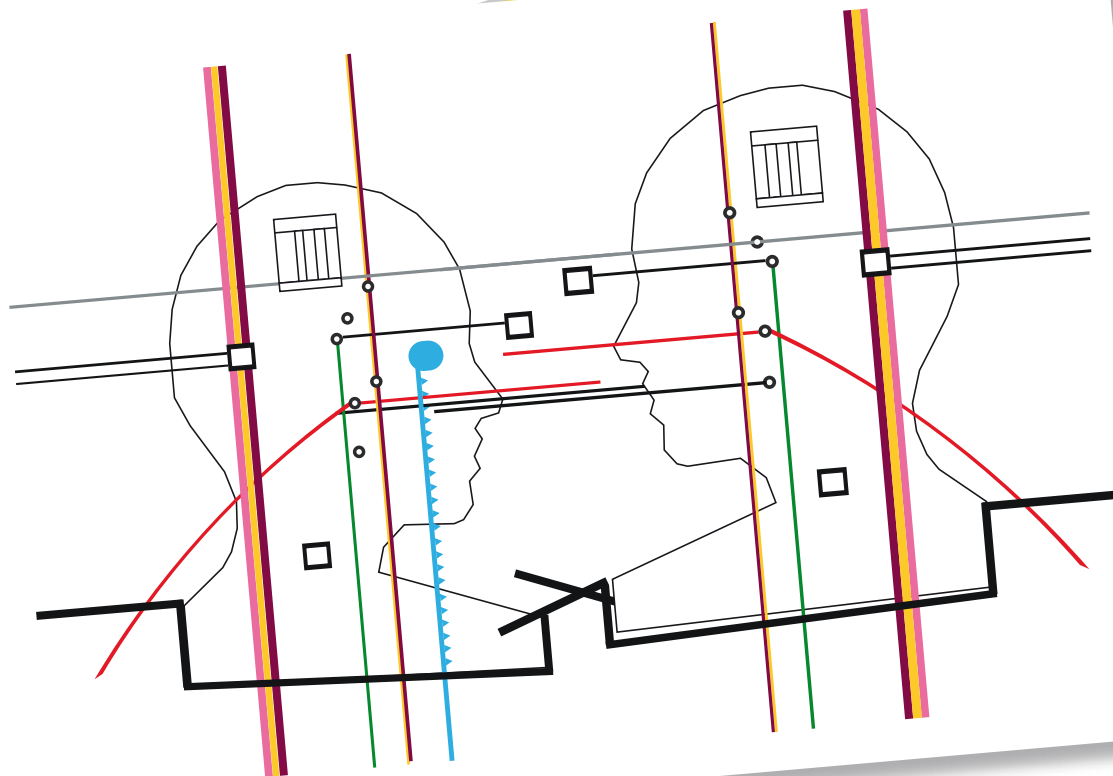


Going Round the Houses

How can health and social housing sector professionals forge better links and what might the benefits be?



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Executive Summary

This research was inspired during a chance conversation about a client who was suffering from poor mental health. The social housing professionals were struggling to engage in meaningful conversations with health professional counterparts to help the client. This prompted questions as to why this was the case and whether these poor experiences were a regular occurrence.

This research uncovers the truth about the poor connections between social housing and health professionals. It maps out emerging issues and identifies opportunities to improve connections and the benefits of doing so. It has been written as one of the core requirements for the Clore Social Leadership Programme and aims to contribute to the body of written work relating to social housing. This qualitative research is based on six in-depth interviews, a case study and desktop research carried out in 2014-15. It is written primarily from a social housing professional's perspective and uses the term 'client' in preference to either 'tenants' or 'patients' as a common term that both sector professionals can relate to.

The research shows that there is a quiet revolution taking place on the frontline and identifies five key emerging trends that are impacting on social housing and health professionals. These are:

- i. A shift from health care provision in the hospital setting to the home
- ii. An increasing need for caseworkers to know more about navigating both health and social housing systems than their clients
- iii. The rise of people with long-term complex multi-faceted problems including physical and mental health issues
- iv. Introspective performance management targets which make driving collaboration increasingly difficult on the frontline
- v. Funding cuts impacting on both sectors – but an acute awareness that the client should still be centre stage

These trends indicate that, without adopting a collaborative approach, both sectors will increasingly struggle to effectively manage their services in the very near future. However, it is reassuring to note that there is determination on both sides to forge better links and work together in partnership.

During the course of my research a number of practical solutions were discussed in response to the trends identified. These include recommendations that require little or no capital costs, as well as strategic actions that can make a difference locally and regionally. These have been collated into an eight-point action plan:

- i. Start as you mean to go on: require frontline officers in both sectors to 'work shadow' each other at induction and regularly throughout their careers.
- ii. Redesign services with the client at the heart: Once relationships are established, it is far easier to carry out holistic service provision that puts the client centre stage in a meaningful manner.
- iii. Build up a 'terms of engagement' around how data is shared: A common obstacle in driving collaboration was the lack of information sharing capacity.

