Integrated lives: building healthier homes and communities

Written by Joe Reeves, Executive Director of Corporate Affairs, Midland Heart. Adapted from an article in Public Finance, December 2016

Personalised support helps people to live independently and keep their tenancies. At Midland Heart we are working with others to provide specialist assistance to various groups, including homeless and older people.

Midland Heart, one of the largest registered housing providers in the Midlands, is working with healthcare colleagues to improve the experience of residents and patients. While joint working is not always straightforward, when it works well, it can reap many benefits, both human and financial.

At Midland Heart, we provide general needs and supported housing to more than 70,000 residents, 12,000 of whom have care or support needs and may need assistance to maintain their tenancies.

Being a landlord often means building close relationships with tenants. We work extensively with them to address issues including hoarding, mobility problems, substance misuse and mental health concerns. This work can lead to significant savings to the public purse.

Our staff have been trained to identify and monitor these issues, and work closely with others including GP surgeries, substance misuse organisations, or aids and adaptations providers to help solve problems and keep people in their homes.

Relationships between Midland Heart and others have developed over time, often resulting from clients' needs and behaviour being identified by housing staff. While these links between organisations are mainly informal, we have recognised they are of such importance that we recently established a people and place team.

Examples of this team's work include supporting customers to visit the GP, putting them in touch with a local aids and adaptations specialist and referral to our in-house money advice team. Using data to anticipate tenants' problems.

Behind the scenes, we are working to improve our customer data so it can be used to identify patterns of behaviour. This will contribute to the development of a unique tenancy trigger system.

By linking information such as the timing and content of help calls with patterns of behaviour, then detecting trends, we hope to gain a good understanding of customers and, ultimately, identify those who might need support to maintain their tenancies. This will lead to earlier interventions, preventing an escalation in needs and reducing the demand on public services further down the line, especially within local health and social care economies.

Specialist supported housing

Research from Homeless Link indicates that the cost to the NHS of poor health in homelessness is around £85m per year. Like many housing associations, we design, build, finance and operate specialist supported housing schemes that focus on individual needs, including those of homeless people.

Tailored packages are by their nature preventive and can offer savings to public services, particularly in health and social care, in the longer term.

Working with Dudley Metropolitan Borough Council, we have opened Saltbrook Place, transforming a traditional homeless hostel into a high-quality accommodation complex. The major refurbishment was financed mainly through Homes and Communities Agency grants, with funding also from Midland Heart and Dudley Council; running costs are paid for through a contract with Dudley Council.

Saltbrook is staffed 24 hours a day and provides a wide range of facilities and personalised support to help people move towards independent living. Customers are assigned a support worker for the duration of their stay who is trained to offer support on a wide range of matters. That might be addressing poor physical health with the use of the gym on site, working with local substance misuse programmes, addressing unemployment through CV writing and volunteering opportunities, or providing meaningful activity to help address mental health concerns or offending behaviour.

Our expertise in supported housing includes direct care provision to older people and supporting the frail and elderly. We have built several flagship schemes made up of homely, independent living apartments with access on site to a variety of facilities as well as care packages, should the need arise. This is intended to help people remain in their own homes while reducing demands on hospital and residential social care services.

Integration from hospital to home

Around 8,500 acute hospital beds per day are unnecessarily occupied by people who are ready to leave hospital, often because there are no suitable options to support them to move on from a hospital stay.

Delayed discharges harm the wellbeing of patients and their families, and are estimated to cost the NHS £820m a year.

We began to collaborate much more closely with the NHS two years ago to address this and developed a pilot reablement service. This was commissioned from Midland Heart by hospital trusts or clinical commissioning groups, often following an open market tendering exercise once the case for a reablement service had been made.

The basic premise was that unused NHS wards would be converted into reablement facilities where care and support staff could deliver a 24/7 service in a less clinical environment, which would be more conducive to reablement and recovery.

Older people deemed medically fit for discharge and who did not require an acute bed were moved to the service directly from wards or from accident and emergency, as well as from community services such as GPs and district nurses.

The reablement team drew up personalised support plans to meet patients' social care needs while continuing to move them along their discharge journey back to home through a multidisciplinary team approach. This involved working with the health, social care and voluntary sectors, making referrals and arranging support packages and home adaptations.

The objective of the reablement service was to free up acute beds and to break the revolving door of readmissions; key performance indicators were included in service contracts to ensure the length of stay was appropriate to facilitate patient flow.

Like many housing associations, we met obstacles to integrating housing and health, including: complex funding regimes; having to forge relationships with many organisations at various levels; diverse and changing demographic needs; and varying stakeholder power in each health economy. We have not identified a magic bullet for making progress, but we feel our focus on identifying individual needs and working with professionals on the ground has been instrumental, allowing us to introduce gradual changes over time that have built trust and led to opportunities for joint working.

These partnerships have allowed us to explore hospital-based reablement and highlight the potential benefit of delivering these types of interventions to help people to return to independent living at home.

The future

For now, however, our immediate focus is on how we can deliver more services to people in our accommodation. We continue to work closely with tenants to address issues that affect whether their tenancies succeed and to find new ways to help people to live independently.

Success requires a coordinated approach. Stepping away from traditional silo working requires strong leadership, a willingness to innovate and a longer term view from the government, commissioners and providers.

We hope our joint working will contribute to debates around prevention and determinants of health such as housing. Equally, plans for devolution and combined authorities in the Midlands may help to create a more unified strategy.

A consideration of integrated commissioning, a long-term view of funding, transitional funds while acute needs are addressed and a vision for how providers such as housing associations can contribute is essential to making progress.

The Housing LIN has started work on a research project aimed at increasing the role of housing associations in reducing the level of expensive delayed discharges from hospitals. Using evidence from existing partnerships between housing associations and local NHS and social care organisations, this project for the National Housing Federation will identify the types of housing interventions that can ensure patients are discharged when they are fit to leave hospital. It will also develop business cases housing associations can use to build partnerships with local health and social care commissioners to deliver their Sustainability and Transformation Plans.

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