ADSS Cymru
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru
Leading Social Services in Wales

# ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES CYMRU

## Delivering Transformation Grant Programme 2018-19

# HOUSING, HEALTH AND SOCIAL CARE: EXAMPLES OF JOINT WORKING AND SUPPORT FOR TENANTS

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**Delivering Transformation Grant Programme 2018-19**
**JOINT WORKING AND SUPPORT FOR TENANTS**

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# 1. Introduction

1.1 In February 2018, the Welsh Government announced a £100 million Transformation Fund to transform the way health and social services are delivered. The Fund is one of the Government's responses to the recommendations of a Parliamentary Review of Health and Social Care. In July 2018, it published "A Healthier Wales", which sets out a broad framework of commitments and action to ensure everyone in Wales have longer, healthier and happier lives and remain active and independent in their own homes for as long as possible.

1.2 ADSS Cymru is leading several pieces of work in the Transformation Programme for 2018-2019. Workstream 2 focuses on Innovative Care Delivery Models in the Community with the aim of designing new models for care. As part of this "Big picture" work, ADSS is committed to engaging with others to identify and promote effective models of service delivery and to support new national service developments to improve peoples' lives.

1.3 Over and above examining joint working between the NHS and social care organisations and recognising the importance of housing to people's health and well-being, ADSS commissioned a small study to explore joint working between the NHS, social care and housing organisations.

## Project

1.4 The purpose of the study was to research and identify projects, models or approaches in Wales, which have integrated health, housing and social care to improve outcomes for people. Factors which contributed to their development were of interest as was the extent to which they reflect the national design principles set out in "A Healthier Wales".

1.5 In addition to identifying examples of joint action by housing, health and social care, there was also interest in the support provided to tenants by registered social landlords and the use of neighbourhood or community workers.

## This report

1.6 This report summarises the findings. It is based on the results of a trawl for information on the internet, requests to organisations and requests to representative bodies.

1.7 Chapter 2 summaries the key findings, providing examples of joint working and considering these against the design principles of "A Healthier Wales". Chapter 3 provides examples of tenant support activities by registered social landlords. It also includes a commentary on what is helping or hindering the prospect of increasing joint working in the future. This information was captured during telephone and face-to-face interviews. The Appendix contains more detailed descriptions of the examples of joint working which are listed in Chapter 1.

1.8 The small-scale nature of this study means the outcome is by no means the complete picture of all joint working and co-operation between housing, health and social care organisations in Wales. That said, it has generated a robust set of examples which show

the different ways in which housing can assist health and social care organisations to deliver good outcomes for individuals. This provides a solid foundation to increase joint working in all parts of Wales.

## Acknowledgements

1.9 The help of all who responded to requests for information and those who gave their time for discussion is gratefully acknowledged and appreciated, as is the help of Community Housing Cymru and the Welsh Local Government Association in facilitating requests for information.

# 2. Joint working between housing, health and social care

2.1 This chapter summarises data gathered on joint working across Wales. As stated at the outset, it is not the complete picture as a more extensive review would no doubt uncover further examples. However, it is a robust set of examples of different types of action, which demonstrates what has already been achieved or is being done, and which provide the basis for increasing joint working across Wales.

2.2 The examples are set out in the table below:

**Table 1: Examples of joint working between housing, health and social care organisations**

| Title / Theme | Housing organisation | Key feature(s) of action |
|---|---|---|
| Closer to Home | First Choice Housing | Reducing the need for out-of-area placements |
| Lighthouse project | Taff Housing Association | Reducing delayed transfers of care by addressing housing and support needs |
| Remodelling sheltered housing | Cynon Taf Housing Association | Alternative use of existing accommodation to meet needs |
| Remodelling sheltered housing | Trivallis | Alternative use of existing accommodation to meet needs |
| Training Flats | Trivallis | Help for independent living for young people leaving care |
| Well Being 4U | United Welsh | Social prescribing intervention based on three GP clusters |
| 2025 Movement | Various organisations | Strategic level forum to stimulate joint working |
| Mental health pathway | Isle of Anglesey/ Ynys Mon CC / BCUHB | Improving services and support to prevent cyclical problems |
| Hospital discharge | Conwy County Borough Council (lead) | Reducing delayed transfers of care by addressing housing and support needs |
| Health inequalities and rough sleepers | North Wales Housing Association (lead) | Improving access and support to people who are homeless and sleeping rough |
| CARIAD | Linc | Step down arrangements and alternative pathway |

2.3 Each of the above is described in more detail in Appendix 1.

2.4 Some other examples of joint working were noted during of this study. These range from working protocols between organisations or departments within organisations to co-

locating members of staff on a part or full-time basis. Co-locating staff was frequently highlighted as important to stimulating and sustaining joint action between organisations.

