONS Data, Excess Winter Mortality England and Wales

Furthermore, excess winter deaths can be under reported, as the cause will be recorded as heart disease or flu rather than hyperthermia or cold and 90% of the excess winter deaths occur before cold weather alerts are issued. The temperature only needs to drop below 6^{o}C for death rates to rise and cold weather may span several days or weeks. Neither is the health impact of cold weather immediate; heart attacks peak in day two, strokes peak day 5 and respiratory disease day 12. NICE suggest that for every winter death there are eight non-fatal hospital admissions due to cold housing conditions. On top of these numbers are those experiencing poor health but not needing hospital treatment.

There is much more evidence to support interventions in the home than to support the action triggered by severe weather[71]. Fuel poverty can be alleviated through income maximisation initiatives for householders, such as benefits entitlement checks and winter fuel and cold weather payments, improved home energy efficiency through (grant funded) heating and insulation improvements and energy efficiency advice, and through reduced fuel costs through the warm homes discount, fuel switching, tariff switching and fuel debt grants. Each of these is incorporated into local initiatives to address the prevalence of cold homes.

Local Action

Peabody employs a sustainability team to visit residents and advise on ways of reducing fuel bills. They also run a Winter Warmers programme every year, visiting all residents over 75 years of age to give fuel advice and promote services to support health and well-being. The handyperson team offers free insulation and water usage advice on every visit and provides water saving measures and draught proofing free of charge.

In March 2015, NICE published its guidance: "Excess winter deaths and morbidity and the health risks associated with cold homes". This makes recommendations for reducing fuel poverty and/or its impact, emphasizing the need for collaborative work between both the commissioning and provider arms of health, Adult Social Care and Housing and with other front line services, such as advice workers and heating installation companies. The recommendations focus on improving access to services, the need to identify and target vulnerable groups, to include clients and their carers in identifying tailored solutions, the need for improved connectivity with NHS providers, with discharge planning and on ensuring that 'every contact counts'. Despite the challenges for addressing fuel poverty in the three boroughs, outlined in section 3.2, there is much in the NICE guidance which is pertinent locally.

Overcrowding

The Child Poverty JSNA highlights the impact of overcrowding on the health and wellbeing of the family, particularly on children, and recommends three priority areas for action. These include the effective use of all planning, housing investment and housing allocation powers to respond to the need for good quality and affordable family sized housing, regardless of tenure, and greater integration between REHS and other front

Local action

Both LBHF and WCC seek to alleviate overcrowding through bespoke space saving solutions such as sofa beds, fold away tables and chairs, bunk beds and shelving. The impact is reduced tension in the household, appropriate sleeping arrangements, improved sleeping patterns, facilities for doing homework. Families are also put in touch with other social support services.

[71] The evidence presented in the DECC fuel poverty strategy suggests that tackling cold homes offers by far the best value for money.

line services, particularly health and social care, to ensure that poor housing conditions are addressed, regardless of tenure.

Recommendation 2: Develop a strategic approach to improving housing conditions, cross tenure, ensuring:

a) Residential environmental health teams are sufficiently resourced to address housing conditions across the three boroughs, taking a proactive approach and utilizing the HHSRS as appropriate to tenure.

b) A cost-effective handyperson scheme, potentially co-ordinated across three boroughs, to deal with a range of maintenance issues and minor adaptations.

c) Appropriate engagement of registered providers.

d) Integrated referral pathways for front line professionals working with vulnerable residents ensure that housing conditions are considered and concerns addressed through every resident contact (see also recommendation 6).

e) Full understanding of the shape and scale of fuel poverty in the borough and of the appropriate solutions and mitigation of impact, each Health and Wellbeing Board considering NICE's recommendation to undertake a fuel poverty JSNA. Action might include proactively lobbying central Government for policy solutions and revenue to improve hard to treat properties, including common parts of flats.

f) The reach of initiatives to alleviate the impact of overcrowding on children, e.g. homework clubs, active play space, ensures they are sufficient and appropriately tailored and targeted.

6.1.3 Maintaining independence in the community

The drive to maintain independence for as long as possible, ensuring 'the right care at the right time,' is dependent on the availability of interventions/services which can respond to episodes of greater dependence and focus on reablement. The aim is to provide, after a period of hospital admission or life changing illness, enabling support for people to re-build their range of life skills and confidence to be able to live independently in the community.

Recent work undertaken locally by the CCGs and Adult Social Care has considered the availability of step up and step down beds as a mechanism to avoid unnecessary hospital admissions and unnecessarily long hospital stays.

Good practice

Across the country sheltered schemes are allocating flats as step down accommodation - this should be a key component of any new builds and consideration should be given to implementing this across the piece.

Good practice elsewhere[72] provides limited stay accommodation (6-8 weeks) for patients who are medically fit for discharge but not yet ready to return home. It is important that these are time limited and explicitly focused on reablement to ensure that the default position is a return home[73]. The reablement period facilitates thorough assessment of the care package required and, where necessary, time for the patients, their carer, friends and family to consider alternative housing options. Without this mechanism, hospitalization can lead for some to premature and long term dependence on a number of services.

Assistive technologies offer an important tool in enabling people to live independently in the community in their own homes or supported housing. Take-up of this service is not as expected and feedback suggests that assistive technologies can be seen as an optional extra for some residents. This can lead to unnecessary hospital admissions or greater reliance on local authority services. ASC are looking into how to better incorporate assistive technologies into a range of their preventative services.

The NICE Guideline on Excess Winter Deaths, referenced above, includes in its recommendations the need to improve upon discharge planning arrangements, ensuring that care planning takes account of patients' home environments. Consistent feedback from Housing and Adult Social Care colleagues is the need for the home environment to be systematically built into routine discharge planning – not just to identify and address fuel poverty, but to consider the appropriateness of a patient's housing conditions more broadly. While such provision exists, process and practices need to be reviewed to ensure they are completed in the timely fashion required for any changes to be implemented in advance of discharge.

Local action

ASC's Community Independence Service provides a range of vital functions for up to 6 weeks including:

- Rapid response nursing services to prevent people with urgent care needs either attending or being admitted to hospital.
- Hospital In-Reach, to speed up discharge.
- Rehabilitation and reablement, which enables people to regain or retain their independence and stay in their own homes.
- As part of the rehabilitation programme, a range of community equipment is provided to enable people to live independently in a safe environment for as long as possible.

[72] http://www.housingcare.org/service/list/s-38-intermediate-after-hospital-care/l-427-cambridgeshire.aspx or http://www.cambscommunityservices.nhs.uk/docs/default-source/news---press-releases/ccs-2015-legacy-document---april-2015.pdf?sfvrsn=0

[73] This is not an appropriate mechanism for securing timely discharge of homeless patients, for which there are separate mechanisms.

Delays in hospital discharge for over 65s accounted for 1.15 million bed days in 2015 costing around £820million[74] in the UK. Over 60% of all patients in hospital are over 65 years of age. Timely discharge relies on existing adaptations or fast tracked adaptations. Delays mean wasted hospital beds at high cost, and the risk of deconditioning and contracting infectious illnesses in hospital. It also means that the lengthier the assessment the greater the likelihood of a change in need, rendering the original assessment less useful.

Local action

RBKC Housing assists with discharge arrangements and the single homeless team is well engaged with mental health services and attends hospital panels to discuss cases.

With hospital teams under substantial time pressures, serious thought should be given as to how early assessments could be completed through the wider social care and health systems. For example, consideration could be given as to whether this could be carried out by homecare agency staff under Adult Social Care's homecare contracts which will already see agency workers undertaking low level health tasks as part of whole systems working.

Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community, including:

a) Sufficient investment in integrated community support services to enable 7 day provision.

b) Greater integration of assistive technologies in all care planning, and increased up-take.

c) Sufficient investment in localised, time-limited 'step up and step down' beds.

d) Discharge planning procedures and protocols which are commenced on admission and systematically and which routinely incorporate assessment of patients' home environments, ensuring the introduction prior to discharge of appropriate aids and adaptations.

6.1.4 Social isolation and community resilience

The Care Act 2014 establishes the "wellbeing principle", making promoting wellbeing the core purpose of local authorities' exercise of their care and support functions[75]. Wellbeing is defined as relating to a range of factors including social wellbeing, contribution to society and personal and family relationships. Given the links between

[74] National Audit Office 'Discharging Older Patients from Hospital'

[75] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted Section 1

loneliness and poor wellbeing, care and support functions must include action to address loneliness and isolation, as set out in the supporting statutory guidance.

The New Economics Foundation developed the framework 'Five Ways to Wellbeing: Connect (with the people around you), Be Active (keep moving), Take Notice (environmental and emotional awareness), Keep Learning (try something new at any age) and Give (help others and build reciprocity and trust). These actions promote wellbeing and refer to simple activities that individuals can do in their everyday lives[76]. Importantly there is a direct connection between these and reducing isolation.

Local Action

The BME Health Forum (funded by RBKC public health and the three CCGs) has commissioned an emotional wellbeing project to support people who are going through a difficult time and who are not fluent English speakers. The project is delivered by six community organizations in five different languages. The BME Health forum trains staff and volunteers to support clients in 1:1 sessions offering emotional support and practical help. Outcomes include:

- Improved scores on the Warwick Edinburgh Mental Wellbeing Scale
- Improved scores on self-reported health
- Self-reported reduction in the use of health services
- Self-reported improvement in managing general health and long term conditions.

Evidence from this JSNA's third sector engagement workshops suggests that loneliness is linked more to vulnerability than to age. Section 4.1iii presents Census data showing that an average of 43.1% of people living in the three boroughs aged over 65 lives alone, carrying a risk of social isolation.

Adult Social Care is now embarking on a programme to transform its current model of care. This will see a shift of resources into effective prevention and early intervention, including reducing loneliness and social isolation, in order to focus more heavily on keeping independent, safe and well. The 'Fs of Frailty' framework for prevention, outlined in section 2.5, highlights the loss of friends and family as key drivers of deterioration. It promotes a more co-ordinated and joined-up approach to activity on frailty across council, NHS and third sector agencies.

Local action

Hammersmith and Fulham council has established a Social Inclusion Forum which brings together key officers from public, private, voluntary, community & faith sector organisations to deliver improved social inclusion outcomes for local residents. The Forum is currently developing a strategy on social isolation, which will focus particularly but not exclusively on Older People.