- iv. Adopt an integrated approach at a strategic level: Both sectors should be involved in setting a joint model for working together at a strategic level. Current forums already exist at a regional level such as with Clinical Commissioning Groups or Health and Well Being Boards and would provide a good setting to map out joint models.
- v. Be aware of the evolving context and strategic direction of the NHS: Over the next five years the NHS proposes to shift the focus of care and public health initiatives to the home and local community. This will clearly have an impact on how health and social housing professionals will interact over the coming years.
- vi. Work together with local mental health trusts and hospital trusts to develop or use existing forms of social housing more effectively: There is an acute shortage of bed spaces in many local hospitals and mental health trusts. Social housing professionals have experience and capacity to help house vulnerable members of society. There are a number of emerging examples of significant savings made through partnership working.
- vii. Adopt an explicitly psychological framework specifically within the social housing sector: This would help legitimise using different approaches that take into consideration health issues when managing tenancies. For example undertaking training that helps staff spot signs of mental health crisis. It would also inform the development of a more sustainable form of housing management that is less reliant on legal interventions.
- viii. Let go of inward looking performance management styles and adopt a collaborative model: This would give both sets of professionals the authority to reach out and build networks between sectors. It would cultivate innovative approaches such as ‘social prescriptions’¹ and give caseworkers much needed mastery in navigating their local health and housing systems.

This research calls for action from leaders in both sectors to nurture collaborative working. It proposes a range of practical changes that they can adopt. It also sets out why this is important given the context of emerging trends, whose scale and impact cannot be ignored, if the sectors are to continue to provide their much needed services effectively. As this health professional put it so aptly:

“What we’ve got to do is pull ourselves out of this silo environment we’ve been operating in, so health thinking ‘we just make people better’. Housing thinking ‘we just need to provide a roof over someone’s head’. We’ve actually got to join that together”

1 Social prescribing is a mechanism of linking patients with non-medical sources of support within the community; Source: Study into the Impact of the housing workforce on Health Outcomes, March 2015 (Sitra and Public Health England).

Section 1: Preamble and contextualisation

This section sets out the background and context within which social housing professionals are increasingly working in, and seeks to describe the emerging scene. It begins with a case study, describing a typical working day on the social housing frontline and continues by setting the operational context.

Case Study: A typical Neighbourhood Officer's day, 9:00am

A neighbourhood officer, T, starts her morning dealing with administrative matters then moving on to her first interview of the day at 10:00am. She meets a client who has come in to complain about noise nuisance from his neighbour. The client is unhappy as his neighbour played loud music late into the evening and generally keeps unsociable hours. This is not the first time this client has come in to complain. This seems to be a 'lifestyle' clash as the complainant is an older client in his 50's whilst his neighbour is a young man in his 30's. In addition, she notes that both neighbours suffer from enduring mental health conditions. The neighbourhood officer admits she has few connections with health sector professionals and struggles to engage with them in a meaningful way.

This is a typical scenario faced by frontline social housing professionals on a daily basis. Traditionally, neighbourhood officers deal with these types of issues through a complaints system or through anti-social behaviour case management. However, it is clear that these options will not be effective in dealing with the issue on a permanent basis.

This case study highlights how health and housing issues are closely related; yet social housing professionals have limited experiences of interaction with health professionals even though they see the same person in different settings.

Social housing professionals are increasingly struggling to deal with the underlying causes of these neighbourhood issues in an effective way. In many cases, they are treating the 'symptoms' of mental health issues as 'complaints' or 'anti-social behaviour'. These issues form the bulk of the work that they deal with as this social housing professional says:

"We do have a lot of customers affected by mental health and drug and alcohol issues, and for us it's not about saying 'We won't house you', it's about saying 'Have you got the right support in place to support you, to maintain your home, and do it in a way that you don't breach your tenancy?' So for us making sure that support is in place is really key, and I think it's very difficult because there have been so many cuts...particularly drugs and alcohol and mental health".

There is a direct correlation between the funding cuts to the health sector and the increasing costs of managing neighbourhoods successfully. When a social housing professional is unable to secure the right help for their client, they will revert to enforcement action. This is a costly process, as another housing professional recalls a recent case where the client had a mental health illness:

“It was really difficult because we just couldn’t get him the support he needed, nobody wanted to know, every agency was wanting to pass that responsibility onto somebody else...It got to the point where we were about half an hour away from eviction before any support agencies would get involved and it was a really difficult decision for us... because we just wanted to get him some help”.