2.5 Over and above the examples in Table 1, examples of joint working which are at a relatively early stage were also identified:

- **Coastal Housing** is working with the Accident and Emergency Department in Morriston Hospital. Where frequent attenders are identified as tenants of the Association, consideration is given to additional support which could be offered, particularly if it can prevent the need for further attendance.
- **Monmouthshire County Council** is leading a regional dementia project with the NHS and other local authorities. The potential of assistive technology will feature as part of the project
- In Gwynedd, **Grwp Cynefin** is working with Betsi Cadwaladr University Health Board, the local authority, two single-handed GP practices, a pharmacy practice, and the local community. The aim is to develop accommodation under one roof in a "hub" type approach. Time is being devoted to engaging with, and involving, the community to design an appropriate model thus ensuring a "doing it with the community" approach as opposed to "doing it to the community".
- The Welsh Government's **Integrated Care Fund** continues to support a variety of work, some of which is engaging registered social landlords and local authority housing departments.

2.6 Better outcomes for people, notably health and well-being, is common to all examples of joint working. In achieving this, other social issues e.g. housing, debt, etc as well as physical and mental health issues often need to be addressed. Problems are often interrelated, which emphasises the importance of the "whole system" approach and joint working by organisations to identify and help people to address the root cause(s) of problems as opposed to simply treating only issues e.g. health issues, which may surface as the symptoms. For example, a mental health issue may present as the problem whereas housing and/or related problems, particularly those which could result in losing a home, may also be underlying factors which cause or exacerbate the condition. Identifying issues as early as possible and acting by way of interventions and preventative action to negate, or at the very least to limit and manage, the problem(s) before they get worse is vital. Given the interface they have with tenants and communities, social landlords are very well placed to do this and as Chapter 3 shows, this is happening in communities across Wales.

2.7 Achieving better outcomes for individuals often generates benefits for others. In some cases, this will be the families of individuals who need and receive help. However, it also extends to the organisations involved. This includes preventing or reducing the need to use, or reuse, NHS services, or social care services and reducing overall demand. For social landlords, it can help to ensure stable tenancies.

2.8 The examples in Table 1 vary. They have been identified for the different settings in which they operate, and the different models deployed. The factors behind their development also differ as does the precise nature of the help being given to people to improve health and well-being outcomes.

2.9 Looking at the models of working behind the examples, they can be grouped under six main headings. Better outcomes for individuals directly or indirectly are common to all. The broad ways in which the NHS and social care can work with, and benefit from, registered social landlords and local authority housing departments are:

- Using local housing providers to reduce the need for, and cost, of, out-of-area placements;
- Preventing delayed transfers of care (and as far as possible, the possibility of readmission) by addressing housing or housing-related issues;
- Using housing providers to identify opportunities to provide earlier intervention and more support, and options for primary care to address health and non-health issues which affect people's health and well-being;
- Alternative use of existing local housing assets to better meet the needs (sometimes complex needs) of people who are receiving services and support from the NHS and/or social care;
- Improving the lifelong prospects of care leavers by using local housing provision to help equip them with the skills necessary for successful independent living;
- Improving the way in which services and support are delivered by involving housing providers (social landlords and/or housing-related support providers) in service delivery (i.e. towards more of a "whole system" approach).

2.10 The follow pages look at each of the above in turn and consider the examples of joint working against the design principles of "A Healthier Wales".

## Using local housing providers to reduce the need for, and cost, of, out of area placements

2.11 "Closer to Home" by First Choice housing is a good, and long standing, example of joint working between a registered social landlord, the NHS, local authority and other support providers to accommodate people with complex needs. The original development was not driven by a top-down directive but by like-minded individuals seeking to help people with complex needs. At the same time, the prospect of financial and other benefits of a local solution were recognised.

2.12 First Choice undertakes the landlord function, providing ongoing housing management. In conjunction with the NHS and local authority, it sources and develops the type of accommodation needed with appropriate care and support, which is contracted out to specialist providers.

2.13 The savings from a local registered social landlord accommodation solution over of out-of-area placements can be considerable. For example, an out of area placement cost of £311,000 per annum compared to an annual cost of £90,000 under a "Closer to Home" arrangement would generate a saving of £221,000 per annum. There is a lead time for development before savings can be realised e.g. not necessarily in the first year or so given the set-up costs. The timescale for savings will vary according to a range of factors, including whether the solution is new build or the conversion of an existing property. However, when in place, the savings are realised on an ongoing basis.

2.14 Anecdotal information points to similar developments in other parts of Wales, some of which have been possible as a result of funding from the housing capital budget element of the Integrated Care Fund. However, there is far from a complete picture of all developments which have happened, or which are in train, and the precise nature of developments and individuals who have been helped. A more extensive trawl of developments which captures more evidence of the outcomes (financial and non-financial benefits) and the experience of those involved would be valuable as a rich source of learning to inform future developments and greater use of the approaches.

## Preventing delayed transfers of care by addressing housing or housing-related issues

2.15 Examples of this approach fall into two categories – hospital based and community-based interventions.

2.16 The Lighthouse Project and the project led by Conwy County Borough Council involve housing professionals at the front end i.e. hospital based. The Lighthouse Project was developed by Taff Housing and Newport City Council's Supporting People team. The development in which Conwy is the project lead was the result of discussion and joint working commitments at a strategic level via the 2025 Movement in North Wales.