A key challenge is to manage the demand for high cost services and sustain the focus on empowering people and developing stronger, resilient communities which will work together to maintain

[76] The five ways to wellbeing were developed by NEF from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing to support dissemination of the key findings.

independence. This means unlocking the potential of local support networks and building community capacity to reduce isolation and vulnerability[77]. Services which offer opportunities for social contact and facilitate community cohesion, such as volunteer befriending services, health and wellbeing hubs, link up / connecting projects and the Community Champions are central to the preventative agenda. Despite this, these services can be reliant on short term funding which can undermine sustainability of outcomes and destabilise service provision.

The Councils recognise the need to ensure that people are better placed to help themselves and each other; that when extra support is needed this is found within communities. Efforts to strengthen communities will focus on preventative actions which can help to keep people away from needing services delivered by the Councils; very often the best and most sustainable help comes from neighbours and peers.

This means that we will look first at the strengths within people's lives – their family and community networks, their interests and their abilities, in order to link people with the right sources of support and help which build upon these strengths. Communities that are more connected need fewer public services, create good places to live, and improve outcomes for residents. People are not passive recipients of services – they have an active role to play in creating better outcomes for themselves and for others, and they themselves will be the starting point for tackling emerging issues.

Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation. These should incorporate:

a) Recognition of community cohesion as a specific objective towards securing community resilience and promoting independence and self-reliance, with appropriate resourcing plans.

b) Plans for identifying residents at risk of social isolation and the appropriate mechanism(s) to best engage and support them.

6.1.5 Information, advice and outreach services

Information and advice is fundamental to enabling people to take control of, and make well-informed choices about, their care and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support, including preventing homelessness.

[77] A glass half full: how an asset based approach can improve community health and well-being, I&DeA 2010

The Care Act places a duty on local authorities to work with its partners to ensure the availability of information and advice services for all people in its area, regardless of whether or not they have' eligible care needs' (a wide definition including care and support related aspects of health, housing, benefits, and employment). Information and advice must be available at the right time for people who need it, in a range of accessible formats and through a range of channels.

ASC is developing a new 'front facing' service, with a bundle of 'front door' services which include signposting, information and advice. The aim is to give people the information they need at the earliest appropriate point, empowering people to direct their own care and support. Indeed, there are a number of local services which have enhanced their traditional offer, to secure greater impact. One example is the Housing Options service, as outlined in the adjacent *Local action* box. Others are outlined below.

Local action

In Westminster, the Housing Options service is being reviewed to secure a greater contribution to the prevention agenda.

- Ensuring a clear articulation of the options in advance of considering individual units to facilitate informed choices
- Facilitating residents' links with other support services, such as care services and employment support, as appropriate.

People First

People First is an easy to use website, www.peoplefirstinfo.org.uk, that provides a wealth of information and resources covering the whole of the private, voluntary and public sector across the three boroughs. The site is aimed at the older adult population, people living with disabilities of whatever kind, and those who look after others. Its main purpose is to facilitate independence and wellbeing.

Care co-ordination service

In July 2016, Central London CCG launched the Care co-ordination service to support care planning by GP practices as they introduce a Proactive Care Management Specification. This requires GP Practices to proactively care plan for 30% of their population. The target groups are those aged over 65, anyone over 18 with one or more long term condition and anyone else that the GP thinks needs extra support, for example those nearing the end of their life, those recently bereaved and those transitioning between services. The new care plans will put the patients' goals and the actions they want to achieve at the heart of the plan. The Care co-ordination service will consider the wider support needs of the patients to inform care planning. Patients will be encouraged and supported to engage in activities to improve their health and wellbeing, making referrals as appropriate. Those practices in the Regent's Canal, South Westminster and Marylebone GP 'villages' will, in addition to the standard resource of one Care Navigator and one administrator, receive additional support as

part of a trial group to test out the benefits for patient outcomes of having three clinical co-ordinators and a social prescriber[78]. The Social Prescribing element of the service will seek to connect patients with health and wellbeing activities delivered, largely by local and voluntary sector organisations, in a way which best suits their support needs.

Older People's Hubs

Adult Social Care has just refreshed its offer at four older people's hubs providing an evidence-based range of prevention activities to those most in need of support around improvements in physical and mental health, and most at risk of social isolation. They seek to achieve the following outcomes:

- Control over daily life and preventing deterioration of health (including falls)
- Living independently at home
- Respected and treated with dignity
- Feeling safe and secure
- Feeling a part of the community
- Improved social contact
- Good physical and mental health

Floating support services

Floating support services specifically seek to support vulnerable clients, including those who do not fit eligibility criteria for Adult Social Care but have clear support needs. They are an important part of the system available for vulnerable clients to support them maintain their independence and avoid residential care / hospital admissions, linking them with appropriate services and facilities. With tighter eligibility criteria, greater consideration may need to be given to how best to support those who do not meet the eligibility criteria but do have clear care needs (see section 6.4, Improving the offer to those in severe and multiple disadvantage).

In the current financial climate, many advice, information and outreach services are struggling to source adequate resources. The need to demonstrate cost effectiveness is paramount and the inherent difficulty of proving the impact of preventative initiatives makes this extremely challenging. Local commissioners will need to ensure both that social value is taken into account and recognise that for some vulnerable clients, tailored and targeted services are essential – that 'one size will not fit all'.

[78] They will also trial use of Patient Activation Measures (PAM) - a 13 question test to ascertain people's confidence and interest in self-care. These will be used with high risk patients to ensure that tailored interventions to help them make positive lifestyle choices can be appropriately targeted.

Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services which promote independence and self-reliance and are tailored and targeted to secure best impact.

6.1.6 Making Every Contact Count (MECC)

Commonly residents in touch with one service or facility will benefit from others but may not find their way to that service in a timely fashion. The pressure on resources and the volume of residents needing some level of support requires local authorities and the NHS to secure greatest impact from each contact with a resident and patient, with all contracted services and providers actively promoting and facilitating engagement with health and wellbeing – focusing on self-reliance, self-care or appropriate access to the right service at the right time. In some areas the fire service has offered a successful gateway for residents wary of contact with other services.

Local action

A group of local front line professionals from Nutrition, housing providers, REHS, health and VCS organisations considered in partnership how best they might make every resident contact count. A toolkit was devised, supported by web-based materials accessible through the *People first* website. This will support front line professionals to address a broader range of needs, through direct referral as appropriate, and reduce the number of separate, disconnected resident visits.

The 'Making Every Contact Count (MECC)' approach provides an opportunity to optimize the current capacity and capability of the broad range of front line professionals across the public and voluntary sectors to actively support prevention and early intervention. The Public Health team is leading on developing the MECC approach across the three boroughs.
The aim is for all frontline workers – be they from a council or NHS body, other public sector or voluntary/community sector organization - who have face-to-face interactions with residents to be trained and supported to have purposeful conversations with them about issues that can facilitate their improved health and wellbeing and to facilitate improved access to prevention and early intervention.

Good practice: S.A.I.L[Ω]

Safe And Independent Living (SAIL) is a partnership of statutory and voluntary organisations able to identify an older person who is at risk or needs some help. Areas of concern which may be addressed through use of a checklist and referral process include:

- Health and well-being
- Mental resilience
- Isolation and social exclusion
- Financial inclusion
- Fire safety and wider home security issues
- Safeguarding concerns
- Personal safety and security

Feedback from stakeholders highlighted

the value of MECC, given that different residents access support from a variety of front line services which might not otherwise be able to address important issues.

The transformation agenda is leading to all three councils considering which services might be brought together as hubs, the services which might be delivered through libraries. MECC offers an ideal framework to support this agenda.

Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' (MECC) approach. This will require:

a) The establishment of appropriate systems: MECC incorporated into specifications and contracts; front line workers having ready access to information; agreed referral routes; data sharing protocols and the IT infrastructure to support them (see recommendation 7).

b) Establishing MECC as a routine component of staff induction and regular training programmes in both the statutory and voluntary sectors, exploring links with other partners with front line workers, such as the fire service and refuse collection.

c) Providing training and support to formal carers and other commissioned agency workers to ensure they have the skills and information to contribute to the MECC approach as part of a quality care package.

6.2 Developing personalised housing support and care

Personalised support and care offers the best use of resources and the best experience for the resident. Increasingly policy documents and published strategy warn against 'one size fits all' approaches on the basis that, however strong or otherwise prevention and early intervention services might be, if they are not readily accessible and appropriate for the individual customer, their effectiveness might be expected to be compromised. Stakeholders consistently reported a number of barriers which mitigate against smooth customer journeys and compromise cost effectiveness. This section draws on national and local intelligence gathered and considers mechanisms for securing smooth customer journeys which respond to the range of support required.

6.2.1 Supported housing

Supported housing is an essential part of the system for enabling vulnerable people to be as independent as possible and maintain or improve their wellbeing. It is key to reducing the need for people to access higher supported housing/care packages or be hospitalized if needs are not met sufficiently early (see section 6.4 focusing on those with severe and multiple

Local Action

Leonora House offers a successful model of extra care which focuses on commonality of need, rather than care group. This might achieve greater flexibility of housing schemes and facilitate mixed communities.

disadvantage).

Supportive housing is most effective where it can be sufficiently flexible to respond to customer's changing needs, house mixed communities to provide positive environments, where sufficient move-on accommodation is available, and residents' transition supported. These aims are difficult to achieve when there is a shortage of options. Schemes which are not flexible can lead to customer remaining in receipt in packages greater than is required, effectively blocking placements for those who do need that level of care.

Despite significant investment in move-on accommodation, and it being a key focus of work within supported housing schemes and hostels, ensuring sufficient move-on accommodation remains a challenge. Move-on accommodation is central to reinforcing progress to greater self-reliance and reducing dependency on public services. However the cost of land makes it difficult for providers to develop schemes, high rents raise costs above the housing benefit cap, which can mean that independent housing is unaffordable to residents who might otherwise be ready for move-on, and commissioning approaches (contracts and service specifications) can provide too few incentives for providers to focus on pathways into more independent forms of accommodation.