Most housing associations use varying degrees of enforcement action to deal with mental health issues, majority of which will be classified as anti-social behaviour. This is a costly means of managing neighbourhoods that is not sustainable. As is noted below, the cost of anti-social behaviour to social landlords is on the rise:

Recent House Mark benchmarking data reveals that cost of managing anti-social behaviour has increased to £295 Million (2012/13) up from £270 Million (in 2011/12). The median cost per case in 2012/13 was estimated at £709 (from a data set of 318 social landlords) and half the landlords recorded costs per case of between £454 and £1,061. They also found that the typical landlord spends on average £33,238 on each full time post to tackle ASB.

ASB Benchmarking-Analysis of results 2013/14 (Housemark) p5, pp21-23 (John Wickenden, July 2014)

The House Mark report states that referrals to external agencies make up fewer than 8% of the total number of actions and there are considerable differences in the number of referrals. For instance, there were four times as many referrals to the police as there were to mental health teams. They note further that over 80% of social landlords’ day-to-day actions to tackle anti-social behaviour involve interviews, visits, warnings and other intervention work prior to taking legal action or involving external agencies.

With increasing strains on resources – from other areas such as welfare reform – it is clear that current methods of operation will need to evolve if the social housing sector is to cope. At the same time, the health sector is changing the way it operates and the nature of health care provision will change, as this health professional puts it:

“We have an increasingly elderly population and a population that is suffering from long term ill health conditions, so the health sector itself is having to change the way it operates and the health sector certainly needs to start interacting with other sectors, because when you look at the determinants of bad health, many of those root causes go back to housing and I think traditionally health has been there to put the plaster over the wound, but health now needs to work with partners to try and address that wound developing in the first place”

Some housing associations have taken on tenancy support co-ordinators or run family intervention programmes to help the most vulnerable clients. But this is only aimed at small proportion of the client base.

There is a real need to widen the networks of frontline social housing professionals with health sector counterparts as this will increase efficiency and productivity in both sectors. This would have a number of benefits, for instance, it would improve working methods so that health and social housing professionals can focus on preventing, reducing and delaying needs for care and support, rather than only intervening at crisis point. It would also enable both sectors to evidence that they have responsibly discharged their duties as set out in the Care Act 2014² (the Act). The Act has raised the profile of housing where provision of suitable housing accommodation is defined for the first time as a health related service and significantly imposes a duty to co-operate particularly in safeguarding of vulnerable adults. Finally, and perhaps most importantly, partnership working between both sectors would provide clients with better levels of care.

2 See the Care Act 2014, Part 1, Section 3- promoting integration of care and support services where the provision of housing accommodation is defined as a health related service. See also Sections 42-45 for new statutory duties which include a duty of co-operation relation to safeguarding of vulnerable adults.

Section 2: Emerging trends in health and social housing sectors and their implications

This section will consider the wider emerging issues within both sectors. This information is drawn primarily from interviews, a case study and desktop research. These issues have been divided into five themes:

- i. A shift from health care provision in the hospital setting to the home*
- ii. An increasing need for caseworkers to know more about navigating both health and social housing systems than their clients*
- iii. The rise of people with long-term complex multi-faceted problems including physical and mental health issues*
- iv. Introspective performance management targets that make driving collaboration increasingly difficult on the frontline*
- v. Funding cuts impacting on both sectors – but an acute awareness that the client should still be centre stage*

We continue first with the case study of the typical neighbourhood officer's day which highlights the increasing frequency of health related matters faced. It establishes the need for improving links with health professionals.

Case Study: A typical Neighbourhood Officer's day...continued

After the meeting ends, the neighbourhood officer goes back to her desk to file a record of notes taken. She briefly turns her attention to the post received that morning. She has received a letter from another client's doctor. The doctor has written that the client's health is being adversely affected by poor relations with nearby neighbours. The doctor recommends that the client be moved to another property. This letter is typical of most interactions that the neighbourhood officer has with health professionals.

Later in the afternoon, she spends another two hours dealing with another client who also suffers with mental health illness. She estimates nearly 50% of her caseload is generated from mental health illness. In common with many sufferers, the symptoms of the client's condition change over time. These have worsened lately, and anti-social behaviour incidents have been reported to her. She plans to carry out a joint visit the local policing team (Safer Neighbourhood Team). It has not been possible for her to contact the health professionals her client is seeing. She has few connections. She says 'it is not easy to figure out who or which team to speak to for help'.

The case study indicates the high proportion of time spent by neighbourhood officers managing health related matters and the need for closer working relationships between health and social housing professionals to provide more effective services.

The case study also highlights that social housing professionals are most likely to contact the police than other agencies including mental health services. In part, this is because there are already established working relationships with the police service. It is clear that there is scope to build similar working relationships between health and social housing professionals to provide that final link which secures better outcomes for clients.

