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Case Study Report

Approaches to integrated housing, health and social care services: case studies from North Tyneside Council and Northumbria Healthcare

The Care Act 2014 places a duty on local authorities to integrate services, including housing, where this could improve wellbeing by preventing, reducing and/or delaying care needs (LGA 2015). Despite calls for greater collaborative working between housing and health professionals, there are limited examples of live projects taking an integrated approach to service delivery.

This case study report presents three case studies of innovative approaches to integrated working across housing, health and adult social care from North Tyneside Council and Northumbria Healthcare Foundation Trust. The case studies highlight the relevance of understanding access processes within different services, the role of workforce development in aligning referral and access pathways, targeted and more cost-effective health intervention delivery via housing services, and the potential for achieving health outcomes through housing improvement. Understanding of these issues informed the approach that was developed for the co-ordination of services and departments to work together across organization and sector boundaries.

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Introduction

The report 'Integration across government' by the UK National Audit Office (2013) suggests that integration offers the opportunity for the co-ordination of working arrangements where multiple departments or public sector organisations work together for the delivery of a public service or programme. Whilst the European Foundation for the Improvement of Living and Working Conditions (2013) has highlighted the impact that the economic crisis across Europe has had on every aspect of life since 2008, this is only one key factor that has focused attention on the imperative to develop integrated approaches not only for services and teams, but also across housing, health and social care sectors. Other important drivers for the current transformation of public services include improvement through integrated services that promote wellbeing of communities and provide care and treatment in the community rather than through hospital-centric services (Health and Social Care Act, 2012; Care Act, 2014; LGA, 2015; NHSE, 2016).

Figure 1: State-of-the-art accommodation for older people

In England, the Care Act 2014 placed a duty on local authorities to integrate services, including housing, where this could improve wellbeing through prevention, joined-up support, early intervention, reduction and/or delay of care needs (LGA 2015). A key aim of integration is to ensure that services and resources can be better used to meet need. For too long silos in public services have existed resulting in duplication and gaps in provision. In the context of substantial pressure on public finances there is recognition that transformation of the whole system is all-important, yet difficulties remain in practice of how to cross boundaries of knowledge, organization and understanding.

This policy framework is grounded in the substantial evidence of the interrelationship between housing and wellbeing, and the health impact of poor housing (Marmot, 2010; Thomson and Thomas, 2015). Whilst this is applicable to all sectors of society, the interrelationship between housing and wellbeing is particularly evident in later life. Hence, another key driver for integration and partnership working is the expectation that 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 will increase.

The older population and those with complex health problems often require prolonged treatment and care from a range of professionals and carers, services and agencies at the same time. When so many staff, services, sectors and agencies are involved it is all too easy for gaps in care, fragmentation of care, lack of co-ordination between services, or duplication of services to occur. These problems have been well documented.

In a literature review of integrated care, Reed et al. (2005) identified that these outcomes were attributed to the following factors:

- demarcation of professional responsibilities and the 'turf wars' that exist in the boundaries between professionals
- reneging and shunting of responsibilities across the boundary of health and social care
- weak channels of communication between and within health, social care and housing organizations
- information is shared within a service sector, however this does not occur across sectors
- that there are multiple points where older people access housing, health and social care systems with no centralised systems to co-ordinate what / when older people access services
- older people are routinely, systematically assessed and reassessed by multiple agencies and different professionals with minimal or no sharing of this data
- gate keeping mechanisms inhibit the smooth transfer of patients from one care sector to another
- budgetary controls in the UK are divisive and constrain the integration of services, although recent policy has promoted shared budgets and joint funding.

In the decade that followed this review there has been a continual call for joining up of services, yet integrated provision of services remains a vision rather than a reality (Yaxley, 2015). The barriers to integrating housing, health and social care systems are immense. Different governance arrangements, funding streams, regulatory regimes and professional cultures present a range of challenges and layers of complexity that make working together incredibly difficult. Yet this is not preventing determined local leaders from developing small scale, bottom-up initiatives to address local problems and cost-effective sustainable solutions (NHF, 2010; LGA, 2015).

