Housing LIN Cymru
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Case Study 140

Bridging the gap between health and housing. A united approach in South Wales

With housing and health increasingly integrating to respond more effectively to citizens' needs, Karen Tipple from Caerphilly-based housing association United Welsh explains a new wellbeing partnership, Wellbeing 4U, that is drawing from housing expertise to improve the patient and GP experience across 25 surgeries in Cardiff and Barry.

Senior Wellbeing Coordinator Alyson Vorres meeting a patient

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What is Wellbeing 4U?

Through the provision of specialist housing and support services, social landlords such as United Welsh have long provided opportunities to improve people's health and capacity for self-care which align with the aims of statutory agencies such as the NHS.

At United Welsh, we provide homes and targeted help when people need it the most, so we regularly work with individuals in hard to reach groups who are experiencing social challenges and detrimental lifestyle habits that affect their health.

Improving wellbeing has therefore been part of United Welsh's business strategy for a number of years, as we strive to create positive outcomes for our tenants and the wider community.

Wellbeing 4U is a community wellbeing service delivered by Thrive, the team that manage specialist accommodation and support services for United Welsh. It is a joint partnership between United Welsh and Cardiff and Vale University Health Board.

The project uses a Social Prescribing (SP) model which involves the team co-locating in GP surgeries with the aim of delivering public health priorities through social intervention, therefore assisting GPs and patients to improve their health and wellbeing.

The main areas of focus are:

- Increasing physical activity
- Improving diet
- Improving immunisation and screening uptake
- Helping to reduce harmful habits such as substance misuse, heavy alcohol consumption and smoking

Wellbeing 4U is based on a strengths-based approach that has underpinned our housing provision for a number of years now. The approach shifts the focus of intervention by concentrating on people's strengths rather than their deficits to help them take control of their lives; helping them to achieve their goals by building on their skills and establishing healthy connections with the wider community.

Working with GPs to improve health outcomes

Currently, Wellbeing 4U is offered in seven GP surgeries in Cardiff and Barry but the team also take patient referrals from 10 other surgeries in Cardiff and the Vale.

The team of 11 comprises of Wellbeing Co-ordinators, a Wellbeing Health Coach and a Wellbeing Team Leader who were specifically employed to deliver the service.

It is available to anyone registered at the designated GP surgeries. People are referred by their GP or other primary health care workers but they are also able to refer themselves via our self-referral form.

Wellbeing 4U is an agile way of working so it can easily be adapted to work from different locations. While we are co-locating with GP surgeries at present, the service design could also work in other health care environments and community settings which is something we are keen to test in future.

The results of the service so far are wide-ranging, with over 960 patients engaging with Wellbeing 4U since it launched in May 2016. One of the key outcomes of the service is that it has reduced pressure on GPs' time.

As our team don't have the same time constraints as GPs, we are able to offer a mixture of outreach, one-to-one work and signposting to community activities and the third sector while freeing up medical appointment time.

The programmes of intervention which we establish alongside the patients can last as long as they are needed, from signposting people to wellbeing and community activities such as parenting courses and exercise options through to helping people through therapeutic approaches with issues such as substance misuse or depression.

In September 2017, we introduced a Wellbeing Health Coach into the team to organise and run a programme of events for patients to be referred into so we can also support people with more focused intervention in those areas where there is a gap in provision or extended lead times.

Some of the ways we have helped people include:

- Access and engagement with a specific Education Programme for Patients to support people with low level anxiety and stress to make positive changes
- One-to-one work focusing on emotional wellbeing for people with mental health challenges
- Accessing specific support such as Care & Repair, Dementia UK and Local Authority support interventions
- Grants and funding referrals
- Helping people to find out what is going on in their local area with support to get involved
- Debt and money advice signposting
- Access to the Foodwise weight management program
- Access and support to engage with Action and Commitment Therapy
- Support and access to services to advise on benefits

Prevention is another key outcome of the Wellbeing 4U service. It is well recognised that improving wellbeing can prevent longer term reliance on statutory and professional services, as well as saving money for the public purse.