2.17 Having a housing professional based in hospital realises the benefits of co-location and of being part of the whole team, which goes some way towards the whole system approach. The latter is important when matters such as suitable housing play such an important part in people's health and well-being and in helping them to live safely and as independently as possible in their own homes for as long as possible. It also helps to overcome factors which work against joint working i.e. lack of understanding of others' roles, who to contact, and how systems work. There are clearly gaps in the knowledge and understanding of health and social care by people who work in housing and vice versa, a lack of knowledge among health and social care professional of housing, housing rights and entitlements (in some cases), and perhaps most importantly, all that can be done for people in respect of housing and housing-related support.

2.18 The CARIAD scheme, developed by Linc, aims to ensure patients who no longer require a medical bed have an alternative pathway which supports and facilitates their long-term care needs. It enables them to 'step-down' from hospital when their treatment has finished and when they may require a further period of assessment. It also aims to prevent unnecessary admission to hospital due to short-term illness or injury.

## Using housing providers to provide earlier intervention and more support and options to address health and non-health issues which affect health and well-being.

2.19 The Wellbeing4U programme was launched in May 2016 after being commissioned by the Cardiff & Vale University Health Board. The specification for what is a social prescribing approach was broad, with the emphasis on developing a service to test what works and what doesn't. United Welsh secured the contract and developed the service.

2.20 The model, which has evolved over time and with experience, is flexible enough to work in different ways and to different needs and priorities. It operates across three GP clusters. The 2-year contract was retendered in 2018 with the specification being more detailed as a result of experience and practice in the first two years. United Welsh secured a further 2 years funding from the Health Board plus a possible one-year extension.

2.21 The service harnesses the resources and expertise of a registered social landlord with a track record of providing specialist housing and support to improve people's health and capacity for selfcare. This fits well with the aims of the NHS but goes further. It provides a means of giving patients of primary care more support and support options to address health and health-related matters including, but not limited to, housing. This also helps reduce demand on GPs. The benefits of co-location – housing staff working in GP surgeries - also shines through with increased understanding of what housing and support providers can do to help people.

2.22 The challenge in the early days was getting GPs on board as the service depended on referrals. Now, in its third year, it has clearly proved its worth in the eyes of GPs. Word has spread with more GP practices requesting the support. This is a challenge as the funding and thus the capacity of the service is limited. Two GP clusters have funded support from their own budget albeit on short-term funding when budgets permit. This is encouraging although of some concern as people can be wary of short-term funded projects which may at some point disappear leaving gaps in the support available.

2.23 Given the direction towards community-based care and their interface with the public, General Practice is a vital part of a "whole system" approach, particularly for early intervention on matters which may present as health problems e.g. mental health problems, anxiety etc. but where the root causes are, for example, debt and financial problems which risk eviction and homelessness. The effects of the latter extend to whole families with major negative health impacts on all concerned but particularly children. For this reason, preventing homelessness is a national priority and its positive impact can be further increased if part of a "whole system" approach involving GPs and social care professionals.

2.24 Opportunities for an early intervention/prevention approach are enhanced if GP practices work with other organisations which can provide support for people, be it health, health-related or other matters which affect people's health and well-being. Co-location and its benefits are also important. The Wellbeing4u project is a very good example of what is possible, and action is in hand to enhance the "hard numbers" evidence base for it. Issues such as data sharing need to be addressed to achieve this.

2.25 Anecdotally, there are other examples of third sector organisations working with, and in, GP surgeries. The picture of local arrangements, and the benefits it brings, is not clear. It is reasonable, however, to conclude the picture is inconsistent across Wales. While the priorities in different parts of Wales e.g. priority needs identified by GP practices and clusters, may vary, it is reasonable to assume there is a Wales-wide need for the type of support delivered by the Wellbeing4u model, which is flexible enough to be adapted to suit local circumstances. Furthermore, if such a model can work for GP practices, to what extent could it be used by social care providers to help their clients?

## Alternative use of existing local housing assets to better meet the needs of people receiving services and support from the NHS and/or social care

2.26 Cynon Taf Housing Association and Trivallis, which operates in Rhondda Cynon Taf, have worked with the local authority and/or Cwm Taf University Health Board to utilise existing accommodation for which there is much lower demand or no demand at all. This is a win-win situation, making the best possible use of local assets and at the same time meeting the accommodation needs of people who require on-going support.

2.27 Cynon Taf is converting accommodation into 19 one-bedroom flats to house adults with learning difficulties. They will not mean living in just one bedroom; residents will have their own front door, kitchen, and adapted shower, with support available on site 24/7. This helps them live in a community not an institution. A community hub facility has been designed into the development. Similarly, Trivallis have remodelled two buildings for a supported housing project for people with low-level ongoing support needs and for crisis accommodation.

2.28 Both developments stem for good working relationships between individuals in the respective organisations. Understanding needs and constraints but also opportunities provides a solid foundation for dialogue to find long-term solutions which work for both parties and for prudent financial decisions to achieve this.