This paper presents three case studies from the North East of England of approaches to integrated working across housing, health and adult social care. The case studies highlight the relevance of understanding access processes within different services, the role of workforce development in aligning referral and access pathways, targeted health interventions delivered in housing services, and health outcomes achieved through housing interventions. Taken together these case studies present illustrations of integration in action.

Case study 1:

Direct referral from North Tyneside Living sheltered housing officers to Northumbria Healthcare Emergency Care Practitioners and Admission Avoidance Resource Teams

North Tyneside Living (NTL), the local authority's sheltered housing service, has placed emphasis on integrated working with adult social care and health services. Since 2013, this has included an innovative referral pathway between NTL and Northumbria Healthcare NHS Foundation Trust's Emergency Care Practitioners (ECPs) and the Admission Avoidance Resource Team (AART) (Marston et al., 2014). These teams are responsible for delivering urgent assessments for North Tyneside residents in health or social crisis, to help them remain in their own home and prevent them attending hospital unnecessarily.

ECPs are nurse specialists in providing diagnostic tests and healthcare for older people, including treating minor injuries and illness (such as following a fall or chest / urine infections), and can refer patients directly into hospital. AART are a multi-disciplinary team who work with people to prevent unplanned admissions into hospital and reduce hospital stays, particularly for patients with declining mobility and frailty. Existing Sheltered Housing Officers (SHOs) (previously wardens) were skilled-up to make direct referrals on behalf of tenants to ECP and AART services. ECPs respond to a referral from SHOs within two hours and the AART professionals respond within 24 hours. Referral from North Tyneside Living has been included in health service referral pathways since the reorganisation of these services, and within social services pathways since 2013. Figure 2 provides a diagrammatic representation of the referral pathway that SHOs follow to refer tenants to ECP and AART services.

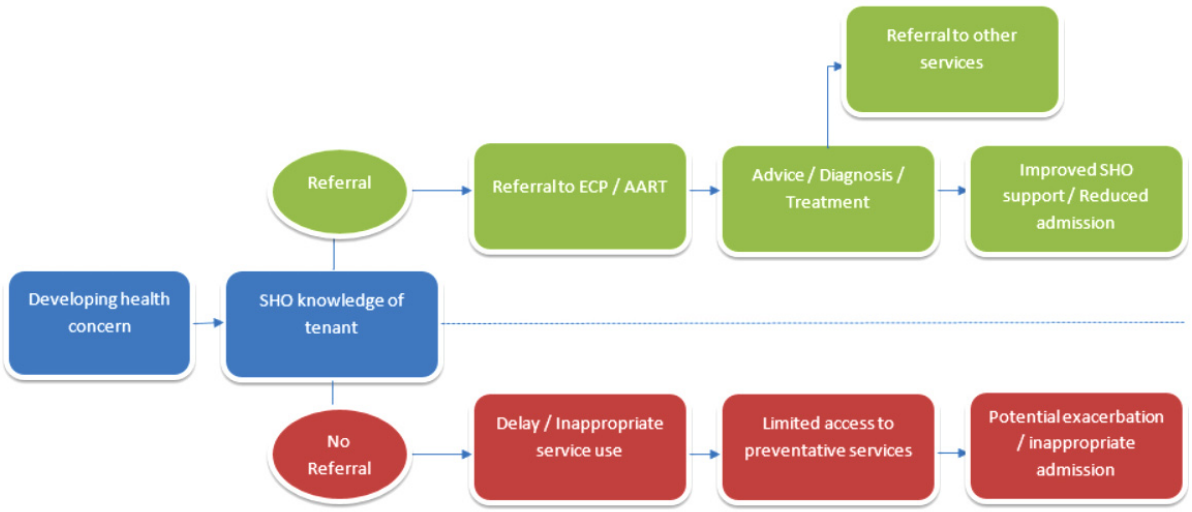

Figure 2: Referral pathway from NTL to ECP and AART services

However, in order to meet the aim of supporting NTL tenants to remain safely within their own home and avoid unnecessary hospital admissions, it was important to recognise the importance of the role of the SHOs. Although not previously included within the health referral pathways for this population, they now provide an invaluable resource to health care teams through sharing their understanding of the needs of the tenants and supporting access to appropriate services. Accordingly, the development of skills for recognition of the early signs of disease or changes in health status, and understanding of health pathways, these workers have contributed to the success of this approach to housing and health services working collaboratively.

