

## Improving Older Services (ref 29)

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### Introduction

We are acutely aware of the problems of some hospital resettlement services created over the last 30 years. The Campus services were one example of well intentioned change to hospital services which unfortunately replicated some of the institutional problems they were intended to solve. These are being dealt with through a programme of change funded largely from health capital and revenue. The Campus programme is thought to cover about 2000 + places still needing change out of a potential total of 35,000+.

### Hospital Resettlement - Health Funded

In 1971 the *White Paper* on learning disabilities<sup>1</sup> proposed a major shift towards community from hospital services. In 1983 the health minister announced a pilot programme to boost this change and new joint funding arrangements and the transfer of health funding for 'care in the community'. Some of the new services were the 'campuses' owned and managed by health authorities and trusts sometimes on hospital sites.

Also in 1983 there was design guidance for local authorities providing new community placements<sup>2</sup> suggesting special 16 - 25 bed units should be built giving some idea of the prevailing thinking of the time.

The 1971 *White Paper* said there were 52,000 beds for in patients with learning disabilities and nearly all of them have moved to community based services probably most in registered care homes. Most of these new community home places were funded by DH grants, the grant is usually covered by a charge that the grant is repaid should the home be closed or no longer used for an approved purpose.

### New Supported Housing - Housing Corporation Funded

The Housing Corporation since 1974 had begun to provide supported housing through the national capital funding programme.

When the *Community Care Act* was passed in 1990 there was formal policy recognition of the need to enable people to live as normal a life as possible in their own home or in a homely environment in the community.<sup>3</sup> Section 47 of the Act said that social services should as part of a care assessment involve housing authorities in any assessment where housing needs are identified. In later Circulars<sup>4 5</sup> partnership planning and working between social services and housing was encouraged and guidance given.

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<sup>1</sup> DHSS 1971 Better Services for the Mentally Handicapped

<sup>2</sup> DHSS Local Authority Building Note No. 8 (1983), Residential accommodation for mentally handicapped adults, HMSO

<sup>3</sup> DHSS 1989 Caring for People

<sup>4</sup> DoE 10/92 Housing and Community Care

<sup>5</sup> DoE 2/97 Housing and Community Care: Establishing a Strategic Framework

Although the Housing Corporation under the *Housing Act 1974* could make capital and revenue grants to registered housing associations it could only fund housing with this money and any funding for care had to come from elsewhere. However, following the *Registered Homes Act 1984* the Housing Corporation did allow that homes provided with Housing Corporation Grant might need to register as care homes. It seemed to fit with the *Community Care Act* intentions.

So throughout the 80's and 90's increasing numbers of Corporation funded homes, registered and unregistered as care homes, were provided and supported housing comprised between 10% and 14% of the capital programme. In the 80's, the Department of Health had new powers as well, to fund homes for people moving from hospital. Some hospital resettlement was funded by the Corporation programme and for a time in the late 80's the Corporation and DoH tried to agree a joint funding mechanism but failed and this ended all Housing Corporation funding for hospital reprovision.

### An Overview of Housing Needs

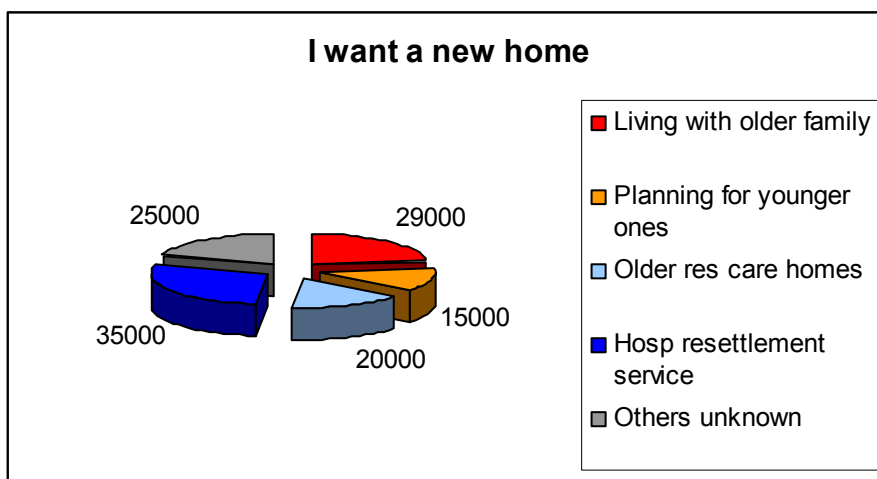
The most recent Core Bulletin 2007 indicates 24,291 lettings by housing associations to people with learning difficulties and CSCI records for 2007 show 66,000 places available in registered care homes. Because many of the housing association lettings are in registered care this does not represent a total of places available but it does indicate that housing associations provide a substantial proportion of lettings to people with learning difficulties.

The chart represents some fair assumptions about the demand for a new home, either because services are too old, too big or otherwise unsatisfactory. There is then a steady demand for new places, as people reach adulthood, want independence or because carers are getting older and existing family arrangements can't continue.

The estimate of those in health funded resettlement services including campuses is 35,000.

The number of registered care homes continues to grow and provides the largest share of places provided. Just under one in four (22%) were still living in houses for more than 10 people in 2004.<sup>6</sup>

More than half of those with learning difficulties known to services are still living with their families and this represents the growing future demand for new places. Mencap estimated 29,000 living with older carers in the UK.