In exploring this challenge, stakeholders identified a number of potential solutions:

- Ensure flexibility is built into contracts to enable more efficient use of placements, avoid unnecessary uprooting of residents (which could lead to deterioration of wellbeing) and improve cost effectiveness.
- Reclassification of schemes to enable residents to remain settled but reducing the level of support provided to allow greater independence and self-reliance, thereby reducing individuals' call on council resources. This approach must be twinned with re-investment to avoid a deficit of more intensive places in the system.
- Renewed emphasis on the provision of move-on accommodation, coupled with incentives in supported accommodation contracts for supported move-on, might facilitate independence and self-reliance and secure greater cost effectiveness.
- A review of classification systems, to ensure a focus on commonality of need and facilitating mixed communities, may help to ensure that residents can build their independence and reliance more effectively.
- Asset based commissioning[79] may provide a fresh perspective on how best to respond to the challenge, utilizing and building on communities' strengths.

[79] A glass half full, I&DeA 2010

6.2.2 Integrated assessment and placement

Personalized housing support and care requires strong partnerships between different Local Authority departments, registered providers and voluntary sector agencies. Services need to be integrated where possible, and effectively dovetailed where not, if they are to have best impact and thereby cost effectiveness. Stakeholders consistently report that a cultural shift in partnership working between Housing and Adult Social Care front line staff is required for efficient decision making and on-going support.

Stakeholders also consistently suggested that multi-disciplinary panels to consider/review cases have proved fruitful and should be considered for the routine, default position. A case-conference approach was seen as routinely producing positive outcomes, and is considered particularly beneficial where clients have complex needs and circumstances. They were also reported as contributing towards robust partnership work, facilitating improved mutual understanding of each-others' limitations and reducing inappropriate referrals between departments.

6.2.3 Data sharing

Chapter 5 made the economic case for data sharing. Stakeholder feedback consistently endorsed this, highlighting concerns that while progress has been made with data sharing between health and social care, Housing staff are often left without the intelligence they need to ensure they support residents with optimal effect. Registered providers need the intelligence gained from a risk assessment undertaken by Housing Options to ensure appropriate and person-centred care. Data sharing is an on-going challenge yet no party saw this as inherently the case. Concerted investment in bottoming out the barriers to data sharing protocols between Housing, ASC, REHS, NHS providers (MH, SMS), RSLs, Children's Services was consistently requested.

6.2.4 Effective communication across support agencies

The work undertaken with vulnerable residents is complex and requires the effective engagement of a number of providers each with specialist skills. Services need to be familiar with each other and how they dovetail to be able to make effective referrals and undertake timely, effective assessments. Stakeholders suggested a multi-agency approach to promoting and facilitating secondments across teams to support front line workers

Local action

The Community Champions initiative is developing effective partnerships across housing and health to support the delivery of champions projects across the three boroughs. These include the registered providers, many of whom co-fund the initiative out of recognition that the Champions are able to reach hidden and isolated individual and communities through the peer to peer approach.

in housing providers and in Adult Social Care to develop greater mutual understanding of respective responsibilities and constraints and identification as complementary parts of the same team.

The required cultural shift among front line practitioners across the system can only be achieved through a mutual understanding of roles, responsibilities and realistic expectations. The importance of multi-agency networking forums, promoting and facilitating skill mix and partnerships (across voluntary/community sector services and statutory services) was highlighted as an important tool in this and in improving and maintaining an understanding of the range of services available in the area.

Recommendation 7: Establish data sharing protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents.

Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care.

Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape. This would aim to inform future investment in and commissioning practice and include the options identified in 5.2.1.

6.3 Strengthening collaborative approaches to supporting carers

Introduction

The Department of Health defines a carer as a person who spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, disabled or has mental health or substance misuse problems. In addition to adults, some children under the age of 18 help to care for a parent or sibling: they are likely to be assuming a level of responsibility usually taken by an adult.

The support carers provide can enable the person they care for to remain living independently at home for longer and retain social networks. Their knowledge and understanding of the cared-for person's needs can also enhance care planning when

remaining at home is no longer a realistic option[80]. The Care Act places upon Local Authorities a duty to provide for carers. Emphasis is placed on ensuring needs are assessed, information and advice provided and they are able to access services and pathways established for raising concerns. The carer is afforded rights independent of financial capabilities or needs of the dependant.

6.3.1 The Local Picture

Nationally, studies have shown that 3 in 5 people will be a carer at some point in their lives, and that 600,000 people become carers each year. This would be roughly 1,000-1,500 in each of the three boroughs.

The 2011 census estimated that in the three boroughs there were 39,200 residents providing unpaid care, almost 21% of whom providing 50 hours or more care each week and that there will be an increase in need for a further 1,000 informal carers per borough over the next decade[81] to support the larger number of older people (resulting from better life expectancy and greater numbers born since World War II)[82]. However, just 3,706 such carers are known to Adult Social Care (735 in LBHF, 1,536 in RBKC and 1,440 in WCC, according to 15/16 SALT returns), and while others will be known to third sector carer support agencies and to GPs practices, this suggests a large majority of informal carers are not known to services and are not having their needs assessed and addressed by Adult Social Care or commissioned agencies. Given the role carers play in helping the cared-for person to remain independent, it is important that they are supported and that they are able to sustain this activity without their own health and wellbeing deteriorating.

6.3.2 Who does this affect?

An Adult Carers Survey is undertaken in each borough by Adult Social Care every two years and findings contribute to 5 indicators in the Adult Social Care Outcomes Framework. The response rate to the 2014/15 survey was 30.9% in Westminster, 32.7% in Kensington and Chelsea and 39.3% in Hammersmith and Fulham. Across the three boroughs, two thirds of all carers have been caring for five years or more and four in ten are retired.

[80] Assessing the barriers to achieving genuine housing choice for adults with a learning disability: the views of family carers and professionals'. SCIE Social Care Online. Oxford University Press. British Journal of Social Work, 35(1), January 2005, pp.139-148.

[81] http://jsna.info/document/highlight-reports-2013-14

[82] It has also been estimated that, as a result of new responsibilities set out in the Care Act 2014, a further 2,600 – 2,800 informal carers across the thee boroughs might come forward annually to be assessed/reviewed, although this increase has not yet materialised.

i. Gender

In all three boroughs, the large majority of known carers are women. This is reflected in the survey response, with 66% of respondents in Kensington and Chelsea, 74% in Hammersmith & Fulham and 75% in Westminster being female.

While caring responsibilities more commonly fall on women, consideration should be given to whether male carers are under-represented among known carers, perhaps as a result of being less likely to engage with services (Milligan and Morbey, 2013) and, if so, how best to promote and facilitate uptake[83].

There appears to be no gender difference in carers' quality of life.

ii. Age

The largest age groups among carers were the 65-74 age group in Kensington and Chelsea (24% of respondents), and the 55-64 age group in Hammersmith & Fulham (26%). The numbers of respondents aged over 75 was 15% in both Hammersmith & Fulham and Kensington and Chelsea, but 17.5% in Westminster. This is a high proportion for a group which itself needs increasing support. There appears however to be no difference between the adult age groups in carers' quality of life.

Between 1 and 3% of carers across the boroughs are aged under 16 years, of whom the majority are female. The Child Poverty JSNA (2014) highlights that the number of residents aged under 15 providing unpaid care is estimated at: 267 (LBHF), 186 (RBKC), 332 (WCC). Young carers are in a position where they have to assume a level of responsibility that would normally only be asked of an adult. The stress and anxiety that this can cause can leave them feeling isolated and unsupported. Many miss out on their childhood and youth as time constraints make it impossible for them to attend school or take part in leisure activities with their peers. Young adult carers aged between 16 and 18 years are twice as likely to be not in education, employment, or training (NEET) [84]. The JSNA suggests that young carers are considered to be at risk of child poverty[85].

Interestingly the age profiles by gender differed between each borough: in RBKC the age profiles of male and female carers were roughly the same, in LBHF female carers have a younger age profile than men, and in WCC they have an older age profile than men. This suggests there will be quite different needs among carers in each of these boroughs.

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[83] Older men who care: understanding their support and support needs, C Milligan & H Morbey, Lancaster University Centre for Ageing Research, December 2013 http://eprints.lancs.ac.uk/68443/1/Older_men_who_care_report_2013Final.pdf

[84] https://www.spurgeons.org/our-services/young-carers

[85] http://www.jsna.info/document/child-poverty

iii. Ethnicity

There was a slight under representation of the Asian group in each borough in the survey (particularly in Westminster, where this group was recorded at 17% in the census, but equates to only 10% of respondents to the carers survey). This is consistent with anecdotal evidence that Asian groups may be less likely to identify themselves as carers and access services.

iv. Hours of care provided

The survey asks carers the number of hours of care per week they provide. In Hammersmith & Fulham, 92% of all unpaid carers provide over 20 hours of care every week. In Westminster the figure is 85% and in Kensington and Chelsea 79%. Furthermore, in Hammersmith & Fulham and Westminster more than 4 in 10 respondents provide over 100 hours care each week. In Kensington and Chelsea the figure is 1 in 3, which is the same as the average for Inner London.

v. Location

The 2011 Census identifies highest levels of provision of 50+ hours a week in areas of relative deprivation and social housing. ASC assessed a higher proportion of the high intensity (50+ hours per week) carer population in these areas of deprivation: they are less successful at reaching more affluent areas, some of which have larger older populations. In part this may be due to successful targeting of initiatives in areas where a larger number of carers can be expected, including those who care for a larger number of hours per week. It may also be due to more affluent carers making private arrangements for care.

6.3.3 The human cost

Evidence shows that investing in carer support is a cost effective way of reducing ASC costs, yet the State of Caring report 2016[86] predicts that the financial strain on public services affects carers particularly adversely.

In the 2009/10 survey, carers reported several ways in which their caring responsibilities role had affected their health over the last 12 months. The most significant factors were disturbed sleep and stress, for roughly half of carers. Other factors included feeling depressed, physical strain, being irritable, loss of appetite, developing their own condition or making an existing condition worse[87].

The Census 2011 showed that carers caring for 50 or more hours a week are more than twice as likely to be in bad health than non-carers[88].

[86] https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2016
[87] Information on this survey in the JSNA Carers Evidence Pack.
[88] Census analysis (2013) Carers UK http://socialwelfare.bl.uk/subject-areas/services-activity/social-work-care-services/carersuk/166981carers-at-breaking-point.pdf

The 2014/5 survey sought responses about specific health conditions. In all three boroughs half the respondents had a health condition themselves, recorded as either a long standing illness, physical disability, sensory impairment, mental health problem, learning disability or 'other'[89]. 50% have co-morbidities – more than one long term condition[90].

A strong theme in the stakeholder feedback was the prevalence of loneliness and social isolation, with carers feeling trapped in their homes and unable to access support services due to their caring responsibilities.