Trend 1: Out of the hospital and into the home

Health providers are under pressure to minimise the amount of time that patients spend in hospital. A key driver for this are the high costs associated with this as this health professional points out:

“If you think about a health bed...costing between £350 and £550 a day, it’s not a cheap place to keep somebody who doesn’t need to be there”

Furthermore, there is evidence that prolonged stays in hospital can have an adverse effect on recovery times for patients as this health professional explains:

“Unfortunately...there are some older people who are medically fit, but they’ve been in hospital for 30-40 nights when they did not need to be there at all, and their condition deteriorates because of the environment they are in. They lose their confidence...Home is where people want to be, not in a hospital”.

The greater focus on care taking place in the home will have major implications for the way that social housing professionals work as the number and frequency of health related matters increases. To respond, current models of working practice must change with a greater emphasis on effective referral at an early stage and utilising networks of support. A recent report into the future of frontline services states:

*“I don’t think the traditional model of housing officer will exist within three years. It’ll be more akin to a relationship manager with a network of support on and offline... from doing rents and lettings, we are now going into a support role which is completely alien to general needs housing”.*³

With the change in the operating environment, and impacts and costs described, it is clear that health and social housing professionals will need to work in partnership and increase their networks.

There are a number of benefits that would arise from acknowledging this shift in the operating environment. Social housing professionals would benefit from effective case management as they would be able to call on health professionals’ advice early on. It would improve the efficacy of interventions, increasing the range of solutions, so these would not be limited to either ‘complaints’ or ‘anti-social behaviour management’.

Health professionals would benefit not only from clients spending less time in hospital but also have the added benefit of knowing that they are well supported within the home environment by social housing professionals. Similarly they too, would have an increased the range of tools available to help clients recover. For instance they could work with social housing professionals in the providing ‘social prescriptions’ in addition to medical or clinical interventions.

³ Frontline futures, New Era- Changing role for housing officers by Jo Richardson, Lisa Barker, Jacq Furness and Merron Simpson) CIH/ Wheatley Group p. 13

Trend 2: Case workers need to know more about navigating both health and social housing systems than their clients

Both sets of professionals note that their efforts to work collaboratively are hampered because they struggle to navigate each other's systems. As cited in the case study social housing professionals describe just how difficult it is to understand how various health partners work together:

"In my experience, it's how the agencies link together, its identification of health issues and getting people the right support and engagement with the right agencies... to deliver what's best for that tenant and that is just like banging your head against a brick wall a lot of the time".

Data protection was also cited as a major stumbling block, impacting the ability to manage caseloads. Both health and social housing professionals echoed these thoughts, noting that the structural systems in place limit the easy resolution of issues as this health professional notes:

"I think there still is quite a gap between health professionals and social housing professionals, mainly relating to the structural way that services are delivered and that people tend to work in their own professional silos"

Thankfully, this failing has been recognised by health professionals and is clearly set out in the NHS's 5 Year Forward plan which specifically advocates greater community engagement and partnership working:

"One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'. Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and underdeveloped advocacy and action on the broader influencers of health and wellbeing".⁴

This shift in focus within the NHS presents a number of opportunities for health and social housing professionals to form strategic and productive alliances. This would create partnerships that puts clients' wellbeing at the heart of decision making. This is easier said than done especially given the complexity of the NHS. As this health professional explains:

"One thing I noticed when I was speaking with your colleagues was how they were amazed at all the twists and turns in the structures of the NHS... and I think it must be very difficult for people working in those sectors to keep up with all the many myriad of changes in the way the NHS is being managed and run".

There are some very good sources of information which can help increase understanding. These include the Kings Fund website, which provides an introduction to how the health system works⁵. County council websites can also assist; see this link to Norfolk County as an example: www.norfolk.gov.uk/Health_and_wellbeing/Norfolks_health_system_explained

4 NHS Five Year Forward View (October 2014) p.9, <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

5 The Kings Fund, [http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england \(updated April 2015\)](http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england(updated%20April%202015))

The National Housing Federation's series of publications titled 'Routes into Health', initially published in 2013,⁶ provide useful in-depth analysis for social housing professionals who would like to understand more about working with health professionals. In particular, their recent report titled 'Prescription for Success - How housing can make the economic case to health' can help inform social housing professionals on how to build relationships at a strategic level.⁷

Trend 3: The rise of people with complex multi-faceted problems including physical and mental health issues

Both sets of professionals reported that they are starting to see the rise of more complex, multi-faceted health issues among the populations they work with. This finding has been reported elsewhere and it is estimated that there are more than 15 million people in England living with a long-term condition⁸, and by 2018 the number of people with three or more long-term conditions is expected to rise to 2.9 million; in 2008 this figure stood at 1.9 million.⁹ This health professional reiterates the long term aspect of mental health care provision as observed in practice and proffers his thoughts on future management of symptoms:

"[For] many people who have enduring mental health issues [these issues] are never solved, it's a chronic, long term condition and like lots of long term conditions, it has exacerbations and then it has periods where everything calms down again... but there is a need for some degree of input to maintain people and to reduce the risks of these sorts of peaks and troughs"

In addition, this social housing professional describes how other complexities arise when clients with mental health illness choose not to take their medication or engage with services. This typically leads increased anti-social behaviour that has an adverse impact on the wider community:

"I ... think mental health is incredibly difficult, because people can choose whether or not to take their medication and the cases we see where people choose not to take their medication are the ones where we tend to see there's an impact"

Both sets of professionals also expressed their concerns about changing demographics and in particular the impact of an ageing population. This social housing professional was concerned about the type of housing stock that would be required given the changes in household formation:

"The population is getting older and the statistics seem to point out that actually, in 10-20 years' time, most households will have someone over 60, so that's really interesting because we need to look at whether or not our stock is built for that and is built to accommodate that."

6 <https://www.housing.org.uk/publications/browse/routes-into-health>

7 McDaid D, Park A, Eliot J, Livsey L, Swan A (2014), *Prescription for Success - How housing can make the economic case to health*, National Housing Federation, London School of Economics and the Personal Social Services Research Unit. [Available at: <http://www.pssru.ac.uk/publication-details.php?id=4845>]

8 Department of Health (2012), *Long Term Conditions Compendium* (3rd edition)

9 *Managing Long Term Conditions in the Community*, part of the *Connecting Health and Housing Briefings*, National Housing Federation

The changes described above indicate that traditional ways of working will no longer be fit for purpose in such a dramatically changing landscape. A new methodology is thus required, one that focuses on working collaboratively and innovatively between both sectors.

Trend 4: Introspective performance management targets that make driving collaboration difficult on the frontline

At a strategic level, both health and social housing organisations promote partnership working. However, this does not always translate at the operational level when performance management targets for those on the frontline are evaluated. These are often 'inward' looking and do not drive efforts to secure collaborative outcomes. At worst, these can be treated as 'tick box' exercises which can leave clients at risk. One health professional describes how this drives staff to 'track back' and become less collaborative:

"When there is more pressure on...the more people will track back into the boxes and...become less...collaborative, and much more about being targeted against X or Y... in a more relaxed environment, you can do that compromise and crossover, when it's as tight as it is at the moment, I think it's increasingly hard for people to see outside of their box. And that's not always through lack of will, it's just about the constraints that are put on people.

Conversely, this social housing professional explains why she is successful in her role. She attributes this to the links and networks she has outside of her organisation:

"I think it really depends on...what experience they've got and also what sort of networking they've done outside the organisation...for me, I don't see it quite as a problem...whereas others...don't feel comfortable with going out and saying 'can you help, can I come and see you? I want to chat about something'. They find networking quite difficult".

The way in which individuals performance targets are set need to change and become more flexible so that real partnership can be nurtured. There needs to be a shift in the way organisations operate, such that they are better able to recognise their role within a network rather than as stand-alone organisations. However, letting go of old management habits won't be easy. As this health professional explains why there are little or no links between health and social housing professionals:

"We don't understand what their day to day pressures are...they don't understand who we are and where we operate, they don't understand if there's anything we can do to help them and they don't understand if there's any way they can help us".

Trend 5: Funding cuts impact everybody – but the client should still be centre stage

Not surprisingly, both sets of professionals cited increased funding cuts as a key source of tension, but were keen to keep the needs of their client centre stage. Cuts to funding are taking place in a variety of settings. As this health professional explains, it has meant that housing options have been severely restricted:

"the problem is that it's not just the health budget that's been cut, its social services [as well], so therefore placement panels are much more difficult to [secure]...Where in the past we would have moved someone into residential housing for a period of time while we looked at housing... this is unlikely to happen now".

On the other hand, social housing professionals argue that the impacts of these changes are felt most where clients struggle with the welfare benefit system. This social housing professional cites this as especially disruptive for those unable to budget, and who suffer from mental health issues. She sees this as the biggest cause of anxiety in how she manages her patch:

“I think the main issue on the financial side is...universal credit coming in...So it will be very, very different, I think, how we work this year...anyone with any health problems, mental illness or who just can’t understand money, can’t budget – then that’s where our work is going to be cut out...I would say about 50% of our tenants suffer from some sort of depression or anxiety.”

Furthermore, the acute shortages of social housing are also beginning to impact on patients asking for help from health practitioners. According to this health professional the shortage of social housing is evident in the requests he receives from his clients:

“What we were aware of was the issues about the shortages of social housing...about the volumes of individuals wanting to be housed under social housing and that clearly there was a preference for people to be within social housing, rather than privately rented housing because it offered better security and also social housing offered a wider range of support to individuals than people who were purely renting in the private sector.”