<sup>6</sup> Emerson E et al (2005) *Adults With Learning Disability In England – National Survey 2003-4* NHSIC

## Health Resettlement Consortiums

Besides the difficulties identified with the health campus services there is a far larger number with revenue and capital funding transferred from the closure of hospital service to social care.

The creation of a Consortium form was adopted by many Health Authorities who saw it as a way of managing hospital resettlement through an independent provider while retaining a health management and sometimes provider interest and suitable links with local authority social services and housing providers. These Consortiums were often constituted as unregistered housing associations. Housing could either be acquired through engaging housing association partners or the Consortium itself could be funded, in the same way as in Worcestershire and Sheffield, by the Health Authority under S28 powers to transfer health revenue or capital to a social care function.

The parties to the Consortium had a varied mix of interests. Health members might want to retain an active interest in the new housing, in management and the direct provision of services. Social service members would probably want to think about the way the new service became an opportunity or responsibility for them. The Consortium as an executive body and any housing partners had to think about the job following transfer and how it would develop thereafter usually led by Social Services who had been given the lead role for community services following the Griffiths review in 1988.<sup>7</sup>

The contractual framework for resettlement services differed. In most cases funding for capital was health S28A transfer or S64 grant which appears as a repayable charge on the property. Revenue, again under S28A could be for the service as a whole or limited to the people who had moved out.

## Problems for the Resettlement Services

Not all hospital resettlement services are problematic but there are many examples from providers.

*The problems today are that some property never was appropriate, some has become inappropriate and we are increasingly moving towards more individualised services, less shared living, trying to manage voids as services are disaggregated and gradually de-registering services. The organisation is working towards using more home ownership options, more family and parental involvement ensuring better quality and providing more for less.*

In another example of about 120 people in shared homes the health authority providing funding for the property they were closely involved in property acquisition and houses appear quite institutional and not well suited for purpose. Another problem was that staff from the hospital were transferred to the service and there were examples of the persistence of institutional habits. A survey of residents looked at where people lived and whether their housing was suitable and whether they like where they lived. It's a critical report - many people are not happy or living the life they want for one or more of the following reasons:

- *They do not like the house they live in*
- *Or they do not like the area*
- *Due to deteriorating health/mobility finding it increasingly difficult to continue living where they are now*
- *Do not like the people they live with or just are not compatible*
- *Did not choose to live where they do and levels of support do not match needs and wishes*

An existing health trust managed service in housing association homes (funded from S28A grant) was put out to tender and it was accepted by social service and health that there was a clear need for a significant reconfiguration project to redevelop and improve the homes. This is in line with the local authority Joint Commissioning Strategy, which clearly states that registered accommodation should be reduced, with more specialist services and individual Supported Living packages commissioned.

*The aim is to focus on the key Valuing People principles - rights, independence, choice, inclusion - fitting these services to the new national agenda. The reconfiguration could offer better person-centred support, to enable some people to explore the potential for owning their own home, and for some to control their own support.*

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<sup>7</sup> DoH 1988 *Community Care: Agenda for Action*

This all requires the agreement of the health partners to change.

The Cornwall investigation gave a nasty reminder of what can go wrong. But we are all aware of other examples of where people have ended up with sub standard services. Sometimes a new housing solution would make a great opportunity for improvement but for a variety of reasons this potential key for problem solving is frustrated.

### **S28A Funding for 'Resettlement'**

There are good examples of the process of change for existing services but they all depend on a continuing partnership between health social service and providers and agreement to the re-use of revenue and capital transferred to social care at the time of the original hospital closure. This in too many cases appears to be frustrated.

*Signposts for Success* from the NHS Executive 1998 says for moving people out of health services health authorities *planning the transfer of residents and resources to support them to the community. (para 6.2) and Resources transferred to local authorities for the community care needs of people who do not require continuing in patient care should also be available for..... their successors who may otherwise have entered the institution. (HSG para (95)45 para 4.1) HSG (92)43 Health Authority payments in respect of social services functions says authorities should note the importance of using health service funds to pay for social services for people who have traditionally been cared for in hospitals and if local authorities assume prime responsibility for arranging care for particular groups and transfer of responsibility should be reflected in a transfer of funds.*

Not all authorities were keen to follow this and sought to reduce the grant as residents died or moved on. Likewise although capital provided through S28A can be recycled for existing or future residents, some authorities prefer not to use the value from the sale of assets for new community services.

These are some of the options for existing homes

- ↑ sale and use of receipts from sales
- ↑ demolish and use site for new build
- ↑ improvement or adaptation to existing
- ↑ deregistration as care home
- ↑ move people to other housing and reuse of existing land or buildings

The current campus closure programme needs to be accompanied by an evaluation of the extent of change required to other existing unsatisfactory hospital closure homes funded by health money for social care.

*Valuing People Now* stated the new proposal for funding and commissioning 'social care' services will transfer from the NHS to local government. The stated vision is for fully integrated local authority led commissioning of learning disability services with resources for social care to be held by local authorities. This needs to take account of capital funding transferred to social care through hospital and campus closures.

This can then be tackled on the condition that existing health investment is retained with the potential for additional capital contributions from borrowing and Housing Corporation programme funds.

If you require further information or have other queries contact Housing Options.

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