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Case Study 98

North Tyneside Living: an integrated housing, health and social care model to deliver preventative and enabling sheltered housing services

In the UK, the government is questioning our readiness for an ageing population, with concerns about housing provision and the restructuring of and reduction in, services to support older people. This paper reports on an innovative service partnership in North Tyneside, between housing, health and adult social care, for the delivery of a preventative and enabling sheltered housing service. This service delivery model provides support for all aspects of a rich and satisfying life, from nurturing and/or maintaining social engagement and activities, to promoting good physical health, or supporting people to manage their chronic conditions and disabilities. There is evidence to suggest that this new model promotes prevention and brings services to the older tenant. Furthermore, whilst this service delivery model is cost effective in monetary terms, it is equally important that tenants indicate that it improves their quality of life.

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Introduction

In the UK, local authorities, public health and adult service providers, in partnership with other public, private and voluntary sector organisations, are charged with developing integrated strategies for housing, health and social care services that enable older people to enjoy a good quality of life. This is, in part, in response to an ageing population. Another key driver for integration and partnership working is the expectation that a greater burden will be placed on public services as the number of people who live to an advanced age with high levels of multi-morbidity increases.

Van den Akker et al (1998) suggested that multi-morbidity was present in 78% of the 80+ population. Wolfe, Starfield and Anderson (2002) identified that on average their study participants had 2.34 types of chronic conditions: 65-69 years an average of 1.88 types of chronic conditions; and 85+ an average of 2.71 types of chronic conditions. These statistics become very important in a context where the population is ageing. There is already a significant number of very old tenants (aged 85+) living in sheltered housing in the UK. Around 60% of those moving to this form of housing have a 'disability-related requirement', with a higher % among older movers (Pannell and Blood, 2012). Hence managing chronic conditions, frailty and disability are significant issues in sheltered housing services.

The Local Government Group report (2010) on the role of councils in meeting the housing challenge of an ageing population, suggests that housing and related services need to adapt to changing needs and abilities, whilst providing environments that promote well-being and independence. Since the NHS health and social care restructuring (Department of Health 2012), responsibility for promoting public health issues has shifted to Clinical Commissioning Groups (CCGs) and local authorities. Ongeri (2013) in a Housing Learning and Improvement Network viewpoint suggests that supported housing, which includes sheltered housing, should be well placed to provide effective synergy between housing and its services, on and off site support services, and in some cases, care services.

Debates about public sector funding highlight the importance of creative and innovative solutions to transform services to reflect population need. One issue that consistently surfaces in these debates is use of hospital services by older people. More than 2 million unplanned admissions per year in the UK occur for people over 65, accounting for nearly 70% of hospital emergency bed days (Imison, Poteliakhoff, Thompson, 2012). Also, it is this group who stay longer when admitted to hospital, and are frequently readmitted there (Cornwell, Levenson, Sonola, Poteliakhoff, 2012). Various factors contribute to these outcomes in addition to health problems. These include housing conditions and social support that may mitigate against early discharge and exacerbation of health problems. Although this debate centres on cost of care and support, it is important that the personal impact of hospital admission and the related decrease in quality of life for the older person is not forgotten. Leng (2012) suggests that these issues are not incompatible:

> "A well-funded, fully integrated system of care, support, health, housing and other services is essential, not just to provide high quality support for individuals, carers and families, but also to provide good value to the exchequer and the tax payer." (p 4)

If possible older people want to remain in their own home accessing services to optimize their health and well-being. Good models of innovative service delivery exist (The Housing our Ageing Population: Panel for Innovation report, 2009; and the All Party Parliamentary Group inquiry report, Housing our Ageing Population: Plan for Implementation, 2012) whereby

housing and NHS providers work together to provide integrated services. The National Housing Federation (2014) briefing on connecting housing and health highlights the following:

> "Some housing associations will be focused on improving the health needs of their existing tenants, working closely with NHS providers and commissioners to raise awareness of unmet need and how to meet that need…..Other housing associations will be interested in developing their organisation as an integrated healthcare provider this is about developing a new service offer to meet health outcomes frameworks." (p 4)

This paper addresses these issues and reports on the development of an innovative partnership across housing, health, adult social care and voluntary sector organisations. The process for redesigning the sheltered housing service, description of the service delivery model and selected outcomes that have been achieved during pilot implementation of the redesigned service is presented in this paper. In addition to the service partnership, the redesign of the service resulted from a knowledge exchange partnership between North Tyneside Council and Northumbria University. To provide context to the main body of the discussion a brief overview of the Knowledge Transfer Partnership project is also provided.