With more funding cuts expected in the near future, both sectors will need to act decisively to find ways to manage the impact this has. Likewise, with increasing expectations from clients for better care and services, as well as greater legal responsibilities to safeguard their clients, professionals will need to forge more comprehensive links among and across different sectors¹⁰. Ultimately, it is important that the links improve dramatically if there is any hope for the client to remain centre stage as this health professional urges:

“What I’m saying is there is a common denominator...that customer[s] in the middle and the three people around the outside are not making the link, so how can it ever come back to the person being well if the three people on the outside aren’t linking. It’s impossible”.

Section summary:

This section has explored a number of common themes that are affecting the operating environment for health and social housing professionals. It began with a description of the typical neighbourhood officer’s day. The case study highlighted the increasing frequency with which social housing professionals deal with health related matters and the need for closer working relationships between health and social housing professionals to provide more effective services.

The section then described the common themes identified from the interviews carried out and how in some instances they impede collaborative working between both sectors. It focussed specifically on the impact of care increasingly taking place in the home within the context of the increased levels in care needed as clients present with more complex multi-faceted problems including physical and mental health conditions.

¹⁰ As before described, the Care Act 2014 makes a clear link between housing, health and wellbeing; establishing a duty to co-operate generally.

Finally it reflected on the impact of a tougher operating financial environment for both sectors, but highlighted the need to keep the customer centre stage. With such a challenging backdrop it is clear that better links are needed if both sectors are able to cope with the changes. In the next section, I introduce some of the ways in which collaborative working can be achieved.

Section 3: Recommendations for better collaborative working and the benefits of doing so

During the course of this research, I asked interviewees for examples of good practice of collaborative working between housing and health. Very few of those interviewed could provide any examples which highlights why better collaborative working is needed. In this section, I outline some ideas of how we can increase collaborative working between both sectors and the benefits this can have.

Case Study: A typical Neighbourhood Officer's day... the end

We are nearing the end of our session together with neighbourhood officer T. As she works, she reflects on some of her experiences with health professionals. She tells me more about a recent experience of helping a client who was struggling to sustain his tenancy. She had been made aware of a number of incidents being reported by neighbours concerned for his health. She had tried to deal with this, and had written to various bodies for support without success.

Eventually, the client was arrested by the police but it was clear that he needed urgent medical help. The client was sectioned in various 'out of county' locations including Bradford over a period of approximately six months before being released. In the meantime, the social housing landlord faced significant costs in making his flat safe and habitable. The neighbourhood officer told me she had been invited to the 'discharge' event by the mental health team and it was here that she made some valuable contacts. She has now got an agreed plan with the team to assist the client at an early stage whenever incidents arise.'

Although in this case, it took some time to establish a meaningful relationship, when both health and housing professionals work together they achieve better long term solutions for the client.

The preceding section described some of the issues that are emerging and highlighted how these issues require collaborative working for future success. This is an opportune time to forge better links at an operational level given that this has been acknowledged at a national level as this health professional notes:

"I think certainly the NHS has got the message now about even greater focus on the holistic needs of people and communities...I'm sure when public health doctors map out health needs, they will find that the super output areas which have concentrations of social housing, are the ones where there are particular issues to do with long term conditions, premature death and a number of those morbidities which impact on the cost of the NHS but more importantly, on the quality of lives of those people."

With links between health and social housing still at an early stage at an operational level, interviewees were asked to describe their vision for the future. This elicited a number of innovative ways in which collaborative working can be facilitated. The suggestions have been collated into an eight point action plan:

- i. **Start as you mean to go on:** Organisations in both sectors should enable frontline officers to 'work shadow' or 'co-locate' with each other at induction and regularly throughout their careers. This is important because it will increase knowledge sharing. It would also build up genuine understanding of the challenges each sector

faces giving a more informed view. As this social housing professional suggests:

“I think it’s important to shadow when you’re training, and that you don’t get sort of dropped in it, because that’s where you’re setting up a member of staff to fail”

- ii. **Redesign services with the client at the heart:** This would generate multiple benefits for both sectors. It would enable them to assess the impact of the emerging issues described in Section 2 in a holistic and practical manner. It would also engender innovation in how health and social housing professionals can support clients with long term conditions carry out self-care such as through use of aids and adaptations to the home. Overall, there would also be lower levels of costs when compared to care provision in traditional institutional settings. This would not only free up capacity in hospitals but also ensure it is aimed at those most in need. Ideally changes could look further at promoting independence as this health professional states:

“The future of health and care services is not about institutionalising individuals with those needs but continuing to promote independence within their level of disability.”