Wellbeing 4U provides a range of interventions to help people address and manage social, emotional and practical health issues so that a future visit to a GP can be avoided.

Customer feedback

> *"I have been very happy with the service I have received from the Wellbeing 4U team at Fairwater. When I first met the team, I was feeling low, had no energy to spare and I was struggling to deal with problems well.*
>
> *"It was great to be able to speak to someone who could understand what I wanted to improve with regards to my wellbeing and help me get there. The team provided me with simple changes I could make to my diet that would give me more energy while losing weight. They helped me gain a better understanding and control of my portion sizes, hydration and a more balanced daily diet."*

"While working through this with the team, I also attended a Confidence Building course that they were delivering. This has helped me to deal with problems well and obviously gain confidence to improve other areas of my life that are important to me.

"I am hoping to start swimming soon with the team's help. I have been feeling optimistic about the future."

Saving time and money

The case study below is one of many examples of how we save time and money for statutory services:

B has a serious illness and needs to attend regular appointments. However, his level of engagement has been poor.

It came to light that B was having issues with his benefits which were impacting on him and this triggered a referral to the Wellbeing 4U team. B had been having problems with his benefits periodically over the last 12 months and as a consequence he was not eating regularly and had been living off foodbank vouchers.

This had impacted on his physical and mental wellbeing. In addition B's housing benefit had been suspended meaning he was at risk of eviction.

Help provided included:

- Exploring with B what the key issues were and motivating him to engage with the service
- Contact and visit to Citizens Advice Bureau
- Contact and visit to local housing office
- Contacting DWP regarding B's ESA claim, making a new application and negotiating a small advance payment
- Ongoing support and engagement to help B understand the requirements he needs to adhere to in order to continue to receive his benefits and avoid his housing benefit being suspended / withdrawn in the future

B is now in receipt of his benefits and therefore able to buy food which will impact positively on his physical and mental wellbeing. It will also increase the likelihood of B engaging with his GP in the way he needs to so he can manage his illness. This will lead to a reduction in missed appointments.

Estimated cost savings*

- Complex eviction and homelessness application: £7,276
- Ongoing hostel accommodation for approx. six months: £3,042

Total estimated savings: £10,318

**These are based on a prediction in reduced use / need of services as a result of our intervention*

Key learning points

It is clear that Social Prescribing (SP) is becoming more widely recognised as a key intervention in helping people to achieve happy and healthy lives. SP is able to provide a holistic intervention and fulfils a gap which cannot be met by GP's themselves, for understandable reasons.

The work of the team has shown benefits to patients, GP surgeries and the local community, as demonstrated in the case study and feedback.

The model of delivery has evolved during the first year as we have overcome challenges and looked to see how we can reach as many people as possible. The service has adapted flexibly to meet the needs of GPs, patients and the wider community.

While this was needed, it has made it more difficult to provide quantitative data in relation to outcomes. This is something we want to explore as we go into our second year of delivery.

As the benefits of this service are becoming better known, the demand for our service has grown with more GPs asking us to provide the service in their surgeries.

It is positive that the benefits of SP are spreading. However, as we are a small team we aren't able to work in every GP surgery within the designated areas at the moment because we do not want to dilute the impact of what we can achieve.

The long term funding is also something that causes us concerns and challenges. Building relationships with GPs, patients and the community takes time and understandably some people can be wary of short term funded projects as whilst they provide benefit while they are operational, they leave gaps in provision when they end.

It also needs to be recognised that the long term benefits for individuals, communities and GPs of SP may not be known for a number of years but there needs to be upfront investment and commitment in order for SP to stand a real chance of becoming part of everyday health provision.

We recognise that there is scope and potential to develop this service further and help patients achieve even better outcomes; having a positive impact on communities and reducing pressure on GPs. However, long-term commitment to funding is needed to achieve this.

Note

The views expressed in this paper are those of the author, 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 the Welsh 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

For further information about the Housing LIN Cymru's comprehensive list of online resources and to participate in our shared learning and service improvement networking opportunities, including 'look and learn' site visits and network meetings in Wales, visit:
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