2.29 There is anecdotal evidence of changes to sheltered housing and the use of community hubs in other areas. In Monmouthshire, for example, a “tired” sheltered housing scheme was converted to provide a 5-unit scheme for people with learning disabilities and two bespoke units for NHS patients.

## Improving the lifelong prospects of care leavers by using housing provision to equip them with skills for successful independent living

2.30 Working with RCT Council, Trivallis provides one-bedroom accommodation to young people leaving care on a trial basis for independent living. A training flat was set up as a pilot in Aberdare in 2009, and another in Rhydyfelin, Pontypridd in May 2010. It came about after a review of tenancy failures among care leavers revealed young people were unable to deal with the realities of everyday life such as paying bills, prioritising expenditure and ultimately facing the reality of living alone.

2.31 The flats are aimed at young people (17+) in residential or foster placements. Young people are referred if their social worker believes that the experience would be valuable as a step towards independent living. The referral is for up to one week initially with an option of a 4-week placement. The trial links with arrangements for care leavers to move to full tenancy via the process for allocating general needs housing.

2.32 The Trivallis example is a long-standing one. Discussions during the study point to similar arrangements being considered elsewhere e.g. Monmouthshire. The extent to which every local authority has such a facility, or has access to such a facility, is not known. While the number of care leavers in different parts of Wales will undoubtedly vary, the importance of looking after care leavers and helping them in their transition from care to independent living will be common to all. The help provided by Trivallis with the local authority is very much early intervention and preventative. The effect, and the benefits, can last a lifetime.

## Improving the way in which services and support are delivered by involving housing providers (social landlords and housing-related support providers) in service delivery (i.e. towards a "whole system" approach)

2.33 A Mental Health Pathway has been developed by the Isle of Anglesey/Ynys Mon County Council and the Betsi Cadwaladr University Health Board. The project, which followed discussions which were triggered by the 2025 Movement in North Wales, is one of two focusing on better links between housing and health services.

2.34 The Pathway has been developed to improve the way in which support and accommodation is provided to people with mental health needs who are accessing services via the Health Board's Mental Health Services, primary care or Housing's Supporting People programme. The aim is to help people to find and maintain a tenancy. and to ensure accommodation is available for individuals with low level mental health and enduring mental health needs. It offers offer choices to the individual to help them to move on towards full independence.

2.35 It is in the relatively early stages of implementation. It facilitates early intervention/ prevention by ensuring housing needs assessments are completed to prevent someone becoming homelessness, including a Mental Health Needs Assessment within the procedures. It is also helping to build closer working relationships between housing and health staff including the Community Mental Health Team and for the development of robust information sharing protocols.

2.36 Also, in North Wales, a cross-agency network was established to discuss and provide support for those in housing difficulty. The goal is preventative with action that ultimately reduces evictions thereby reducing homelessness (and thus avoids the significant negative impacts on people's health and wellbeing) and impact on housing services.

2.37 Challenges have included ensuring early identification of individuals and families experiencing difficulties. This does not always happen. Not all people identified as needing help have a need for secondary mental health services and therefore, there appears to be a gap around who can support people with mild/moderate mental health difficulties. The root causes of the latter vary considerably and manifest themselves in different ways. On this note, it is interesting to note projects such as Wellbeing4U and Hapus Pawb featured elsewhere in this report, which provide means of addressing such needs. Another common issue which was mentioned by several social landlords is "hoarding" behind which usual sits some form of mental health issue.

2.38 Another project in North Wales under the auspices of the 2025 Movement is helping rough sleepers. This aims to address health inequalities which covers not only the inequality in physical and mental health suffered by that group compared to the population but, importantly, inequalities in access to health services. Drawing on local experience, it is led by North Wales Housing and is focusing initially on the Gwynedd area. It started by interviewing rough sleepers to record their experiences of living with poor health and the barriers they encounter to accessing health services. One-to-one working with rough sleepers was required thus action was labour intensive

2.39 As a result of the project. rough sleepers in Gwynedd can now access GP services. They are now offered flu vaccinations (at a GP surgery) as they are considered health vulnerable as a group within the general population. They can also access emergency

dentistry (information provided to all rough sleepers) and they have improved access to mental health services both in the community and in hospital.

## Examples of joint working: The fit with "A Healthier Wales"

2.40 "A Healthier Wales" is the Welsh Government's response to the Parliamentary Review of Health and Social Care it commissioned. It sets out a long-term vision of a "whole system approach to health and social care", which is focused on health and wellbeing, and on preventing illness.