Sheltered Housing Officers were initially skilled-up to make direct referrals to ECP and AART services, whilst also being able to access telephone advice from these health services, on behalf of tenants. The SHO's role leads to regular contact with tenants and understanding their needs, which facilitates an early knowledge of any arising health issues. Following identification of health issues, access to ECP and AART services provides early intervention for older tenants with injury not requiring immediate treatment by emergency services, acute illness or an exacerbation in chronic disease. Simultaneously, this improved access further developed collaborative working by allowing the ECP and AART team greater knowledge of tenants in an efficient and timely manner.

During the period January 2013 to the end of December 2015, 161 referrals were made to ECP/AART from NTL. Three of these referrals were not accepted because the service was not operational at the time of referral. 60 per cent (n=97) were dealt with by ECP or AART services alone. The remainder required other treatment from other professionals and services, such as ambulance, GP, district nurse, hospital staff, social workers and telecare services.

The predominantly recorded cause of the referral to ECP and AART were falls (32 per cent), and contact was also made on symptoms such as pain (16 per cent), respiratory illness (16 per cent), swelling (12 per cent) and injury (11 per cent) (multiple causes were recorded). In many instances, assessment and treatment was provided, although in other situations advice, medication administration and referral to other services were carried out. Tenants reported that they were pleased with the overall service given, particularly the speed of delivery. Some also highlighted their satisfaction of care and treatment being provided in their own home and at not having to consult their GP or go to hospital.

Example: Early intervention through assessment and treatment at home

An example of the success of this service included an 80-year old tenant with Chronic Obstructive Pulmonary Disease who was on continuous oxygen therapy and inhalers. During a routine visit from the SHO, it was noticed that this tenant was coughing constantly and, on further investigation, it was confirmed this had produced discoloured mucus. However, the tenant had been unwilling to contact her GP. The SHO then explained the new ECP service to the tenant and the fact that a home visit could be made by a specialist nurse. This was agreed, and following a visit from an ECP, within two hours, steroids and antibiotics were prescribed, a full assessment was carried out and it was decided that a hospital admission was unnecessary. The tenant expressed her gratitude for care and treatment being provided in the comfort of her own home, and confirmed she would be happy to use the service again in the future.

During the operational period of this service, SHOs, ECP and AART professionals were also asked to estimate what services would have been required if ECP and AART services were not available. Of the 135 cases where this was recorded, contacting a GP was recorded for 84 (62 per cent), 22 listed calling an ambulance (16 per cent) and 14 listed contacting a district nurse (10 per cent) (some SHOs recorded more than one). Other services that would have been used included Accident and Emergency, and a NHS walk-in centre. Critically for commissioners within the local health and social care economy, each of these episodes of avoidance to emergency and primary care services offered a considerable financial saving to the respective services, with each visit from ECP and AART having an estimated cost of £50-60. This is considerably less than the use of ambulance and Accident and Emergency services.

Case study 2:
North Tyneside sheltered housing ‘Healthy Living’ pilot programme

The sheltered housing tenant population has a high risk of falls and general deterioration in health. The majority of tenants live with one or more chronic diseases, and nearly half of this population experience a spell in hospital each year (Cook et al., 2016). Whilst this is the profile of this population, preventative healthcare can support individuals to age

well and maintain their health and wellbeing. Common problems such as falls and general deconditioning can also be reduced if positive action is taken to address problems and slow down deterioration.

The National Institute of Clinical Excellence (NICE) guidelines (2016) recommend that any older person with recurrent falls or assessed as having an increased risk of falls should be considered for individualised multi-factorial intervention (COT, 2006; 2015). Components to this are strength and balance training, home hazard assessment and intervention, visual assessment and medication review. NICE guidelines also include encouragement for participation in falls prevention programmes, with specialist assessment from the appropriate healthcare professionals. To be effective in falls prevention the exercise programme has to be of sufficient intensity, progressive and practised regularly (Barnett et al., 2003: Tiffany and Schubert, 2011).

Stevens et al. (2014) found that an effective intervention for falls prevention was an in-home safety assessment visit completed by an occupational therapist. This allows an evaluation of the individuals' ability to complete activities of daily living. Occupational therapists have significant skills and expertise in the delivery of home hazards assessment and safety interventions, taking into consideration the visual impairments of patients. Environmental assessment must be conceived as greater than a 'checklist' determination of home hazards. It is essential that the assessment explores how the actual use of the environment influences the individual's risk of falling.