Feedback also suggested that the way in which the primary service user has their needs assessed and provided has an impact on the carers' health and wellbeing, with carers' stress and anxiety being heavily linked to whether their views and experience are sufficiently taken into account in the development of the care plan for the cared-for person. Stakeholders reported that involvement of the carer in decision making about the primary users' needs and package of support can help them to feel supported and respected and better able to make effective assessments about their own support needs.

Local action

'Healthy Carers Better Care' is an initiative commissioned from Carers' Network by West London CCG. It aims to:

- improve carers' access to health services, by identifying hidden carers through road shows at GP surgeries, where they are likely to be supporting their cared-for at appointments
- engage carers in the design of, and feedback on, services by encouraging and supporting them to join their PPG
- reduce carers' health inequalities by linking them with existing local services, particularly the Health Trainers.

A report by Carers UK, 2014[91] , highlights that many carers only seek help once they actually reach a 'crisis' or 'breaking point'. At this stage their health and wellbeing needs will already have deteriorated and greater intervention will be needed – for example respite care for the cared-for person while the carer's needs are addressed. Carers whose needs are met and assessed at an earlier stage are less likely to reach this point as soon, some not at all. As recommended in the Dementia JSNA, carers need support and advice to empower them in fulfilling their caring role without detriment to their own quality of life.

[89] Survey of Adult Carers in England 2014/5
[90] As yet unpublished ASC data
[91] Carers at Breaking Point, Carers UK, September 2014 , http://socialwelfare.bl.uk/subject-areas/services-activity/social-work-care-services/carersuk/166981carers-at-breaking-point.pdf

6.3.4 Economic value

As outlined in chapter five, the health, social and economic value of informal care is huge. In 2000, around two thirds (65%) of the value of long-term care support was provided via unpaid care, with a quarter (25%) from the state and 10% funded privately. If carers' support had to be replaced with provision from statutory services, it would cost the NHS, social services and other statutory bodies around £34 billion a year nationally, or around £140 million a year in Hammersmith and Fulham, around £135 million a year in Kensington and Chelsea and around £150 million a year in Westminster.[92]

6.3.5 Identification of carers

Carers are often not known to services because they do not recognise themselves as carers (particularly in the early stages), may see it as fulfilment of family duties, or may be reluctant to make their needs known.

Even where they do self-identify, carers may be in contact with any of a number of services without presenting for an assessment of their needs on the basis of which a support package can be put in place. Their caring role might be known to their GP or social network, for example, or by hospital discharge staff, but not then subject of a referral to the appropriate service for assessment. This presents a challenge for those seeking to ensure carers are appropriately supported.

Local action

The specification for a new carers' support service is currently being designed for the three boroughs. This will seek to ensure the following:

- an emphasis on ensuring care packages have a dual focus, on both the carer and the cared-for resident
- facilitation of the maintenance of a 'viable' home for both parties
- consideration of the totality of the impact of the caring role on the carer's wellbeing
- consideration of respite care as part of the cycle of care rather than solely at point of crisis
- tailored provision of respite care

This service will link with a wide range of partners to ensure that carers' diverse support needs are met.

6.3.6 Carers' assessments / reviews

The national target for initial assessment / annual review of carers' needs is 95%. Unpublished data from Adult Social Care suggests that all three boroughs are falling short of this target, particularly Hammersmith and Fulham where a marked difference in performance between different teams is in evidence. This reinforces feedback from stakeholders which suggests that experience of carers assessments is not consistent,

[92] http://jsna.info/document/carers-evidence-pack

some carers waiting much longer than others. All three boroughs have made a marked improvement since the previous year.

6.3.7 Support packages

i. Carers' satisfaction with services and support

An unpublished finding from the ASC Carers' Survey 15/16 is that satisfaction with services and support is higher than the London average for all three boroughs and is particularly high in Kensington and Chelsea.

ii. Respite care

Stakeholder feedback stressed the need to ensure that respite care provides genuine rest and recovery for the carer as well as appropriate care for the cared-for person. Also that respite care must be seen as part of a cycle of care and be tailored appropriately, in a way which reflects the particular background to the caring relationship and the cultural context within which it operates.

iii. Housing related support

Although there is evidence and information on carers' general health and support needs of carers, there is a relative lack of research and information into specific housing related needs, and interventions which could facilitate and sustain their caring role. Those highlighted[93] include:

- Housing conditions: Carers who live with the person they care for may not have adequate space of their own, as a result of the storage of necessary equipment and/or having to use communal space as their bedroom. Carers who live elsewhere and need to stay overnight might end up regularly sleeping on a sofa. Engagement with voluntary sector agencies stresses that carers having their own space was seen as vital to their wellbeing. The prevalence of this stressor could become greater as a result of the under-occupancy cap, under which rooms used to house equipment or night-time carers who live elsewhere[94] can be defined as spare rooms, with a consequent reduction in the residents' housing benefit.
- Household maintenance: carers can struggle to cope with these tasks on top of their caring role (and possibly their own frailty) and might not know how to access support.

[93] Carers and housing: addressing their needs' by Princess Royal Trust. http://trustnet.carers.org/print/professionals/social-care/articles/carers-and-housing-addressing-their-needs,5878,PR.html

[94] Ibid.

- Equipment and adaptations: Feedback from stakeholder engagement, endorsed by the Dementia JSNA highlighted a common lack of understanding regarding the available aids, adaptations and assistive technology and their respective benefits. This can lead to health and safety risks for carers, for example lifting without the necessary aids and/or carrying wheelchairs to enable the cared-for person to use a different part of the house or to go outside. In Australia, installation of home adaptations has led to a significant reduction in the number of care hours. Adaptations to assist with bathing reduced care giving hours by 60%, toileting by just under 50% and mobility equipment by 40%.[95] Technology such as tele-care might save up to £2,000 per year per installation[96].
- Security of home situation: whether owner occupiers or social or private tenants, carers can become vulnerable if the needs of a primary user of services deteriorate to the point of requiring residential care, either for financial reasons or where they are not named on the tenancy agreement. Anxiety relating to this can impact on their wellbeing before the event[97].

Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support. These should ensure:

a) The promotion of self-identification through tailored and targeted outreach which is sensitive to cultural conceptions of social roles, working with front line providers in a range of services, statutory and voluntary.

b) Referral mechanisms and smooth care pathways which ensure expediency and the provision of support for a range of needs from the right place at the right time and provide a fair and equitable experience for all carers.

c) Ready access to the breadth of advice and support necessary to ensure that carers' needs are addressed (see section 5.1.1 Prevention).

d) Care management protocol (including discharge planning) should identify how systematically to ensure that carers' views and needs are better taken into account.

[95] http://www.australianageingagenda.com.au/2016/04/07/home-modifications-reduce-reliance-care-study/
[96] http://www.kingsfund.org.uk/sites/files/kf/telecare-older-people-wanless-background-paper-teresa-poole2006.pdf
[97] Ibid.

6.4 Improving the offer for those in severe and multiple disadvantage (SMD)

Introduction

The term severe and multiple disadvantage (SMD) refers to individuals who present a range of challenging behaviors and needs which in isolation may not warrant specialist intervention but which in combination become highly significant. Further, where specialist interventions are put in place to manage one condition, these may fail or be less effective than anticipated as client barriers and multiple needs often reinforce and exacerbate each other.

National estimates suggest there are 4,440 residents experiencing Severe and Multiple Disadvantage (SMD) across the three boroughs[98]. They show a high prevalence of challenging behavior, homelessness, mental health issues and substance misuse and commonly suffer deep social exclusion. Individuals can lead chaotic and highly risky lives, experiencing poverty, stigma and discrimination[99]. Problems often develop after traumatic experiences such as abuse or bereavement and there is a high prevalence of challenging behavior, mental health issues and substance misuse issues[100].

Those in SMD can present a disproportionately high cost to the public purse through the repeated use of public services in an unplanned way. Individuals are often subject to a cycle of homelessness as housing placements become untenable. Rehousing is challenging due to the limited availability of appropriate social housing stock and the need to consider the potential impact on both the individual and the community (housing scheme) into which a placement is made. The provision of adequate and safe accommodation for individuals in the early and late stages of entrenched dependency has been highlighted as a key issue in all three boroughs.

Health and social care services are commonly designed either as generic services which address low level issues or to specialized services to address specific conditions, for example mental health conditions or learning disabilities. Many housing services currently work with individuals with a wide range of needs that go beyond requiring assistance with housing, and interact with health and social care. However, when an individual in SMD seeks help, the multiplicity of needs presented leads to challenges in providing services in the most effective way, which can lead to support being offered

[98] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[99] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[100] Alcohol and substance misuse is not within the scope of this JSNA, see 'Substance Misuse and Offender Health 2013/14 for local information http://www.jsna.info/document/substance-misuse-and-offender-health-2013-14

by multiple professionals from different services, overwhelming the individual and causing them to disengage.

Existing support services and pathways can be poorly suited to needs and, as a result, effectiveness in supporting recovery compromised. As a result many become 'frequent flyers', individuals who repeatedly find themselves needing to return for additional assistance. In the face of multiple problems that exacerbate each other, and the lack of effective support from services, individuals can end up in a downward spiral of mental ill health, drug and alcohol problems, crime and homelessness. They become trapped, experiencing regular crises with no apparent realistic way out.

National evidence and best practice both support local findings that individuals experiencing SMD require person-centred and flexible care delivered in a timely fashion, and that appropriate care can generate significant cost savings. Evidence suggests that safe and suitable housing is a key enabler in recovery and stabilisation.

6.4.1 The local picture

Individuals who present with Severe and Multiple Disadvantage are predominantly white men, aged 25–44, with long-term histories of economic and social marginalisation and, in most cases, childhood trauma of various kinds[101]. Data from the national Multiple Exclusion Homelessness (MEH) survey[102] however, indicates that migrants make up a significantly higher proportion of the SMD population in Westminster: data excluding Westminster's figures suggest <10% but including Westminster's suggests 21%[103]. Equivalent estimates are not available for Hammersmith & Fulham or Kensington and Chelsea.

As elsewhere, individuals who fall into the SMD cohort are not systematically identified and registered in the three boroughs so full prevalence is not known. National estimates suggest 4,440 residents across the area fall into this cohort, but recognise that this is likely to be an underestimate given that it does not take account the higher prevalence of in Central London[104].