2.41 To help translate ideas into reality, the approach incorporates ten "design principles". They are listed in the following table:

**Table 2: Design principles of "A Healthier Wales"**

- Prevention and early intervention – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing.
- Safety – not only healthcare that does no harm but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other kinds of harm.
- Independence – supporting people to manage their own health and wellbeing, be resilient and independent for longer in their own homes and localities, including speeding up recovery after treatment/care, and supporting self-management of long-term conditions.
- Voice – empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care; simple clear timely communication and co-ordinated engagement appropriate to age and level of understanding.
- Personalised – health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes.
- Seamless – services and information which are less complex and better co-ordinated for the individual; close professional integration, joint working, and information sharing between services and providers to avoid transitions between services which create uncertainty for the individual.
- Higher value – achieving better outcomes and a better experience for people at reduced cost; care and treatment which is designed to achieve 'what matters' and which is delivered by the right person at the right time; less variation and no harm.
- Evidence driven – using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working.
- Scalable – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.
- Transformative – ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now

2.42 The table below is the result of assessing each of the examples against the ten design principles of “A Healthier Wales”.

2.43 Inevitably, the assessment is subjective and based on the information obtained, some of which is limited by the fact that several developments are relatively new. Nevertheless, and as set out in “A Healthier Wales” as one of the reasons for the principles, it provides a basic check of the extent to which the developments are heading in the right direction and in line with the vision.

**Table 3: Examples of joint working set against the design principles of “A Healthier Wales”**

| Title / Theme | Organisation | Relevant design principle(s) |
|---|---|---|
| Closer to Home | First Choice Housing | Safety; Independence; Personalised; Seamless; Higher Value; Evidence driven; Scalable |
| Lighthouse project | Taff Housing Association | Safety; Independence; Personalised; Seamless; Scalable |
| Remodelling sheltered housing | Cynon Taf Housing Association | Safety; Independence; Personalised; Seamless; Scalable |
| Remodelling sheltered housing | Trivallis | Safety; Independence; Personalised; Seamless; Scalable |
| Training flats | Trivallis | Independence; Seamless; Scalable |
| Well Being 4U | United Welsh | Prevention and Early Intervention; Independence; Personalised; Seamless; Evidence driven; Scalable; |
| 2025 Movement | Various organisations | n/a (Strategic measure) |
| Mental health pathway | Isle of Anglesey/ Ynys Mon CC | Safety; Independence; Personalised; Seamless; Scalable |
| Hospital discharge | Conwy County Borough Council (lead) | Safety; Independence; Personalised; Seamless; Scalable |
| Health inequalities and rough sleepers | North Wales Housing Association (lead) | Prevention and Early Intervention; Voice; Safety; Independence; Personalised; Seamless; Scalable |
| CARIAD | Linc | Safety, Independence; Personalised; Seamless; Scalable |

2.44 There is no requirement for any development or idea for change to meet all the design principles It is acknowledged that some may just meet one or a few of the principles.

2.45 The table reflects is based on available information and is thus a basic, initial, assessment of which principle(s) appear to fit each of the examples. Additional information would be required for a more robust assessment to be made. This is particularly true for the “transformative” principle given its “affordable” and “sustainable” characteristics, hence its absence from the table. With one exception, the position is

similar for an assessment of the extent to which a development embodies the "voice" principle. The exception is the health inequalities and rough sleepers project, where information about the project shows an explicit, early, stage in its development to talk to rough sleepers about their experience, their needs and what they wanted.

2.46 The basic nature of the above assessment also holds true for the "evidence-driven" principle. Two of the examples have been tagged against this principle. This has been done on the basis that the "Closer to Home" project has been implemented over several years, more developments are being commissioned and some cost savings information has been identified. There are similar developments elsewhere, some of which e.g. the "In One Place" development in Gwent and developments funded by the Integrated Care Fund, may also have produced hard evidence of cost savings.

2.47 The "Wellbeing4u" project has been tagged with the "evidence-driven" principle on the basis that the experience of the first two years of the project led to it being contracted for a further two, possibly three, years. The model of delivery has changed as a result of learning from the first two years and decisions by some GP clusters to fund it from their own budget, albeit for relatively short periods, also suggests evidence is playing some part in the direction of travel. As stated earlier, the team is working to generate more hard, quantitative evidence of the project's impact and benefits, which will also assist an assessment of the "transformative" nature of the project.

## Refining the use of the design principles

2.48 In assessing and applying the principles to development and actions for change, one can question the extent to which a design principle is present. While in some clear-cut cases the answer could be a straight "yes/no" answer, there is logic in considering not just whether something demonstrates a straightforward indication of a principle but the extent to which a principle is shown. This will help determine the relative strength of different developments and actions. For example, is something is as seamless as it possibly can be i.e. there is no scope at all for further improvement? Is preventative or early intervention action as effective, and perhaps cost-effective, as it could be?

2.49 The assessment and application of the design principles warrants further consideration. However, to have such a set of clear principles to guide and frame developments and change is very helpful. The priority is to use the characteristics of the design principles described in Table 2 to stimulate and drive change and developments including, but not limited to, joint working between all organisations who can play a part in improving the outcomes for individuals and their families. This approach can also be applied to existing services and working arrangements with the aim of building on what is already in place – systems, services, ways of working - and enhancing them wherever possible. As time passes and with the benefit of experience, there will be ample scope to capture learning to refine the approach to assessment and application, and to document the increase and spread of joint working.