- iii. **Build up a ‘terms of engagement’ around how data is shared:** Efforts to work collaboratively are being hampered because case workers struggle to navigate each other’s systems. Both sets of professionals cited ‘data protection’ and increased ‘bureaucracy’ and the ‘complexity’ of the health system as stumbling blocks. Information Sharing Agreements can provide the legal context for how data can be shared in a responsible manner to overcome these obstacles. There is an encouraging example in Leeds, where an integrated health and care system has been adopted and clients can access an online database and see what information is being shared and with whom.¹¹
- iv. **Adopt an integrated approach at a strategic level:** Both sectors should be involved in setting a joint model for working together at a strategic level. Current forums already exist at a regional level, such as Clinical Commissioning Groups or Health and Well Being Boards which would provide the ideal setting to discuss and establish partnership working. There has been an increased integration of services within the health and care sectors. This should be extended to include social housing, and form the basis to build alliances for working on larger cross-cutting themes. For instance joint working in this way could set the scene for developing innovative solutions in providing care to an ageing population. There are a number of case studies ongoing such as ‘Health Begins at Home Study’ led by housing association Family Mosaic or ‘The Collaborating Care Programme’ at Good Hope Hospital which is a re-ablement facility developed in partnership with Midland Heart housing association that aims to reduce delayed discharges.¹²

11 Leeds Health Pioneer Status award given in 2013- Crucially, the scheme includes information governance and mapping to enable it to flourish...<http://www.leeds.gov.uk/news/pages/Pioneer-status-gives-Leeds-a-healthy-future.aspx>

12 See <https://www.housing.org.uk/policy/health-care-and-housing/health-hub/building-partnerships/health-begins-at-home-family-mosaic/> as an example case study found on National Housing Federation website.

- v. **Be aware of the evolving context and strategic process that the NHS is taking:** Over the next five years the NHS proposes to shift the focus of care and public health initiatives to the home and local community. For instance they propose to:
- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
 - Create a new care model – Multispecialty Community Providers (MCPs) which would shift the majority of outpatient consultations and ambulatory care out of hospital settings.¹³

These changes will have important implications for social housing professionals seeking help for clients. This shift in strategic focus provides an opportunity to work together at a community level in such a way that clients can easily access the help they need.

- vi. **Work together with local mental health trusts and hospital trusts to develop or use existing forms of social housing more effectively:** There is an acute shortage of bed spaces within current hospital and mental health trusts. Working with social housing professionals can help manage some of the issues, utilising their expertise in providing care homes and supported housing facilities.

A good example of where this has worked is in Wales, where 33 patients are being housed by a coalition of 8 housing associations and 5 local authorities and the local health board. In this instance, they have focussed on using existing facilities to reduce reliance on out of county placements. The cost saving to the NHS is estimated at 1.6 million simply by avoiding the out of county placements. The actual cost to the NHS is £208,000, which pays for the housing costs and the provision of two officers with the clinical knowledge to manage the scheme. See this link for more details: <http://www.insidehousing.co.uk/policy/health-and-care/health/housing-project-saves-nhs-17m>

- vii. **Adopt an explicitly psychological framework of working specifically within the social housing sector:** There is increased awareness specifically of mental health issues within the social housing sector. However, this awareness should be turned into active knowledge among social housing professionals. Adopting an explicitly psychological framework would help legitimise and inform different approaches which social housing professionals can use. It would generate a shared language and understanding of where challenging behaviours are coming from. Some methodologies, such as PIE- Psychologically Informed Environments which embrace reflective practice have been shown to provide a practical means of relating with clients and at the same time helped improve resilience amongst frontline social housing professionals.¹⁴

13 NHS Five Year Forward View (October 2014) p.18-19 , <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

14 Frontline futures, New Era- Changing role for housing officers by Jo Richardson, Lisa Barker, Jacq Furness and Merron Simpson) CIH/ Wheatley Group p. 15

- viii. **Let go of introspective performance management styles and adopt a collaborative model:** Discussions with both health and social housing professionals revealed that current methods of working hamper closer working. By letting go of inward looking target measures, professionals on the frontline would gain the authority to reach out and build networks between sectors. It would also provide much needed support that nurtures innovative approaches in health care such as 'social prescriptions' which can be done in partnership with social housing professionals. Crucially, it would also give caseworkers much needed mastery in navigating each other's systems.

Section 4: Conclusion

This piece of research has sought to understand the social context within which social housing and health professionals operate. It found that a quiet revolution was taking place and described the impact of a number of emerging trends. Cumulatively, these trends indicate a number of things, chief amongst them that the current 'silo' approach is not working and that partnership working is required urgently if both sectors are to cope.

Through in-depth qualitative interviews, the research unearthed a range of common issues and themes. These include:

- i. the impact of care provision moving from the hospital setting to the home
- ii. the unhelpful culture of working in professional silos which reduces capacity to understand and navigate each other's systems
- iii. the impact of increased complexity in care needs both physically and mentally
- iv. the need to change introspective performance management systems so that they focus more on collaboration and
- v. the impact of funding cuts to both sectors causing increased pressure on frontline professionals but reassuringly there is a strong will to keep the client centre stage

All these changes are set against a backdrop of increasing expectations from clients and the use of inadequate solutions which are ineffective at best, and at worst highly costly. These factors compound and hamper the ability of frontline professionals in both sectors to deliver the services they are trained to give.