It is perhaps symptomatic of this higher prevalence that Westminster uses a local definition and the term 'Complex and Multiple Need' (CMN), referring specifically to individuals who are:

[101] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[102] A quantitative survey of people using 'low threshold' homelessness, drugs and other services in seven UK cities conducted in 2010.
[103] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[104] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015

- Homeless or insecurely housed (including those living in hostels or temporary accommodation, or in settled accommodation but at risk of eviction),
- At risk of coming to serious harm and / or at risk of perpetrating serious harm,
- Suffering from mental ill health or personality disorder, and
- Have one or more of the following: poor physical health, a learning disability, problematic substance misuse, history of chaotic or anti-social behaviour, history of criminal activity, poor personal care, history of sex working, background in care or have had their own children removed by social services.

6.4.2 The human cost

The Multiple Exclusion Homelessness (MEH) survey[105] highlights increased prevalence of a range of physical health conditions including alcohol or drug related problems (85 times the incidence rate for the average population) epilepsy (five times), difficulty in seeing (3.4 times), stomach/liver/digestive complaints (3 times), chest/breathing problems, cancer and stroke (2 times). Individuals with SMD are also more likely to suffer from poor mental health. Nationally, 55% have a diagnosed mental health condition and 75% report common mental health problems and loneliness[106].

Of particular concern in Westminster are older people with SMD, who often present with complex physical health and mobility issues. General community supportive accommodation may not be appropriate for them due to the level of risk they present, however neither do they meet the threshold for residential care. A small yet significant number of individuals within this cohort are experiencing early onset dementia, most likely brain damage as result of long term substance misuse.[107]

Almost 60% of individuals in SMD either live with children or have on-going contact with their children. Children in these families are potentially affected by chaotic lives, economic and housing insecurity, and social stigma and experience heightened risks of neglect, abuse and domestic violence. As such focus and attention on how we address the negative impact of SMD on children's lives, possibly by joining up with Troubled Families initiatives and the plethora of good quality family services in the voluntary sector should be considered[108]. A recent report by IPPR, *Breaking Boundaries*[109], further sets out the case for government developing, alongside an expanded Troubled Families programme, a new 'Troubled Lives' programme based upon similar principles.

[105] A quantitative survey of people using 'low threshold' homelessness, drugs and other services in seven UK cities conducted in 2010.
[106] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[107] Stakeholder feedback
[108] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[109] Breaking Boundaries, Towards a 'TROUBLED LIVES' programme for people facing multiple and complex needs, Clare McNeil and Jack Hunter, September 2015

6.4.3 Financial cost (cost to society)

Despite making up a very small percentage of the population, the costs to services and society can be significant with failure to effectively support this client group often resulting in entrenched dependency. National estimates range from £16,000 a year for the average entrenched rough sleeper[110], to £21,180 a year for the average client facing substance misuse, offending and homelessness problems[111]. This is compared to average UK public expenditure of £4,600 per adult[112].

The Lankelly Chase research estimates that those accessing homelessness services in addition to criminal justice or substance misuse services or both, cost the public purse £4.3 billion a year[113]. Accumulated individual 'lifetime career' averages are also stark – ranging from £250,000 to nearly £1 million in the most extreme cases for the most complex individuals[114]. One recent study found that better coordinated interventions from statutory and voluntary agencies can reduce the cost of wider service use for people with multiple needs by up to 26% (Battrick et al 2014).

Figure 17: Annual costs of an individual with the most complex needs

Benefits	£6,020	28%
Prison	£5,053	24%
Psychiatric hospital	£3,094	15%
Hostels	£1,948	9%
Physical health	£1,603	8%
Rough sleeping services	£1,230	6%
Support services	£1,145	5%
Substance treatment	£763	4%
Criminal justice	£324	2%
Total annual cost:	**£21,180**	**100%**

Source: DCLG, Addressing complex needs, improving services for vulnerable homeless people 2015

6.4.4 Pressure on current housing and social care pathways

Key stakeholders and service providers fed back their experience of trying to support clients who 'fall into the gaps' between services[115], for example individuals in SMD to whom we have a housing duty but who do not qualify for ASC support and/or

[110] DCLG analysis, 2012 based on criminal justice and health costs for the average entrenched rough sleepers.
[111] Hard Edges: Severe and Multiple Disadvantage in England
[112] Hard Edges: Severe and Multiple Disadvantage in England
[113] (Bramley and Fitzpatrick 2015).
[114] Hard Edges: Severe and Multiple Disadvantage in England
[115] JSNA stakeholder workshop December 2015

specialist housing. This can leading to highly vulnerable individuals being placed without an adequately tailored support package in place, despite best efforts[116].

Due to the limited supply of social housing stock, individuals in SMD may be placed in temporary accommodation for some time, awaiting permanent placements. The provision of appropriate support in TA can be challenging and individuals may fall into a cycle of homelessness as housing placements become untenable, with rehousing opportunities challenging. Floating support services have a particularly important role to play for individuals in SMD.

Local action

Family Mosaic's 'Health Begins at Home'* resident engagement initiative identified particular issues for SMD residents with both a human and financial cost. By putting in place tailored intensive health and wellbeing interventions they achieved a marked reduction in unplanned GP and hospital appointments and a significant improvement in health and wellbeing.

Tenancy Sustainment Officers at **Affinity Sutton** offer intense support at the start of tenancies for people identified as being high need/risk, particularly the under 25s, care leavers and ex-offenders).

There may also be a negative impact of those living around the resident in SMD, if the exhibit challenging behaviours. Further, the need to consider the potential impact on the community (housing block) into which a placement is made means that individuals experiencing SMD are often placed within the same housing block. Whilst existing accommodation schemes can manage a proportion of challenging clients at any one time, the mix is crucial also, as many residents with high support needs can, without the right interventions, cause the service to become unsafe and further exacerbate dependencies and issues.

It has been suggested that the Housing and Planning Act, together with welfare reform will not relieve the significant pressure on housing services across the three boroughs and the following might be expected:

- continued upwards trends in homelessness applications;
- reduction in the overall availability of social housing stock;
- inability to procure suitable and affordable temporary accommodation within the boroughs or indeed London;
- further inability to discharge residents into the affordable accommodation with the private rented sector

In combination this is expected to lead to longer waiting times with more residents being placed long-term in temporary accommodation, an increasing proportion out of the borough. Careful consideration of how this affects responsibilities of care and our ability to affect design of care is needed.

[116] JSNA stakeholder workshop December 2015

* www.familymosaic.co.uk/userfiles/Documents/Research_Reports/Health_Begins_At_Home_web.pdf

http://www.affinitysutton.com/rent-a-home/supported/tenancy-sustainment/

6.4.5 Current activity and best practice

i. Housing First, Hammersmith & Fulham [117]

Hammersmith and Fulham is currently undertaking an 18 month *Housing First* pilot. The *Housing First* model seeks to assist the most entrenched rough sleepers move off the streets and into their own accommodation. Crucially individuals are not required to be "housing ready" and there are no preconditions (e.g. for the individual to address wider social care or support needs) for access. Research has demonstrated the success and cost effectiveness of the model[118].

Traditionally, *Housing First* services target long-term entrenched rough sleepers who have lived in numerous hostels and have either been evicted or have abandoned their placement on multiple occasions. Many individuals will have a long history of anti-social behaviour, poor physical/mental health and substance misuse. Hammersmith & Fulham has achieved good results in reducing entrenched rough sleeping, however there is a small but not insignificant number of people in hostels who struggle to thrive in the hostel setting and are at risk of losing this accommodation, are often placing considerable demands on other statutory services such as the criminal justice system and through unplanned hospital admissions.

The purpose of the pilot is to assess whether the Housing First service model can deliver service improvements for homeless people with complex needs, and secure better value for money through reducing in the longer term the number of hostel places the council needs to commission.

ii. Complex Needs 'Task and Finish' Working Group, Westminster

The Complex Needs 'Task and Finish' working group, operational between August 2013 and January 2014, included colleagues from Housing, ASC, PH, alcohol and substance misuse, Domestic Violence leads and other key support services. It was convened to explore how best to 'meet the housing and support needs of homeless or insecurely housed adults with complex and multiple needs'.

A series of recommendations were developed by the group leading to, amongst other, things an informal case management approach across agencies to better enable person centred care, the Single Person's Housing Pathway (SPHP). This

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117 http://democracy.lbhf.gov.uk/mgReasonsRestricted.aspx?ID=76038&OID=40795&OT=A&RPID=89669278&BM=AI40795

118 'Housing First' or 'Housing Led'? The current picture of Housing First in England, June 2015 Homeless Link Policy and Research Team

offers a more flexible housing solution for those who may not meet the eligibility criteria for the statutory homeless pathway.

The scheme has demonstrated a considerable success in ensuring that those with vulnerabilities are supported and housed appropriately. However stakeholders suggested that the SPHP is often seen as a 'last resort' when all else has failed, which can delay its activation and reduce the speed at which outcomes can be achieved.

iii. Socially Excluded Complex Needs Services, Kensington and Chelsea

Heaney Lodge, Holly Villa and Warwick Road Services are well-established, 24 hour complex needs support (waking night and concierge service) schemes. They continue to meet the Royal Borough's objectives in minimising relapse, reducing pressure on statutory health, social services and criminal justice services, reducing admissions to psychiatric hospitals and enabling people with complex needs and a previously chaotic lifestyle/history of rough sleeping to re-engage with society.

Heaney Lodge and Warwick Road Services are intensively supported housing schemes for eleven people and twenty-four people respectively with a history of entrenched rough sleeping, enduring mental health problems and complex needs (severe and multiple disadvantage), often including dual diagnosis. Warwick Road service also has an emergency bed for those rough sleepers. Holly Villa is primarily focussed on mental health clients with complex needs, including a forensic history.

Heaney Lodge has been in operation since July 2000 and was developed in partnership under the Rough Sleepers Initiative (RSI) and formerly jointly funded scheme between Homelessness Directorate and the Supported Housing Commissioning Team. Holly Villa has been in operation since July 2001 and jointly funded by Adult Social Care, Supported Housing Commissioning Team (formerly known as the Supporting People Team) and Clinical Commissioning Group (formerly known as the Primary Care Trust) and Warwick Road service has been in operation since April 2011 and funded by the Supported Housing Commissioning Team.

These services work with some of the most vulnerable people in the Borough, helping tenants to manage their support needs and to successfully establish and maintain a tenancy, often for the first time. These services aim to support service users to transform and take control of their lives and to take their place as valued members of their local communities.