North Tyneside Homes Services

North Tyneside Council has over 1,000 tenants aged over 60 living in sheltered accommodation. This accommodation includes 26 sheltered housing schemes (10 of these have adjacent bungalows) and 6 group dwelling developments. Securing funding through a Private Finance Initiative (PFI) has enabled North Tyneside Homes (NTH) to embark on a transformative refurbishment and building programme of its entire sheltered housing stock. The building program commenced in April 2014. The buildings will meet Lifetime Homes Standards, have state of the art equipment, be fully accessible, be adjustable to the changing conditions of the tenant and will be dementia friendly.

Exterior views, and plans for dining room and servery area, and main lounge incorporating kitchen area at new development Crummock Court in Howdon, Wallsend

Alongside the programme to transform the built environment the sheltered housing service has been rebranded and marketed, and is now: North Tyneside Living (NTL). This is to give a refreshed, modern image of future housing for older people. The service delivery model, which has been in development since March 2012, aims to optimize the benefits of these environments, and to support tenants to age-in-place. The model that has been evolving is preventative and enabling; and where necessary provides early intervention through partnership arrangements giving access to health and social care services. The aim of early intervention is to support tenants through decline or ill health, and to restore to existing or an improved health status, thus sustaining independent living.

Transforming services through knowledge transfer partnership (KTP)

To realize its vision for preventative and enabling sheltered housing services, North Tyneside Council sought a collaboration with Northumbria University in the form of a KTP. KTP projects are co-funded by Innovate UK and research councils to strengthen the competitiveness, wealth creation and economic performance of businesses through the transfer of knowledge, skills and expertise from UK universities and colleges (www.ktponline.org.uk). KTP projects are resourced by an associate who is employed by the knowledge base partner, and works in the business premises. The associate is jointly supervised by the business and knowledge base to deliver a specific project.

The aim of the NTH/NU KTP was to optimise the health and well-being of older people in North Tyneside Council Housing through a range of preventative and reablement strategies in order to promote ageing in place.

The KTP project plan involved the following activities:

- Scoping local statutory and voluntary services to support tenants' health and well-being (including assistive technology), through service mapping and researching best practice;
- Undertake a health needs assessment (HNA) of the tenant population to inform commissioning of health and well-being services;
- Carry out a risk assessment and develop and implement a strategy for tenant relocation with the transition liaison team;
- Appraise 'early warning' tools and interventions for early detection of health problems in tenant population;
- Development of a training programme for NTL workforce to deliver preventative and enabling services;
- Develop and agree the NTL service model with the KTP steering group;
- Pilot implementation and evaluation of the new sheltered housing service delivery model;
- Develop a strategy for roll-out of NTL service model across NTHs and the local community;
- Disseminate outcomes through workshops, seminars, publicity, multi media reports and professional/academic papers.

Approach to service redesign and development

The KTP commenced with developing an understanding of the local context and the needs of the tenant population. In the context of ageing societies there has been increasing understanding of ageing, and the needs and aspirations of older people. Yet much remains unknown. This is true also of the population of older people who live in sheltered housing. Much is known about the changing demographics and morbidity of this population, however, little remains known about what strategies they adopt to maintain their well-being and achieve their life aspirations. For this reason, the approach to service redesign of North Tyneside Living commenced with a HNA of the tenant population. To do this, World Café events were held with 100 tenants to explore their views of health and well-being; how they maintain health; and, what services they can or cannot access. In parallel to these discussions an analysis of hospital admission data for all tenants during 2012 provided an understanding of this population's use of hospital services.

The findings from the HNA were detailed. For example, tenants indicated that they drew on a range of resources to promote their personal well-being:

- Social well-being: resource examples - relationships with family and neighbours were valued; and services, such as Contact the elderly, enhance social interaction between tenants
- Community well-being: resource examples – service development group; taxi schemes; mobile library
- Physical well-being: resource examples – nutritious meals on a limited budget; falls prevention exercise classes
- Spiritual well-being: resource examples – church groups; funeral preparation
- Economic well-being: resource examples – information services for pension and benefits; bus pass/taxi vouchers
- Environmental well-being: resource examples – home adaptation and handyman service; accessible buildings
- Leisure well-being: resource examples – exercise classes; walking groups
- Emotional well-being: resource examples – friendship groups; advocacy services.

In contrast, analysis of hospital admission data provided a good understanding of elective and unplanned admissions. This is illustrated in the following example. In 2012, 43% of 978 tenants experienced an episode(s) of hospitalisation, (412 elective and 472 emergency admissions). The highest incidence of emergency admission was for Chronic Obstructive Pulmonary Disease, with a total of 131 days of hospitalisation and an average of 4.5 days per admission. The estimated cost to NT NHS was £92,784 (based on HRB national weighted average for non-elective admissions).