## Recommendations – Rolling out developments across Wales

2.50 Spreading good practice and developments across Wales remains a challenge but must be addressed if people are to receive consistent, and consistently good, services irrespective of where they live.

2.51 There is nothing to suggest that the examples of the projects mentioned earlier cannot be replicated across Wales. Their costs, and thus the costs of extending the model elsewhere, will vary. Some developments seek to improve working practices by better use of existing resources e.g. better co-ordination and liaison between services; co-location etc. and are therefore at the low end of the extra cost scale. Some depend on additional funding initially to do more for people, with benefits realised over time. For others, there are up-front costs, but the cost savings are clearer and can be realised within a shorter timescale. Notwithstanding matters such as additional funding where needed, the local capacity and support for change also needs to be considered.

2.52 The examples of joint action appear to address issues which are common to all areas and therefore, they should be considered for adoption elsewhere. This does not necessarily mean a straight copy lifted from one area and placed into another. There are good reasons not to simply lift something from one area and place it “as seen” in another. It is better to take the core features and ethos of a development, including its design principles, and consider how it can be made to work in another area, with any refinements necessary to reflect and suit local circumstances. Where possible, involving service users and the broader community in the process of design and implementation of an idea, whether new or from another area, also has many benefits.

2.53 Seldom is it possible to do everything at once. Given the benefits of a phased approach in rolling out practice and developments, some may warrant earlier consideration that others. The following, which are not in any order of priority, vary in nature, target population group(s) and benefits:

(i) **The “Closer to Home” approach** by First Choice Housing (Rationale: benefits for individual and families from local solutions which avoid out-of-area placements for people with learning difficulties and for people with complex health needs; costs savings to NHS/social care);

(ii) **Hospital discharge projects** such as Taff Housing’s Lighthouse project and a similar development led by Conwy County Council (Rationale: to prevent non-health matters such as housing from stopping or delaying discharge; to ensure discharge into a safe home environment for independent living; to help prevent the need for readmission; demand management for the NHS by freeing up beds);

(iii) **Alternative use of existing community assets** e.g. changes of use of sheltered housing by Cynon Taf Housing and Trivallis, and respite care development by Cynon Taf (Rationale: helping people with complex needs to live more independently in a community not institutionalised setting; potential costs efficiencies for local authorities);

(iv) **Training flats** e.g. Trivallis (Rationale: Care leavers are a priority and the benefits of equipping individuals with the skills necessary to live independently last a lifetime);

(v) **Early intervention and prevention in the community and in GP clusters** e.g. Wellbeing4u developed by United Welsh; Hapus Pawb run by Rhondda Housing (see next chapter); tenant support via front-line staff (Coastal Housing) (see next chapter) (Rationale: identifying people's health and other social needs such as housing-related needs, and intervening as early as possible to help them overcome problems and/or manage conditions; to prevent or reduce the need for health and care; assisting and providing more options to primary care to help patients).

2.54 The above provides a portfolio of joint working developments in areas which should be considered for adoption by other areas. A planned approach is needed to ensure the examples are considered by organisations, and groups of organisations working in the variety of partnership fora which exist, and decisions made for development and implementation action.

2.55 The examples and experience of the joint working identified in this report and those behind the developments offer a rich source of learning. More detailed information on each of the models, their development and implementation might be needed to inform their use elsewhere and can be obtained if needed. If tapped, this information can drive the spread of joint working. It can also help to strengthen the evidence base for, and inform the design of, seamless services between housing, health social care and other public services and third sector providers. All this will contribute to achieving the whole system approach required in "A Healthier Wales".

# 3. Supporting tenants and communities and increasing joint working

3.1 This Chapter provides examples of action being undertaken by social landlords to support tenants and communities which is linked in some way, directly or indirectly, to better outcomes for health and wellbeing.

3.2 The work in identifying and collating information this information and examples of joint working between housing, health and social care involved a series of telephone and face-to-face discussions. These provided valuable context for the work but also a rich source of information on broader issues which are being encountered by social landlords in supporting tenants and in pursuing joint working with health and social care.

3.3 The preparedness of social landlords to do more than provide a basic landlord function shone through in discussions. So too did the desire to do even more. Improving people's health and well-being and better working links with the NHS (primary and secondary care) and social services to develop more integrated services featured prominently. It is driven by a commitment to deliver good services and social responsibility, which improves outcomes for people, be they finding and keeping a home, better health, tackling loneliness and isolation, or economic e.g. employment. Much of this activity, which happens day to day in communities across Wales and which undoubtedly helps reduce demand on other public services, is largely unseen and thus is probably undervalued.

3.4 At the same time, better health and well-being outcomes for tenants and others in the community can benefit social landlords through better engagement which can result in more stable tenancies. The aim is to avoid housing issues and other matters which may cause or have a negative effect on someone's ability to find and keep a home e.g. matters which could ultimately lead to rent arrears, eviction or other difficulties. The importance of a proactive approach to reaching out to people and early identification to offer help to prevent problems in the first place or action to prevent situations from becoming more difficult, time-consuming and costly to resolve is recognised. It can be seen in the following examples.