These services have a strong focus on assertively supporting this vulnerable and challenging client group to engage in meaningful daytime activities and to access education, vocational training and volunteering and employment opportunities. They offer alternatives to previous lifestyles, which have often included anti-social behaviour, social exclusion and contact with the criminal justice system. These

services continue to work with external agencies, such as Homeless Intervention Team (a mental health social worker post funded by Public Health) to prevent people from losing their tenancies.

6.4.6 Recommendations

Stakeholders in Housing and Adult Social Care across the three boroughs expressed a desire to review how better individuals in SMD might be supported and whether there might be potential to secure cost savings as well as delivering real improvements in wellbeing and risk reduction both for these vulnerable clients and the wider public.

Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health, housing and social care solutions to those in severe and multiple disadvantage. These must include:

a) shared mechanisms for routine, earlier identification of those in SMD;

b) an integrated health and social care offer to those in SMD, in all housing settings;

c) integrated pathways into appropriate care and housing support.

6.5 Improving housing options for later life

Introduction

The English Housing Survey indicates that around three million households (53%) of those aged 65+ are under-occupying their home, with more space than they normally need[119]. The Joseph Rowntree Foundation identified a similar proportion, 57% of older households under-occupy, but also found that this differs with tenure: 68% of owner-occupiers compared to 19% of social renters. Of the 8 million households that under-occupy, just over half (4.2 million) are older person households[120].

Among those aged over 60, 58% express interest in moving to more suitable accommodation, however there is reluctance due to a lack of suitable alternatives or fear of an unfamiliar environment, as well as a desire to maintain the asset to pass on[121]. This can lead to premature deterioration and loss of independence, as a result

[119] Savills UK - Housing an ageing population: spotlight

[120] Joseph Rowntree Foundation: *Older people's housing : choice, quality of life, and under-occupation*, 2012

[121] Wood, C. *The top of the ladder.* DEMOS, 2013

of inability to adequately maintain or heat the property and poor access to services where the property does not lend itself to adaptation, to unnecessary hospital admissions and/or premature removal into more residential care.

A review by the Joseph Rowntree Foundation[122] examines the housing options available to older people who may wish to move. They identified some key points which should be considered when considering schemes to encourage older people to down-size:

- Nationally, 75% of all older households are owner-occupiers, but only one quarter (23%) of specialist housing is for sale.
- Most older people want a home with at least two bedrooms (for visitors, carers) but most specialist provision has only one bedroom.
- Owner-occupiers are often reluctant to move from freehold to leasehold housing
- Many older people prefer to remain living in mixed-age housing and communities.

In the absence of a desirable alternative, the advantages which 'staying put' offers, such as maintaining social networks, access to support from neighbours and the local community and keeping pets may mean that 'staying put' is the right choice.

Releasing the 'spare capacity' in under-occupied housing stock could address some of the current and future challenges of housing supply for those in need, particularly for families. However, currently, death is a more significant contributor than downsizing in 'releasing' larger homes: 85% of homes with three or more bedrooms are 'released' by older people due to death rather than a move to a smaller home[123].

6.5.1 Support to 'stay put'

There may be scope for the fitter older population in their own properties and with spare capacity to take a 'lodger'. In Homeshare[124], someone who needs some help to live independently in their own home is matched with someone who has a housing need and can provide some support. Inspired by naturally-occurring, mutually beneficial relationships, Homeshare programmes seeks to facilitate such arrangements it in a way that maintains the non-contractual nature of the relationship while increasing the clarity and safeguards around it. Local authorities may view this as a way of addressing the lack of intermediate housing and/or appropriate housing

[122] Joseph Rowntree Foundation: *Older People's housing: choice, quality of life and under-occupation,* 2012
[123] Ibid
[124] Homeshare Practical Guide, Homeshare Plus http://sharedlivesplus.org.uk/images/publications/01-SL-HOMESHARE-GUIDE.pdf

options for some vulnerable adults, for example those with mild to moderate learning disabilities.

Many larger properties will only become available for families, however, should the resident opt to move to alternative accommodation.

6.5.2 Support to move

The logistics of moving house can be a significant deterrent. Residents may need assistance with sorting through possessions for packing and/or passing on and properties may require some refurbishment as well as a facelift before they can be inhabited other residents. Councils are recognising that support, including financial assistance, with the preparation and arrangements associated with moving house, might be recognised as a cost effective investment.

Stakeholders reported that some boroughs (e.g. Croydon) are looking to property bonds as a mechanism to enable them to purchase homes on the open market, exploring the framing of such purchases as options for investment to support pension funds. Others have found this can serve to inflate house prices further, exacerbating issues they are seeking to resolve (e.g. Newham).

Good practice elsewhere:

- support to 'downsize' to two bed as opposed to one bed properties (Islington), alleviating fears that friends and family will be unable to visit and carers unable to stay over as necessary without discomfort
- co-housing for over 55s (Haringey)
- through assistance with the preparations and logistics for moving and with the actual move+, offsetting the cost with the benefits drawn from the move.

Local action:

- LBHF's Housing department is trialling offering residents help with renting out their home when they move into residential accommodation. The scheme provides a source of income which helps residents to cover their care costs, enables them to retain their asset and provides what is often family sized accommodation for social housing. The Council makes the necessary arrangements and covers the cost of necessary maintenance and decorating costs as part of the deal.
- SharedLives is an approach which supports family-based and small-scale ways of supporting adults. It has just been launched in all three boroughs by ASC.

6.5.3 Providing desirable alternatives

While, in practical terms, the greatest leverage exists in relation to housing association and council tenants who are living in family-sized housing, evidence suggests[125] that under-occupation should be discouraged across all tenures housing.

[125] Kneale, D et al. *Downsizing in later life and appropriate housing size across our lifetime*. International Longevity Centre-UK, 2013

Perhaps the single most important barrier for older people who wish to move is the lack of a suitable and desirable offer. With only around 10% of the older population living in specialist housing nationally[126], there is significant scope, with the right investment and approach, in alleviating some of the pressure on the housing stock. Providers need to offer a range of attractive alternatives in order to offer a real choice[127].

A survey commissioned by the National Housing Federation in 2010 found people aged between 60 and 65 dreaded ending up in a care home or imposing themselves on relatives if they could no longer cope with living on their own[128]. The majority of respondents (80%) were positive about downsizing to a smaller, more manageable home. The research identified the following as central to older people's housing requirements:

- accessible
- spacious and attractive
- safe and secure
- age-friendly environment
- offers freedom, choice and flexibility
- has help at hand
- provides flexible, personalised support
- enables you to socialise and feel included
- allows you to make decisions

The HAPPI report[129] establishes principles which build on this and which have been used by developers and architect in providing housing schemes for people aged 55+ in the Royal Borough of Greenwich[130].

[126] International Housing Partnership. *Fit for the Future: Meeting the challenge of housing an ageing population*, 2013
[127] JRF, ibid
[128] National Housing Federation, "Breaking the mould : re-visioning older people's housing" 2011
+ 'Support to Relocate' project, Stoke on Trent; 'Moving Experience' McCarthy and Stone
[129] Housing our Ageing Population: Panel for Innovation (HAPPI)
https://www.gov.uk/government/publications/housing-our-ageing-population-panel-for-innovation
[130] Berrington, J. *Quality design attracts downsizers*. Housing LIN Case Study 77, 2013

6.5.4 Challenges to providing desirable alternatives

Reasons why housing options for older people are limited nationally are significant[131]:

- A challenging housing market for developers
- There is limited public investment in new social rented housing
- Housing and planning issues, such as strategic vision and data on older people's housing or lack of imaginative ideas or innovation
- Developers offer limited models for specialist retirement housing
- General house-builders do not design for or target older people as a market segment.
- Limited use of creative partnerships between general house-builders, specialist retirement developers, housing associations and local authorities, although interest is growing.

Savills UK report[132] that without homes that meet changing lifestyle needs or financial incentives, such as stamp duty holidays for downsizers, it appears likely that we will see the majority of people staying in the family home for as long as possible. Typically people stay put until faced with a pressing health or social reason (e.g. bereavement, safety or health scare).

Extra care housing is one important response to the diverse needs of a growing older population and is part of the move towards age friendly communities, providing access to care services which are responsive to the changing needs of residents, provides unplanned care when required, and offers an emergency response, which can prevent unplanned hospital admissions.

Extra care is still evolving and various tenure and funding models are being tried and tested across the country. Each borough currently has some socially rented extra care and plans to develop more but there is an increasing pressure to meet the needs of owner occupiers who do not wish move into social housing. There are now greater tenure options with more leasehold and shared ownership properties alongside social renting, which extend equity based choices[133]. These enable authorities to alleviate the pressure on their own extra care stock and may also offer wider benefits to communities in terms of economic and social wellbeing.

[131] Joseph Rowntree Foundation, op cit

[132] Savills UK. *Housing an ageing population: spotlight*. 2015

[133] Pannell, J & Blood, I. *Briefing 1: Quality and choice for older people's housing: what can a new Private Rented Sector offer?* Housing LIN, 2014.

Recommendation 12: Councils must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and promote and facilitate their take-up. This must include:

a) the development of a broader range of options

b) the development of new approaches to providing housing options advice for older people, which promotes and facilitates early planning for ageing

c) the design or enhancement, as appropriate, of packages of support which respond to the barriers to the preferred housing solution, building on existing models of good practice.

7 Recommendations: reliant on robust partnership

7.1 Introduction

The recommendations are not exclusively addressed for Housing departments, for Adult Social Care or indeed other departments or agencies. They will need to be addressed in partnership by the relevant teams or departments and the lead may be different for each borough and for each recommendation. While there is much commonality across the boroughs, residents' experiences, the scale of the challenges and the way in which they are manifested, all vary.

Any implementation plans which stem from this report will need to be produced in partnership and to consider the most appropriate, borough based response to each recommendation.

7.2 The recommendations

Strengthening prevention and early intervention

Recommendation 1: Increase the number of homes in the boroughs which offer residents easy access and manoeuvrability, ensuring:

a) Strong emphasis on refurbishing existing homes to deliver a greater proportion of readily adaptable homes more quickly.

b) Expedient customer journeys for aids and adaptations, from identification of requirement to delivery which offer the best use of available resource.