The findings of the HNA highlighted strengths in the service delivery model that existed in 2012 (for example, effective processes for service user consultation and engagement; timely and responsive interaction between tenant and sheltered housing officers). Areas for development were also identified (for example a need to support tenants, particularly those living with chronic conditions, to address tenants' nutritional needs; developing targeted measures to reduce the emergency hospital admissions of tenants aged 80-89 as this group has the highest incidence of emergency hospital admissions as a result of pneumonias and fractures). Further

categorization of the HNA findings indicated that there were 3 interrelated areas for service redesign and development. These were:

- Area 1: Prevention, reablement and early intervention
- Area 2: Services supporting and promoting the well-being of tenants
- Area 3: Workforce development.

Some of the issues highlighted during the HNA brought to the fore questions about what is the domain of a housing or health service and adult social care? What services should be provided in the context of sheltered housing? Also, it was clear that some services existed within North Tyneside that tenants were not accessing, thus pointing to the importance of sheltered housing officers (SHO) (previously known as wardens) signposting and referring tenants to services. Examination of these issues within the service development team led to the formation of principles that underpinned the approach to service redesign. These were adopting a:

- Partnership approach between housing, adult social care and community health services
- Cyclical action-orientated approach, commencing with the issue or problem, followed by identification of potential solutions, piloting and testing these solutions, and where effective exploring options to mainstream and roll out the new service, or redesigned process across the sheltered housing service.

Pilot implementation of new services and processes in North Tyneside Living

Since 2012, there has been a programme of pilot implementation studies based on the action-orientated approach described above. An example of an early intervention programme is Falls prevention. Falls were identified as a common problem in the tenant population. Of the fractures that occurred in 2012, 46% were due to a fall. The majority (44%) of fractures occurred in tenants aged 80-89 years old, followed by 32% in those aged 70-79 years.

The sheltered housing management team identified the following potential solutions to reduce or prevent falls: falls awareness training for sheltered housing officers; tenant liaison co-ordinators received low level training in housing adaptations aiming to prevent falls that was delivered by NTH occupational therapists; falls prevention events were held in North Tyneside Living (NTL) schemes with tenants to raise awareness of changes in behavior and environment that could prevent falls; risk assessment carried out by NTH occupational therapists; risk assessment and risk modification carried out in all schemes by sheltered housing officers; building maintenance, carried out on the request of SHO or directly by tenants, by NTH contracted repairs service; falls audit completed following all reported trips/slips/falls; referral to specialist community based health teams for treatment of injury or assessment; and the relocation strategy that addressed risk incurred as a product of the building programme. In this service the SHO is responsible for regular health and safety inspections of the communal areas within the built environment (for example identification of frayed carpets that could be a trip hazard and appropriate action to reduce the hazard).

Direct referral of tenants by SHO's to health services required a new way of working between housing and health services; in this case, the NHS Emergency Care Practitioner (ECP) and Admission Avoidance Resource Team (AART – a multi-professional team). ECPs are specialists in providing health care for older people and can treat minor injuries and illnesses including assessing a patient after a fall, minor burns or scalds; sprains and strains; treat chest

and urine infections; and dress grazes and skin flaps. ECPs can perform diagnostic tests to detect infections and prescribe medication if required. They can also directly refer patients into hospital. The AART team work with people to prevent unplanned admissions to hospital and reduce any lengths of stay in hospital. AART work with a range of patients, including those who are experiencing declining mobility and increasing frailty. Both teams aim to treat an individual in their own home.

SHOs were trained to make direct referrals on behalf of tenants to ECP and AART services. ECPs respond to a referral within two hours and the AART professionals respond within 24 hours. In addition to this, these NHS services also provided over the phone advice to the SHOs on behalf of tenants.

When the pilot implementation programme completed, the following services were mainstreamed in NTL services (in addition to maintaining existing services such as regular health and safety inspections of the communal areas to identify and reduce hazards):

- Regular falls awareness and prevention events with tenants
- Falls prevention training is an element of the sheltered housing officer training programme
- Risk assessment by SHO of tenants to identify risk of falls
- Promotion of self-reporting of repairs to the built environment by tenants to NTH contracted repairs service
- Monthly falls audit across all NTL Schemes
- Integrated services between housing and community health services through direct referral pathways from NTL to NHS ECP and AART services.