Physiotherapy is another integral part of the multifactorial approach to falls education and intervention. Age UK (2014) advise that it is important to exercise as you get older to maintain strength, flexibility and energy levels. Aiming to improve posture, co-ordination and balance that will in turn reduce the risk of falling. Activities that promote strength, co-ordination and balance are particularly valuable for older people to help them perform daily activities and reduce the risk of falling and being seriously injured (DoH, 2004). For exercise to be most effective in falls prevention it has to be targeted to those who are most vulnerable and that it addresses key risk factors. These are:

- Strength
- Balance
- Muscle power
- Endurance
- Joint flexibility
- Co-ordination
- Reaction time

The nursing components include monitoring of medication, monitoring blood pressure and consideration of long term condition on falls risk. Patients should have a medication check at least every 6-12 months if taking more than four different types of medication (NICE, 2016). Falls can be caused by almost any drug that acts on the brain or circulation. Monitoring of blood pressure is valid in checking for hypotension. Also considered are a review for adequate nutritional intake and dehydration.

In late 2015 professionals from NTL sheltered housing service and Northumbria Healthcare, and researchers from Northumbria University explored options for a 'Healthy Living' programme

that addressed common problems encountered by older tenants, including risk of falls. The programme selected was a healthy living, balance and gait programme. This was adapted from an existing training programme, previously developed for use at Walkergate hospital in Newcastle upon Tyne.

The programme ran over six weeks and combined structured exercise with educational elements. It was agreed to run the programme in one sheltered scheme to investigate feasibility, acceptability and outcomes. The sessions were delivered by a senior occupational therapist, physiotherapy technical instructor and nurse from AART. The six weekly two hour sessions included an educational element, followed by an exercise class. The educational elements were:

- Session 1 – Exercise and What to do if you have a Fall
- Session 2 – Environmental Hazards (OT focus)
- Session 3 – Medicines (Led by Nurse)
- Session 4 – Food and Nutrition
- Session 5 – Vision
- Session 6 – Footwear and Foot care

The exercise programme was an adaption of Age UK's 'Preventing falls, strength and balance exercises for healthy ageing' (2014), Staying Steady (2016) and the Otago exercise programme (Campbell and Robertson, 2003). This adapted programme was a structured and progressive exercise intervention with key components of warm up, balance and gait training, including exercises that target strength (knee extension and flexion, hip abduction, standing squats, chair raises, toe/heel raises), balance (single leg stand, side stepping), and walking performance (heel/toe walk, walking challenges). Static and dynamic activities included group based games utilising equipment such as gym balls, bean bags, quoits and sticks to promote co-ordination and strength.

Fifteen tenants participated in the programme during February to April 2016. They agreed to the completion of the following assessments prior to and following the programme. The methodology applied was:

- The HOMEFAST (Home Falls and Accidents Screening Tool)
- The Tinetti assessment of balance
- The Tinetti assessment of gait
- The HADS (Hospital Anxiety and Depression Scale)
- The FES-I (Falls Efficacy Scale – International)

Due to 3 individuals not completing the follow-up assessment, paired data for 12 participants was analysed. The mean before and after scores are shown in Table 1 below. Reductions in scores represent improvements in all assessments. Of particular interest, all measures showed a positive reduction in mean score following the class, with the exception of Tinetti gait (in which participations all maintained a highest possible level of ability with a score of 9).

	Before (Mean)	After (Mean)
Tinnetti Gait scores	9.00	9.00
Tinnetti Balance scores	18.00	14.50
FES -I Scores	32.58	31.75
HOMEFAST	1.00	0.42
Had –Anxiety	4.42	4.17
Had – depression	2.83	2.17

Table 1: Mean scores before and after the Healthy Living programme

In order to assess the statistical significance of these results, a Wilcoxon signed rank test was carried out for paired data for each measure. This analysis showed that changes were statistically significant for Tinetti balance ($z = -2.814$, $r=-0.57$), $p = .005$, and FES-I ($z = -2.060$, $r=-0.42$), $p = .039$. This suggests that participants were significantly more likely to have improved balance after attending sessions than before and that they were also significantly less concerned about falling.