Recommendation 2: Develop a strategic approach to improving housing conditions, cross tenure, to facilitate efforts to maintain residents' health and wellbeing, ensuring:

a) Residential environmental health teams are sufficiently resourced to address housing conditions across the three boroughs, taking a proactive approach and utilizing the Housing Health and Safety Rating System (HHSRS) as appropriate to tenure.

b) A cost-effective handyperson scheme, potentially co-ordinated across three boroughs, to deal with a range of maintenance issues and minor adaptations.

c) Appropriate engagement of registered providers.

d) Integrated referral pathways for front line professionals working with vulnerable residents ensure that housing conditions are considered and concerns addressed through every resident contact (see also recommendation 6).

e) Full understanding of the shape and scale of fuel poverty in the borough and of the appropriate solutions and mitigation of impact, each Health and Wellbeing

Board considering NICE's recommendation to undertake a fuel poverty JSNA. Action might include proactively lobbying central Government for policy solutions and revenue to improve hard to treat properties, including common parts of flats.

f) Initiatives to alleviate the impact of overcrowding on children, e.g. homework clubs, active play space, are sufficiently and appropriately tailored and targeted.

Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community, including:

a) Sufficient investment in integrated community support services to enable 7 day provision.

b) Greater integration of assistive technologies in all care planning, and increased up-take.

c) Sufficient investment in localised, time-limited 'step up and step down' beds.

d) Discharge planning procedures and protocols which are commenced on admission and systematically and which routinely incorporate assessment of patients' home environments, ensuring the introduction prior to discharge of appropriate aids and adaptations.

Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation. These should incorporate:

a) Recognition of community cohesion as a specific objective towards securing community resilience and promoting independence and self-reliance, with appropriate resourcing plans.

b) Plans for identifying residents at risk of social isolation and the appropriate mechanism(s) to best engage and support them

Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services, which promote independence and self-reliance and are tailored and targeted to secure best impact.

Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' (MECC) approach. This will require:

a) The establishment of appropriate systems: MECC incorporated into specifications and contracts; front line workers having ready access to information; agreed referral routes; data sharing protocols and the IT infrastructure to support them (see recommendation 7).

b) Establishing MECC as a routine component of staff induction and regular training programmes in both the statutory and voluntary sectors, exploring links with other partners with front line workers, such as the fire service and refuse

collection.

c) Providing training and support to formal carers and other commissioned agency workers to ensure they have the skills and information to contribute to the MECC approach as part of a quality care and support packages.

Delivering personalised housing support and care

Recommendation 7: Establish data sharing protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents.

Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care.

Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape.

Strengthening collaborative approaches to supporting carers

Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support. These should ensure:

a) The promotion of self-identification through tailored and targeted outreach which is sensitive to cultural conceptions of social roles, working with front line providers in a range of services, statutory and voluntary.

b) Referral mechanisms and smooth care pathways which ensure expediency and the provision of support for a range of needs from the right place at the right time and provide a fair and equitable experience for all carers.

c) Ready access to the breadth of advice and support necessary to ensure that carers' needs are addressed.

d) Care management protocol (including discharge planning) should identify how systematically to ensure that carers' views and needs are better taken into account.

Improving the offer for those in severe and multiple disadvantage

Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health,

housing and social care solutions to those in severe and multiple disadvantage. These must include:

a) shared mechanisms for routine, earlier identification of those in SMD;

b) an integrated health and social care offer to those in SMD, in all housing settings;

c) integrated pathways into appropriate care and housing support.

Improving housing options in later life

Recommendation 12: Councils must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and promote and facilitate their take-up. This must include:

a) the development of a broader range of options

b) the development of new approaches to providing housing options advice for older people, which promotes and facilitates early planning for ageing

c) the design or enhancement, as appropriate, of packages of support which respond to the barriers to the preferred housing solution, building on existing models of good practice.

7.3 Implementation

	Housing	RPs	ASC	REH	PI	CCGs	A&C HPs	GPs	OTs	CVS	ChS	PH	CPol	Sch	IG
Recommendation 1: Accessibility															
Recommendation 2: Housing conditions															
Recommendation 3: Maintaining independence															
Recommendation 4: Community resilience															
Recommendation 5: Info, advice & outreach															
Recommendation 6: MECC															
Recommendation 7: Data sharing															
Recommendation 8: Smooth customer journeys															
Recommendation 9: Move-on accommodation															
Recommendation 10: Carers															
Recommendation 11: Those in SMD															
Recommendation 12: Housing options for OP															

Key

Arms Length Management Organisation	ALMOs
Registered Providers	RPs
Adult Social Care	ASC
Residential Environmental Health	EH
Planning	Pl
Clinical Commissioning Groups	CCGs
Acute and community health providers	A&C HPs
General Practitioners	GPs
Occupational therapists	OTs
Voluntary & Community Sector	VCS
Children's Services	ChS
Public Health	PH
Parks and Leisure	P&L
Corporate policy	CPol
Information Governance	IG

	Lead department
	Key partner

8 Foundation stones

The recommendations, framed placing residents at the centre, highlight seven common interwoven threads which offer important messages for how systems might be better structured. These are consistent with themes identified in both the Sustainability and Transformation Plan produced by North West London CCGs and each borough's Joint Health and Wellbeing Strategy. Each of these acts as a foundation stone on which cost effective personalised prevention and early invention might rest.

8.1 Joint commissioning and pooled budgets

NHS, Housing Services and Adults Social Care are under increasing pressure, through a combination of reduced budgets, an aging population, Housing and Welfare Reform and a requirement to implement significant reforms under the Care Act. It is widely recognised that investment in preventing the deterioration of health and wellbeing is needed. Recognising the links between housing, health and social care, and the restrictions on how specific budgets can be used, commissioners need to increase the use of pooled budgets as a way of unblocking solutions and facilitating closer collaboration. This might enable greater weighting towards 'upstream' prevention and earlier intervention.

8.2 IT data sharing protocols and information governance

The health and wellbeing strategies and the STP recognise that investing in information technology and data analytics will all be crucial to delivering an integrated health and social care system which provides patients with a good experience of care. Collaborative work to facilitate and enable information exchange between organisations, supported by robust information governance protocols and initiatives to facilitate patients' confidence in appropriate disclosure, is required if cost effective personalised prevention and early intervention are to be realised.

8.3 Smooth customer journeys, supported by referral rights and pathways

There are a number of examples of good practice, in each of the three boroughs, where specific teams have sought to address broken customer journeys. Work to build on these is required to ensure that, regardless of where a resident makes first contact, the offer is consistent and secures optimal impact.

8.4 Quality services and facilities, appropriately tailored and targeted

The three boroughs are characterised by quality services and facilities. In financially straitened times, the pressure to improve cost benefit ratios and to ensure that services and facilities reach those with the most to gain increases. This report seeks to

highlight services which secure positive outcomes for some of our most vulnerable residents and which might play a greater role in facilitating cost effective provision than may previously have been recognised.

8.5 Asset based approaches[134] (for individuals and for communities)

These look first at strengths rather deficits within a community or a person's life. Communities that are more connected need fewer public services, create dynamic places to live, and improve outcomes for residents. People are not passive recipients of services – they have an active role to play in creating better outcomes for themselves and for others, and they themselves will be the starting point for tackling emerging issues – their family and community networks, their interests and their abilities - in order to link people with the right sources of support and help which build upon these strengths. This report advocates the development of strategies which explicitly seek to strengthen community resilience and practices which utilise residents' own strengths.

8.6 Workforce development

The drive to achieve more for less has implications for our staff. Ensuring that staff teams are skilled up, confident and supported to address this challenge is essential if positive outcomes are to be achieved. If they are to be expected to 'make every contact count', staff working in front line services of different sectors will need the tools to do so. These will include referral rights and pathways but also learning opportunities to ensure that they are able to recognise signs of poor or deteriorating health/wellbeing and to know how best to address them.

8.7 Local intelligence

Distinct from IT data sharing protocols and information governance, this foundation stone refers to securing greater understanding of the local landscape. While much is known about the demographics of the three boroughs and about needs, there remain sources of data which have not been drawn together to shed light on issues pertinent to prevention and early intervention and to the provision of personalised housing support and care. Two specific areas highlighted in this report are Fuel poverty and severe and multiple disadvantage.

[134] A glass half full: how an asset based approach can improve community health and well-being, I&DeA 2010

Appendix 1: Related reports and reviews

Older People's Housing

Review of Sheltered Housing, RBKC

RBKC's sheltered housing was reviewed in 2009 by the Institute of Public Care, who found that 26/32 schemes were not fit for purpose and unsuitable for upgrade. A subsequent survey of the sheltered housing stock, completed in February 2012, highlighted a need for the Council and its housing partners to develop a range of housing options to meet the needs and aspirations of older people in the borough. The existing social sheltered housing stock has large proportions of bedsit accommodation (considered too small to enable residents to receive care at home), has limited and poorly used communal facilities and has significant shortfalls in accessibility. There are also insufficient units to meet the rising demands of an ageing population.

Supported Housing Strategy for Older People (SHSOP), WCC

The SHSOP programme first reported in 2012 stating a need for redeveloping care facilities to meet current and projected future needs of older people in Westminster. However, a number of the modelled assumptions have not happened and Phase 2 is currently re-evaluating what the project will do.

The project rise in funded nursing care has not happened to date. Instead, there has been a high increase in the need for beds for dementia including people exhibiting challenging behaviours. A number of people have been placed in nursing care despite no medical need for nursing due to their behaviours. Additionally, Adult Social Care out of borough spot placements costs are now cheaper than in-borough block contracts.

The projected need for extra care units (100+) is now thought to be over-ambitious, particularly in the south of Westminster, and changes in welfare such as housing benefit caps may have made extra care less affordable than originally thought.

Extra Care Housing

Review of Extra Care, LBHF

Customer engagement work took place in December 2015-February 2016 with all residents invited to one-to-one interviews and a number of focus groups for relatives, carers and friends.

Review of Extra Care, RBKC

RBKC's 'Modernising Older people's Housing and Accommodation with Care Servicers Strategy' includes recommendations about increasing the number of units of good quality extra care, including in the south of the borough where there was no provision. The strategy recommends replacing residential care with extra care, similar to the SHSOP recommendations.