The falls prevention programme has been described as an example of the approach that was taken to redesigning the sheltered housing service on the basis of findings from the HNA report. Services have developed over the past two years in the three areas identified for redesign and development of processes. The following lists summarise the services and processes that have been mainstreamed since March 2012

Area 1: Prevention, reablement and early intervention

- Direct referral from SHO to ECP/AART team
- Direct referral from SHO to reablement team
- Tenant database capturing self-reported health status of tenants
- Falls monitoring and risk modification processes
- Relocation strategy
- North Tyneside Homes Dementia Action Plan and Alliance Membership

Area 2: Services supporting and promoting the well-being of tenants

- Community activities
- Dementia friendly communities
- Breakfast clubs

- Cooking and shopping on a fixed budget
- Cooking nutritious meals in a microwave
- Armchair aerobics
- Keep fit
- Natter and knit

Services in planning

- Exploration of the introduction of henkeeping in NTL schemes through Henpower (April/ May 2015)
- Pilot implementation of i-SPY Care Messenger system (a set top box with related cloud based software) that has messaging capacities for tenants to communicate with services, family and friends through their televisions.
- Dementia-friendly sheltered housing communities

Area 3: Workforce development

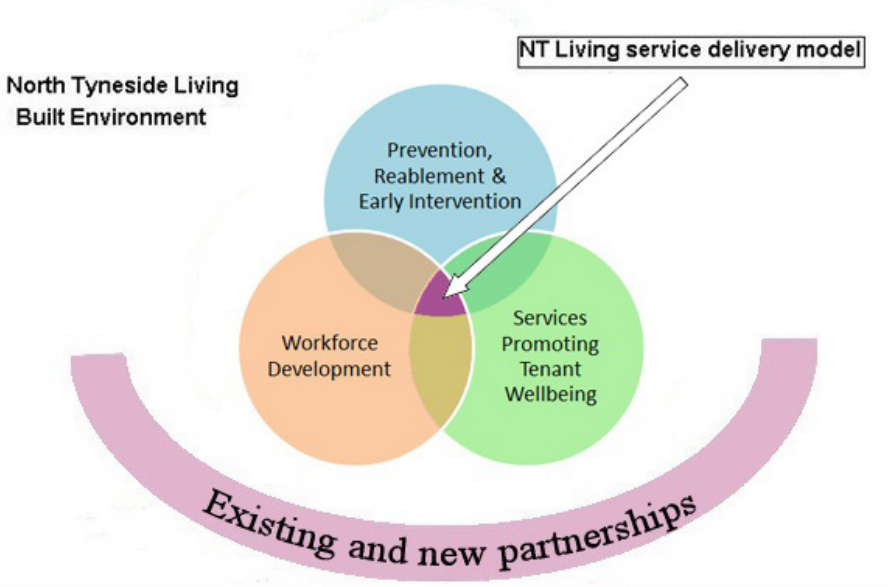
Changes in service provision inevitably have an impact on the knowledge and skills required of the workforce. As services were redesigned and new processes were implemented, a training needs analysis of the existing sheltered housing workforce was completed. This highlighted the competencies that would be required to deliver NTL services. Where knowledge and skills gaps were identified a programme of blended learning was provided. This involved training and workshops for new skills such as use of tele-health modules, and work-based learning to acquire skills such as assisting tenants to engage with community based exercise groups.

North Tyneside Living staff on the telehealth pilot scheme

North Tyneside Living Service Delivery Model

Whilst the three areas - workforce development; promoting tenant well-being; prevention, reablement and early intervention - have been subject to distinct processes during their development the intention was for these to be interrelated in the service delivery model. This is depicted in the following figure.

Figure 1: A Model for Sheltered Housing



The service that tenants experience rests at the intersection between the overlapping aspects of service activity. This service is tailored to the needs of the tenant population because the core of the service development model originated with their understandings of health and well-being that was captured during the World Café events held as part of the HNA. These ideas were balanced with the outcomes of analysis of hospital utilization data which informed decisions about what service developments could have the greatest impact on tenants' health and well-being.

Lessons learned

- Service development, when grounded in an analysis of population need, can enhance quality of life and promote ageing in place;
- Older tenants adopt strategies to optimise independence maintain their well-being and health, and this can be enhanced with person-centred preventative sheltered housing services;
- When illness, injury or decline in tenant health occurs, early intervention and reablement can be provided in their own home;
- Integrated working between public sector housing, health and social care and across sectors can lead to timely and responsive intervention;
- Integrated working between housing, health and social care can result in efficiencies and cost effectiveness.

Conclusion

The service provider would argue that the NTL model is responsive to tenant need as services within this model were based on an understanding of tenants' views and analysis of their use of hospital services. The service is a whole system delivery model for preventative and enabling sheltered housing provision as it is delivered through partnerships between housing, adult social care, health services, PFI partner and third sector organisations. Moreover, as the model develops in the future there is the potential for new partnerships to become integrated into the delivery model with the potential for realising enhanced quality of life for tenants.

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Note

The views expressed are those of the authors and not necessarily those of the Housing Learning and Improvement Network.

About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing Learning and Improvement Network (LIN) is the leading 'learning lab' for a growing network of housing, health and social care professionals in England and Wales involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

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