Importantly the participants enjoyed taking part in the programme.

> *"Keeping fit helps wellbeing and happiness; singing gives confidence and helps breathing. Getting together helps everyone."*
>
> *"Enjoyed the group, had a good laugh, feel a lot better"*
>
> *"Best thing ever. I feel it has been really beneficial and will continue with the exercises myself"*
>
> *"I enjoyed the weekly keep fit. It gave me ideas of what I can do in my own home."*

These older people indicated that they intended to continue with the exercises they had completed during the programme. This is so important for longer term benefits.

Figure 3: NTL tenants enjoying the outdoor space of their new homes whilst engaging in physical and mentally stimulating activities

This case study demonstrates the positive outcomes and impact on service user wellbeing that can be achieved through housing and health professionals working together. The programme is now being piloted in two other sheltered schemes in order to continue to test feasibility and assess outcomes. The intention is to scale-up this intervention and develop approaches to sustain tenant engagement in regular exercise. However, rolling out this programme across the whole service will require substantial resources from health services therefore the implementation team are working together to consider options for skilling-up other members of the workforce such as housing-based occupational therapists. Sustainable and cost effective options for facilitating regular exercise to support maintenance of the health gains, such as volunteer exercise champions and walk leaders are also being considered.

Case study 3:
Safe and Healthy Homes in North Tyneside

Nationally, the Building Research Establishment (BRE) estimate that the cost of poor housing to the NHS today is between £1.4bn and £2.5bn (Nicol et al. 2015).

In 2013, North Tyneside Council (NTC) completed a Joint Strategic Needs Assessment (JSNA) which recognised that the health and well-being of a population is greatly shaped by a wide variety of social, economic and environmental factors and identified housing as one of the key wider determinates of overall public health in our area. North Tyneside's Director of Public Health and the Health and Wellbeing Board decided that a specific project was needed to address the health impacts of poor housing in the borough. Utilising BRE data relating to the condition of the housing stock in North Tyneside and its impact on health, the Safe and Healthy Homes (SHH) initiative was developed to reduce poor housing conditions in the private sector. Working in the private sector, SHH recognises the responsibility of the homeowner (including landlords) to maintain their property.

Figure 4: Team member Rob helped solve heating and electrical problems at Mr Pagden's home who was suffering from Parkinson's disease and making regular calls to the ambulance service due to respiratory problems

The SHH team has now been in place for two years. SHH officers are trained to identify hazards in the home which affect health. The officers visit all individuals in their home, conduct an assessment of the property, complete a health survey with clients and engage in an in-depth discussion with occupants about the services which may be able to support them. Residents are eligible to receive the service if they live in private sector accommodation with problems which are causing or exacerbating health conditions or have the potential to do so. The team thus focus attention on a population outside of the social housing sector, who may have fewer obvious sources of support and guidance available to them yet may live in accommodation which does not meet Decent Homes standards.

The SHH team provides advice and information to clients about services that can address their housing issues and can refer them to a variety of teams and organisations including:

- Age UK - free draught proofing, energy efficiency advice, carbon monoxide detectors and benefit maximisation;
- Warmzones – affordable warmth partner for free and subsidised heating;
- NPower – Health Through Warmth scheme provider;
- Fire service - smoke detectors and fire safety advice;
- Mears Home Improvement Agency for assistance with repairs and falls hazards;
- Trusted Traders;
- NTC's Care and Connect team for help with social isolation;
- NTC's Select and Direct service which installs minor home adaptations free of charge;
- and Environmental Health which can enforce property standards.