By working together, and facilitating networking amongst health and social housing professionals, we can improve the capacity of both sectors to manage the shared problems they face. The report suggests a number of ways in which this can be achieved; from letting go of introspective performance management styles to adopting a shared language and sharing information; to spending more time with each other through work-shadowing and co-location. Only in so doing will the emerging issues facing both sectors be managed effectively in an innovative and client focussed manner.

I'd like to conclude with a final thought from an interviewee which is both a call to action and the basis for successful collaborative working between both sectors:

"Let's take the person and design services around them and put the person- whether they be the patient, the customer or service user- at the heart of the system."

Appendix 1- Research Methodology

The research has been undertaken as a qualitative piece, resulting from interviews undertaken with six social housing and health professionals; a review of a case study; and review of relevant desk-based research material available.

Whilst this was a small sample group, I hope that the quality of their comments and suggestions overall add up to practical, tangible changes that improve the working experiences of both sectors professionals. All interviewees were sent a background piece and set of structured questions as set out below. The interviews took place between December 2014 and February 2015 and lasted between 40 and 60 minutes.

Structured Interview Questions

This project is being carried out by me Njoki Yaxley of the Broadland Housing group as part of my Clore Social Leadership Programme.

I am interested in the relationship between social housing and health. We know that many social housing clients have a greater likelihood of having mental and physical health problems. This interview is to find out your experience of these issues.

There are a number of areas I'd like to discuss, and your views would be very much appreciated. I should make clear that we are recording the interview so that we can listen to it again. Please let me know if that is not acceptable. Everything you say will be confidential and you won't be quoted to anybody by name without your agreement. So please be as honest as possible.

A) Health and social housing issues

- What are the big issues do you think in social housing at the moment?
- What are the big health issues in social housing in your experience?
- How well prepared do you think social housing professionals are to deal with health issues?

B) Experience of health and social housing

- How would you describe your experience of dealing with tenants or clients where a health issue is concerned?
- What do you think are the most difficult cases to deal with and why?
 - In Mental Health issues
 - In Physical Health issues
- In your experience are health professionals better or worse trained/prepared to deal with social housing tenants than the housing profession?

- To what extent would you say that the systems where you work are helpful in managing health issues? How could they be improved?
- How well established are the relationships and connections with housing professionals who you know are working with the customer?

C) Models of good and bad practice

- What models or examples have you seen of housing and health professionals working together well?
- What examples or experiences do you have of a good multi-agency working? How are they set up and what makes them good?
- Conversely, what examples are you aware of where the interaction with health professionals has not been great? What do you think we could learn from those situations?

D) Advice to the next generation

- What advice would you give to someone who would like to work on health and social housing issues?
- How would you train them?
- What would you tell them is the most important thing to be aware of?

E) Finally

- Lastly is there anything we haven't talked about that you think is important or that you would like to say?

Appendix 2- List of Partners

Health Partners

- Dr Ian Mack, Chair of West Norfolk Clinical Commissioning Group & practising GP at Kings Lynn & West Norfolk
- Jon Barber, Head of Business Integration at James Paget Hospitals NHS Foundation Trust & CCG
- Caroline Cunningham Brown, Commissioning Manager - North Norfolk Community Health and Social Care, North Norfolk Clinical Commissioning Group & Norfolk County Council (Community Services)
- Kerrie Gallagher, Housing and Public Health Partnerships Officer- South Norfolk District Council

Mental Health Trust Partners

- Del Mitchell, Head of Norwich Centrality, Norfolk and Suffolk Trust Foundation
- Gary Hazeldon, Partnership Lead, Norfolk and Suffolk Trust Foundation

Social Housing Partners

- Margaret Bryant, Neighbourhood Officer, Broadland Housing Group,
- Stephani Davis, Regional Manager, Broadland Housing Group
- Andrea Smith, Operations Manager, Flagship Housing Group

National Housing Federation Partners

- Claire Astbury, External Affairs Manager
- Amy Swan, Health Partnerships Manager
- Lynne Livsey, Health Partnership Coordinator
- David Orr, Chief Executive Officer

Clore Social Leadership Programme

- Hannah Wallace, External Relations Manager
- Liz Lowther, Programme Director
- Ralph Kennedy, Operations Manager
- Dame Mary Marsh, Founding Director

Research Partner

- Joe Saxton, Founder & Driver of Ideas, nfpSynergy

Front cover artwork

- James McLoughlin, Broadland Housing Group