## Examples of supporting tenants

3.5 The examples of support for tenants are:

- Rhondda Housing
- Cynon Taf Housing
- Linc Housing
- Coastal Housing

3.6 Given the limits of this study, the sample nature of the following information must be emphasised. A wide range of support is provided by registered social landlords and by local authorities. This extends well beyond priorities such as homelessness to address issues of debt and personal budget management, skills, volunteering and employment, substance misuse and anti-social behaviour. The following illustrate what is being done and why, and some of the benefits in doing so.

3.7 **Rhondda Housing Association** runs the "Hapus Pawb" project in partnership with Cambrian Village Trust. Established in May 2017 with grant funding, it was originally known as "Strive and Thrive". The Association was one of the partners and became the main source of referrals to the project. It recognised there were clear benefits for its tenants who participated, including better mental health, improved mood, self-esteem and confidence, social and community interaction (e.g. tackling loneliness and isolation), and trying out activities they wouldn't have otherwise tried. When grant funding came to an end, Rhondda Housing took it over the project and now funds it from its own resources.

3.8 The core of the project is a six-week interactive course to improve people's social, health and well-being. Ten people are on each course and there are currently four courses per year. The target audience is tenants of the Association (age range is broad 16-80) with low level mental health issues and people with learning difficulties. They are reached by home visits or by calling direct, and referrals from housing officers, maintenance staff and other front-line staff.

3.9 After the course, there are opportunities to join established groups, to organise their own social activities with others who have been on the course e.g. friendship groups (thus continuing to address social isolation and community building), volunteering (e.g. on an allotment project in Treherbert). Some of those who have participated in the project have gone on to act as mentors to new people joining the project.

3.10 The project helps to maintain and improve the Association's overall relationship with its tenants. If someone has rent or tenancy issues, they may feel more confident to approach the Association for help. It helps to reduce any "us and them" situation. Ideally, the scheme could be expanded to take referrals from local GPs, community nurses etc. At present, however, due to funding and capacity constraints, the scheme is limited to its own tenants.

3.11 **Cynon Taf Housing Association** has 13 staff in support roles. The basic concept of the model – early intervention and prevention – is straightforward. Basic needs such as food in cupboard and money in the meter are fundamental. Without those and setting aside the potential health problems that could result, it can be difficult to maintain a tenancy.

3.12 The Association is helping people in several ways, including the basics of budgeting, action to ensure appropriate benefits are claimed, and action which helps people into employment or helps move them towards employment e.g. by volunteering. Tackling issues such as a lack of friends, family or support in the community support and helping them to engage in social activities is also important and helps tackle loneliness and isolation

3.13 Low level mental health issues including stress and anxiety are common. A survey of tenants by the Association revealed nearly three out of four (72 per cent) reporting they had some mental health issues. The Association works with Merthyr and Valleys MIND with one of its staff co-located with housing staff. Action from this arrangement includes the delivery of therapies and mindfulness. It also provides access to counselling which can be accessed sooner than via health services e.g. within 2 weeks.

3.14 The pressures on tenants continue to increase. The benefits freeze for several years, bedroom tax and now Universal Credit, combined with rising costs of living have taken their toll. There is a sense that levels of vulnerability have increased. The Association is proactive in reaching out to its tenants to identify needs and to provide support.

3.15 The front-line staff of social landlords are utilised to spot tenants who may need help or issues which need to be addressed and referred e.g. to social services if circumstances warrant. The proactive approach taken by **Rhondda Housing** is typical of many. Additional support is given to a tenant if a notice or eviction situation is becoming a reality. The underlying issues tend to be medical/health, substance misuse, chaotic lifestyles, etc. With zero evictions last year, its preventative approach is working, and the Association is keen to increase joint working with health and social care to maintain this and as part of its support for tenants.

3.16 **Linc** set up a small community empowerment team in 2017. The aim was to support tenants who would struggle to maintain their tenancies without support. These were often tenants who either do not meet the thresholds of existing support provision or have failed to engage with existing support. It currently has two officers, who support up to 40 tenants between them. They work with tenants on a short or long-term basis, dependent on the needs of the individuals. Issues addressed include domestic abuse; hoarding; low level mental health and confidence building. The team has trialled using a star outcome framework to measure individual's progress and whether they have met their personal goals. The team have also explored the 'HACT – Social Value Measurement Tool' to track positive outcomes.

3.17 Recognising the potential of front-line staff to identify issues and the benefits of early identification and engagement, **Coastal Housing** has refocused the role of its front-line staff. It has moved away from what was originally a reactive approach i.e. if nothing heard from a tenant, the assumption was that everything was alright. However, this did not uncover loneliness and isolation, mental health problems, alcohol misuse and other problems such as hoarding. etc. Now, it does not assume no contact means nothing is wrong or no help is needed and has a far more proactive approach.