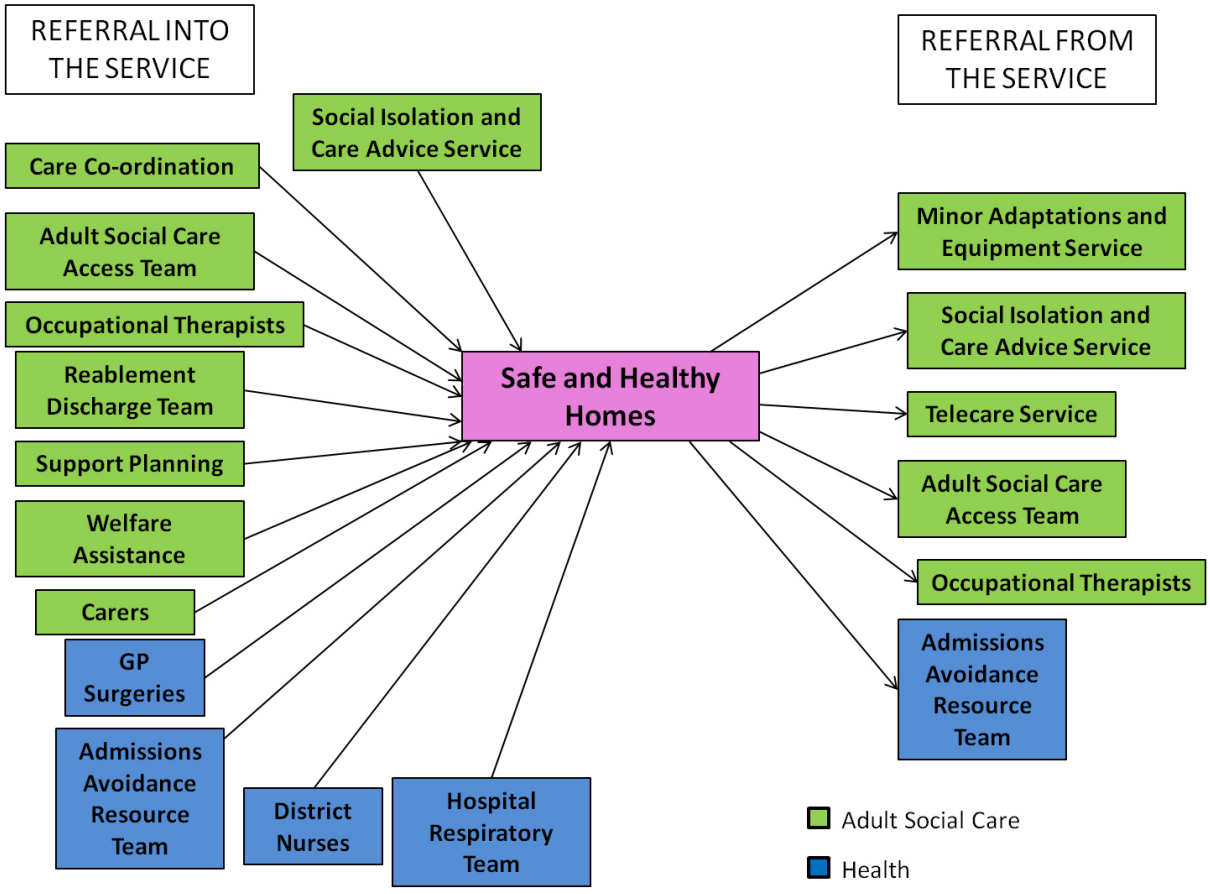

Figure 5: Adult Social Care and Health Service Referrals to and from the Safe and Healthy Homes Service

The SHH team has received over 960 referrals, resulting in over 700 visits to clients' homes since commencement in 2013. SHH receive referrals from residents and other professional teams, including adult social care services, community and hospital NHS services, voluntary sector organisations such as Age UK, and the emergency services. Figure 5 above shows

the referral pathways both into and outgoing from the Safe and Healthy Homes team, for both adult social care and health services. These referral pathways have been developed via a series of information sharing sessions with services to explore whether SHH could assist other teams' existing patients or customers and/or if they could fulfill any unmet needs of SHH clients. Integrating services in this manner has enhanced both the offer of SHH and its referral partners.

Due to a low number of contacts from GP surgeries (13 patients in 13 months) an innovative referral pilot was implemented. Registered patient data is held on a practice's clinical information system and patients with particular clinical or long term conditions are identified on registers. As a result, data from the following registers were included in the pilot referral programme: patients on the COPD, asthma, depression, falls and high risk registers. In partnership with the surgery, we developed a 'flagging' system that provides a pop-up alert on the computer screen when patients on these registers next attended the surgery for an appointment with the GP or practice nurse. This alert prompts the practitioner to discuss with the patient whether they would benefit from assistance from the SHH service. If the patient wants a referral the pop-up alert can be used to make a direct electronic referral. To protect patient confidentiality SHH staff did not view the registers and only received patient details if they had consented to a referral being made. To date there have been a total of 33 referrals from this GP surgery to the SHH service since the referral pathway was established.