Consultation with residents of Extra Care Housing, WCC

The following findings are also from the consultation with tenants in extra care in Westminster in 2016:

- A quarter of tenants entered extra care due because they were attracted by the offer: “nice people”, “lots of space”, “things to do”. However, three quarters moved in due to a significant life event or situation, making their previous accommodation unsuitable such as change in health status, eviction or bankruptcy, harassment from a neighbour. Close to two thirds felt their move to extra care was a permanent one.
- Over three quarters said they felt they get the right amount of care delivered to them.
- Although many of the clients with cognitive decline did not have access to some of the benefits of extra care (cooking facilities, freedoms resulting from having their own tenancy), some tenants are supported to cook, or can cook on their own, with appropriate technology. Furthermore, some carers have reported that tenants had formed relationships with other tenants prior to the progression of dementia that benefited them as their condition progressed, through greater social interaction.

Supported Accommodation: People with Learning Disabilities

Learning Disabilities Accommodation Strategy, WCC

The review has highlighted the number of people with a learning disability who are living with more complex needs, in particular a young cohort coming through transitions in the near future and an older cohort who are developing dementia. The emerging priorities are increasing high support services in borough, increase of autism specific supported housing in borough and developing the workforce to meet the needs of more complex and challenging behaviour to prevent where possible hospital admissions and protracted stays in Assessment and Treatment Centres.

Supported Accommodation: People with severe mental illness

Review of Mental Health Supported Accommodation, RBKC

There are a number of clients who need continuing support and care due to the fact that there is a limited possibility of them living independently. If these clients are no longer able to be supported in supported housing there is a risk of them going back to hospital.

Over 12 months, 50% of referrals made seeking a high support placement were not placed. However, only four of those referrals failed due to the lack of a vacancy at the time of referral.

Recommendations

- Placement and/or step down can be delayed where the client has a history of chaotic behaviour, tenancy breakdown and a dual diagnosis support need. The services need to work with those with an ongoing presentation of chaotic behaviour and/or a resistance to rehabilitation and hard to place clients.
- There is a need to have a further discussion with health colleagues about how to facilitate the development of either more high support or stepping down supported

housing services, such as a female only high support supported housing service and or medium support service who works more effectively and efficiently with those with an ongoing presentation of chaotic behaviour and/or a resistance to rehabilitation and hard to place clients.

- There is an emerging business case for more high support/care provision that can support people with complex needs who face eviction in mainstream supported housing and need more intensive support. The service model would need to look at additional staffing and it may involve the procurement of a specialist building.

Accommodation for homeless single people

Use of B&Bs for vulnerable people, RBKC, Spring 2014

- One third of applications in B&B have a secondary need or vulnerability on top of their presenting need, and are likely to need support even if they are not eligible for Adult Social Care and support. These are the cohort referred to as 'complex and multiple needs'
- The majority of people in B&B placements have a presenting need of mental illness or physical disability, and so may be eligible for more supported accommodation
- There is room for improvement in the connection between the Joint Homeless Team, the Tenancy Support Team and the categories used to record presenting need on IBS and the report recommends that the links are reviewed.

Health in the community

Malnutrition risk in Kensington and Chelsea: Recommendations for action

The Public Health-funded review of malnutrition in Kensington and Chelsea (February 2016) found that the risk far exceeds national estimates. The survey found that nearly 1 in 5 residents who live in the community are at risk of malnutrition and the very old are at an even greater risk. The burden this places on individuals and society is, furthermore, set to increase.

The report included a number of recommendations to raise awareness of malnutrition amongst professionals and the third sector, and that day centres and supported housing settings should participate in a tiered award scheme which involves training, regular audit, 'MUST' screening, policy development and recognition of achievement.

Appendix 2: Stakeholder engagement

Multi-agency Workshops

An engagement workshop took place in November 2015 with around 40 attendees from Housing departments in each borough, Adult Social Care, Public Health, the Community and Voluntary Sector and each of the local Clinical Commissioning Groups as well as residential environmental health services and some providers of social housing and supported accommodation. This brought together the expertise from different parts of the system to identify issues and potential solutions. This was used to inform the key lines of enquiry in this report.

A second engagement workshop, attended by another 45 delegates from the same agencies was held in June 2016. Discussion centred on the key messages of the report and a set of draft recommendations. The focus was on ensuring that they had resonance for attendees, captured the most pertinent issues and offered recommendations which might act as agents for change.

Kensington and Chelsea Voluntary Sector Forum

An engagement workshop was held at a Kensington and Chelsea Social Council meeting in January 2016 with representatives from many local voluntary sector organisations. This workshop sought to expand on some of the themes from the staff workshop, and focused on person-centred care, early intervention and the needs of carers.

Westminster Voluntary Sector Forum

An engagement workshop was held at One Westminster's Westminster Community Network meeting in February 2016 with representatives from many local voluntary sector organisations. This workshop covered the same discussion topics as the Kensington and Chelsea forum.

Carers' event

In February 2016, the JSNA findings were fed into a consultation event organized by Adult Social Care to be incorporated into the design of the new tender for a carers service across the three boroughs. This ensured that carers' views informed the report, particularly, but not exclusively, section 6.3.

Online consultation

An online consultation on the key findings and draft recommendations took place following June's stakeholder event. All those who had engaged in the production of the JSNA, were invited to give their feedback. The online survey had a distribution list of 150 people.

Targeted engagement

Targeted engagement with various departments and agencies took place throughout the process. In June 2016 key stakeholders were invited to comment on particular sections and

key recommendations of relevance to them. The team meetings of each Housing department and the Wider Adults Leadership Team were part of this approach. Presentations were also given to each CCG.

Appendix 3: Core community services

1. Residential Environmental Health Service (private tenants)

- Make sure homes comply with the Housing Health and Safety Rating System (HHSRS) and Houses in Multiple Occupation (HMO) standards
- Help reduce the number of privately rented homes that lack modern bathroom and kitchen facilities, contain hazards or have poor thermal insulation
- Help residents who are experiencing fuel poverty, especially older residents who are at greater risk of poor health as a result of living in a cold home
- Deal with pest control and drainage problems
- Help people with a disability to adapt their homes to improve their independence

2. Council Neighbourhood Service teams, RSL estate teams and ALMO estate teams

Social housing providers, from the councils, ALMOs, and other registered social landlords such as Housing Associations and providers of supported housing have a team of Housing Officers who manage tenancies including anti-social behaviour. They are in frequent contact with residents across their patch, and often visit residents in their own homes.

Additionally, each estate has a team of caretakers. Some estates will also have a grounds maintenance person. They are familiar to residents, and are able to act as the eyes and ears of the estates.

3. Community independence Service (CIS)

CIS provides a range of vital functions for up to 6 weeks including:

- Rapid response nursing services to prevent people with urgent care needs either attending or being admitted to hospital.
- Hospital In-Reach, to speed up discharge.
- Rehabilitation and reablement, which enables people to regain or retain their independence and stay in their own homes.

The CIS is a key example of the three councils and three CCGs' commitment to a preventative approach and targeted interventions that promote independence and keep people out of hospital. It is a person-centred service, and is provided by a team of people working together including a case manager who puts together a care plan.

4. Floating support

Floating support services provide support to a range of vulnerable client groups including people with mental health issues, as well as older people, young people who are at risk or leaving care and families. The service helps people to maintain their independence in their own home, and in their wider life. Floating support is available across the three boroughs and people do not have to be eligible for care and support in order to receive it.

5. Housing options

The vehicle for accessing social housing the housing options service(s) provide a range of housing advice and support including assessment for social housing eligibility. The service also offers on-going support for residents in temporary accommodation awaiting permanent placement.

6. Befriending

A number of local third sector organisations offer befriending volunteer schemes, where a volunteer may be paired with a vulnerable adult. The relationship can be practical, such as providing assistance with letters, or simply improving their wellbeing by offering company.

7. ASC Care at home service

The population of people that are being supported to live at home now have a range of complex needs and long-term conditions, and this service includes hybrid health and social care workers who take a reablement approach to help people to live as independently as possible.

The service aims to achieve outcomes for people, moving away from 'time and task' focused provision, working more directly with customers to agree the details of their care and how the outcomes will be achieved.

8. Supporting People services

Supporting People is a programme of hostel and supported accommodation, predominately for people with a history of rough sleeping, mental health problems or substance misuse. Every scheme is different; residents will typically have a key worker who helps tailor their support package to their needs, and there is often target timeline for 'move-on' to help the individual to become more independent.

9. Meals on wheels service

The aim of the home meals service is to deliver a safe, reliable, nutritious service for customers who are unable to provide this for themselves. Malnutrition is a significant issue for maintaining good health. Good nutrition advice can help prevention, early intervention and reablement allowing people to stay healthy and at home for longer. It can also reduce hospital and potentially residential care admissions as well as keeping people well who are in these places.

10. Falls prevention services

Falls can have a serious impact on the quality of life of older people. They can undermine the independence of older people, cause multiple A&E attendances, inpatient stays and increase the level and cost, of social care services provided.

Falls may be caused by the person's poor health or frailty, or by environmental factors, such as cold homes and trip hazards inside and outside their home. There are a number of services for older people funded by the CCG, Public Health and Adult Social Care that

promote healthier active lifestyles and build confidence through physical activity, strengthening exercises and health talks.

11. District Nursing

CLCH provide a district nursing service is for housebound people aged over 16 who require nursing care in their home and local community. The service includes managing chronic long term conditions, caring for acutely ill patients in their own homes, caring for post-operative patients, delivering end of life care, and medication management.

12. Health Visiting

This is a universal service offering support for parents of children age 0-5, including the mental health of parents when this may affect their child's welfare.

Additionally, the Family Nurse partnership works with young parents (where the mother is under age 20 at conception) to improve aspirations the mothers, such as by encouraging further education.

13. Day services

Adult Social Care and the NHS commission a range of services for vulnerable adults including older adults, people with a learning disability, and people with mental health problems. These provide activities and outings, exercise and fitness sessions, classes, information and advice, social opportunities and spaces. Additionally, they offer services for people with complex needs who often require safe and accessible building environments and very close support, alongside personal care.

Many of these services are provided by the third sector.

14. Carers' services

The importance of providing services to carers to enable them to continue in their caring role is widely recognised, and reinforced under the care act with a duty to assess the needs of all carers.

Each borough provides a service to their carers. Part of their remit is to identify unpaid carers, and provide support to known carers through peer support groups, information and advice and promote awareness of carers' rights with other partners such as GPs.

If a carer is assessed as eligible, they may be entitled to a carers' personal budget, which enables carers to decide for themselves what they most need and what outcomes they would like to achieve. Desired outcomes may be related to health improvement or reducing loneliness. Things that carers may purchase include a holiday, gym membership or educational courses.