Example: A life saving intervention

Client F was one client to have been referred to the Safe and Healthy Homes Team by a local medical practice. Client F was terminally ill, suffering from a number of health issues including angina, diabetes, COPD, osteoporosis and as a result had mobility problems and was being cared for by her partner. When Client F attended her surgery, the practice nurse read the flag on the system and offered her a referral to the SHH team.

Upon visiting the property, the SHH officer's main concern was around ensuring slips/trips/falls risks were reduced given Client F's mobility issues. The officer made referrals to North Tyneside Council's Select and Direct Service which was able to install a second banister on the stairs and a referral to an occupational therapist led to the installation of bathing equipment in the bathroom. Concerned about the temperature in the property, the team also organised a service for the client's boiler and organised draught proofing of the property at no cost to Client F. Social isolation was also an issue and so the client was referred to the council's Care and Connect service who have since been involved in helping connect Client F with local exercise classes, potentially allowing her to improve her mobility and meet new people.

Ms F's concerns about falls and cold have been reduced, and she now has more opportunity to engage in the community and become more active. In her review questionnaire the client claimed that she had felt suicidal before the team's involvement and stated that her Safe and Healthy Homes Officer saved her life.

Discussion and Conclusion

At the heart of the principle of service integration is the acceptance that no one profession or team can fully meet the demands of citizens. This means that all services cannot meet all the needs of service users in isolation and gaps exist. Recognizing these gaps, how they might be filled and, critically, what service currently in existence is able to meet that need is central to the process of integration. Furthermore, service users' needs are varied and complex and only through integrated working by several services will the best outcomes be achieved.

All three case studies demonstrated how professionals reflected upon the services provided, whether there were gaps in service provision, and how the needs of service users could be addressed differently through collaboration with other services. This involved consideration of the existence of other services and the associated workforce; an understanding of its role; and the potential the service has for meeting service-user needs (see table 2 below).

	Case Study 1	Case Study 2	Case Study 3
"Learner Service"	NTL	Health Services	Health and Adult Social Care Services
Gap	SHOs unable to provide rapid medical assistance in situ	Appropriate delivery sites for preventative service delivery	Unable to tackle housing issues affecting health and wellbeing
Awareness Gained	The existence of ECP/AART	The existence of NTL schemes around the borough	The existence of Safe and Healthy Homes
Role	Multidisciplinary rapid response team to prevent admission to hospital	Provision of rental accommodation specifically for those aged 60+	Information, advice and guidance service for those in private sector accommodation which is impacting on their health and wellbeing
Potential	Delivery of medical attention in-situ without GP visit or admission to hospital	Well-placed conduit for delivery of preventative services to older population	Tackling housing issues and other wider social determinants of health

Table 2: Gaps in service provision and potential for an integrated response to address the gap

The case studies highlighted different approaches to integration across departments, services and sectors.

Case study 1 pointed to workforce development being instrumental in enabling professionals to build competencies to fulfil roles required of new referral pathways between housing and health services. By utilising the knowledge and understanding of the health needs of tenants within a workforce usually excluded from health and social care pathways, this allows the targeted services to work more efficiently and effectively.

Case study 2 presented an innovative intervention developed and delivered by health service teams in NTL sheltered housing. This intervention supported NTL's preventative agenda of optimizing older tenants' health and wellbeing and allows health professionals access to a population well situated for receipt of an intervention to prevent falls. Housing, leisure and health teams continue to work together to explore sustainable options for building upon achievements through this six-week programme. For example, older tenants may be invited to volunteer as walk leaders. This approach draws on the social capital that exists within these sheltered housing communities and supports active living in later life (Mohnen et al. 2012). Without housing, leisure and health professionals working together to develop innovative approaches, whilst addressing the inherent risk in the vulnerable sheltered housing population this programme would not have been possible.

Case study 3 presents a housing service that delivers interventions specifically designed to address health issues. One of the referral pathways to this service is direct referral of individuals with specific health problems directly from their General Practitioner or practice nurse. This process increases the likelihood that individuals with unmet housing needs that directly affect their health can be identified. Identifying potential SHH service users in this way required general practice and housing service teams to work together to develop a computer programme within the practice's sophisticated clinical information system, EMIS web, that alerted the GP or nurse to the presence of particular types of patients and a referral mechanism that required minimal time commitment. Hence this is potentially a cost-effective, reliable whole population based approach for housing services to work with general practice.

The case studies draw attention to several themes. These include:

Co-operation and partnership between individuals and teams were critical to the successful implementation of each of these innovative services. For example, in case study three, the initial attempt to programme the general practice clinical information system led to over 150 discussions but only 6 referrals to the SHH team. Analysis of the initial pilot data led to rewriting the programme and targeting of different patient groups. This required commitment and co-operation of housing and health professionals to develop a successful referral process that worked well in both organisations. In this instance decision making occurred at the local level between service leaders rather than having to overcome the complexities that exist in housing and healthcare organisations. More importantly, the outcome led to individuals with specific health and housing problems being supported with relevant interventions.

Prevention and early intervention is a key aspect of all the case studies. Whilst the focus in each of the developments discussed in this paper is different, the focus is on supporting people in their communities and providing services that have the potential to optimize wellbeing and not just preventing hospital or care home admission. The Chartered Institute of Housing has argued that there is too much emphasis on commissioning for higher level need at the expense of lower level preventative services (CIH, 2012). Our case studies demonstrate that service

outcomes can be achieved through the implementation of preventative strategies that aim to improve wellbeing through addressing health problems and optimizing the capabilities of service users. While such preventative strategies may appear to be difficult to identify or implement, each of these case studies illustrates that the necessary information and understanding may already exist within other teams which sit outside of existing silos.

Lessons can also be learnt about what works and does not work from these case studies that aimed to develop integrated services where this could improve individual and community wellbeing through prevention, joined-up support and early intervention.

In addition to the commitment of professional leaders locally, the aspects of the services and interventions that worked well required service and system transformation of housing, health and social care systems. This was achieved through linking systems and referral pathways. Skilling-up the workforce is essential to make these 'linkages' work. For example, in case study 1 the SHOs required knowledge of NHS services and the competence to assess when older tenants required referral to the ECP and AART teams. This suggests that the integration of systems required skilling-up a workforce and placing individuals and roles in a position where they can facilitate navigation of service users through systems and across health, housing and social care sector boundaries. The demonstration that this is an effective approach to integration rests in the evidence of whether it allows each contact with the system by a service user to occur in a context that links the service user to the appropriate service or professional and bridges gaps within and between services.

And lastly, the key question is how to scale up these types of small local successes so they become a consistent feature of mainstream services. The Local Government Association (2015) suggested that this is one of the major future challenges for all services:

> *"Currently innovative developments led by the housing sector tend to be developed largely as one-off projects, rather than the adoption of large scale institutional change"* (p.12).

All of the case studies discussed in this report, highlight the need for local leaders who are committed and are flexible in their approach to design services around local need that can be implemented and sustained within local contexts. Some of the solutions were quite straightforward to develop and others required complex transformation of the way that services work together. The overriding message from these innovative approaches is that they do work, the service can be adopted at-scale, and they do provide a better quality of service to the user.

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Other Resources

Video on Supporting Independence and Improving Health and Wellbeing for Older Tenants: https://www.youtube.com/watch?v=_212Z8V6ehI

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Note

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

About the Housing LIN

The Housing LIN is a sophisticated network bringing together over 40,000 housing, health and social care professionals in England and Wales to exemplify innovative housing solutions for an ageing population.

Recognised by government and industry as a leading 'knowledge hub' on specialist housing, our online and regional networked activities:

- connect people, ideas and resources to inform and improve the range of housing choices that enable older and disabled people to live independently
- provide intelligence on latest funding, research, policy and practice developments, and
- raise the profile of specialist housing with developers, commissioners and providers to plan, design and deliver aspirational housing for an ageing population

To access further information and resources on the links between health and housing, visit the Housing LIN's dedicated online 'Health Intel' pages at:
www.housinglin.org.uk/ Topics/browse/HealthandHousing/

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