3.18 It has found time for its 20 housing officers to understand their locality, local activities and community events. Thirty caretakers work day-to-day on estates and know the communities and people. The Association's repairs team undertake around 20,000 repairs each year. They are not driven by targets and it is perfectly acceptable for them to spend time to have a cup of tea with someone, to get to know them and identify any issues or help they may need.

3.19 All of this provides better intelligence and increases the Association's capacity to understand tenants and their circumstances and its ability to help them. If front-line staff locally can help someone – and they are often able to – there is signposting to in-house service or to external services and providers, and grassroots community support connecting with others who can share skills (community assets). The approach aims to be restorative, working with tenants so they can achieve what matters to them rather than doing things to, or for, people.

## Broader issues relevant to more/better joint working between housing, health and social care

3.20 The benefits of joint working are recognised and there is commitment and enthusiasm among social landlords to do more.

3.21 Positive and negative issues came to the fore during discussions with social landlords and local authorities on examples of joint working and support for tenants. These are

important to identifying matters which, if they can be addressed, will at least support but more likely stimulate more and/or better joint working between housing, health and social care organisations.

3.22 Co-location and the benefits were frequently mentioned for the benefits it brings. This can be housing staff working all or part of the time from health or social care premises or vice versa, with health or social care and other staff from specialist third sector organisations working from housing association premises. Over and above the practical working connections, it increases mutual respect and understanding of roles and opportunities to do more for people by staff from the respective organisations working more closely together. This fits well with the aim of, and indeed need for, achieving a "whole system" approach.

3.23 Given the interface social landlords have with the public through their services, their front-line staff are a particularly valuable resource in generating a true early intervention/prevention approach within communities. The value of training staff in a trauma-informed approach and/or restorative practice was mentioned on several occasions.

3.24 Joint working around hospital discharge where a housing professional is co-located is welcomed. It can ensure a housing issue does not delay or stop someone from being discharged after medical treatment. Over and above helping to speed up discharge, it can also help ensure that when someone can return home, they can live safely and as independently as possible. Additional aids can be arranged and adaptations e.g. to prevent circumstances where someone is discharged back home yet has been unable to use aids e.g. a wheelchair, due to the physical aspects of the property.

3.25 Discussions have reinforced the idea that people make the difference as far as joint working is concerned. Many examples of joint working have come about as a result of like-minded, forward thinking, individuals coming together, keen to make a difference to people's lives, being prepared to push for change and overcome hurdles along the way. One challenge is to convert joint working developments into standard, and sustainable, practice, so it becomes "the way things are done". This overcomes situations where someone changes job, a previous joint working arrangement withers and things revert to how they were before. This is particularly relevant when organisations are in a state of flux due to organisational change although currently, this appears to be less of an issue.

3.26 Experiences with health services across local areas and regions is mixed. Positive interactions with district nurses, GPs and Occupational Therapist services are often reported. Helping tenants to access primary care when it is needed can sometimes be a challenge. As a need, mental health is an issue that is presenting to landlords more and more frequently. Initially, support in terms of going through primary care system is quite straightforward. However, after initial assessments, support from health services can sometimes dissipate. For some clients, loneliness and isolation exacerbates their health conditions. Delays in being able to help people to engage with statutory or third sector services and support risks further deterioration of health to the extent that someone's willingness to engage, be it a tenant of a social landlord or someone else with a housing need, can disappear.

3.27 There is anecdotal evidence of social landlords and housing staff from local authorities struggling to get referrals on behalf of individuals who present to them. For example, a referral may be turned down if there is just a possibility that someone could lose their

home but accepted if a social landlord serves a notice of eviction. This appears to work against the broad principle and goal of prevention and early intervention. It certainly sits awkwardly with national policy (and law) on preventing homelessness, in which earlier intervention to avoid someone becoming homeless is a fundamental principle. Capacity problems and demands pressures may well be behind this. However, the result of circumstances where someone "doesn't meet the need for referral" or "doesn't meet the criteria for support" means that some people fall into gaps in provision. Single people of working age are particularly affected, and it seems more difficult to get them into services. And there can be a gap between what might be considered "low level" mental health and the threshold for NHS services, with waiting times for assistance e.g. counselling and other specialist services, also being mentioned.

3.28 When referrals are made e.g. to social services, feedback afterwards can be missing. Without feedback, a social landlord does not know whether to continue supporting a tenant. The social landlord must rely on the tenant themselves to give feedback on the situation and any assistance being given, which may not be complete or accurate. Where someone has been sectioned and there are no family members, the social landlord often needs to chase for feedback and it is not always forthcoming, possibly on ground of data protection of professional confidentiality. If they can't be overcome, data protection and patient confidentiality issues can be a barrier to effective joint working and ongoing support for tenants.

3.29 Developments such as the proposal to amend the Partnership Regulations under Part 9 of the Social Services and Well-being (Wales) Act 2014 for housing representatives to sit on Regional Partnership Boards are welcomed for the potential to stimulate more joint working. It is recognised that given the number of social landlords, such a development would require sound practical working arrangements, and over time, there would be benefits to be gained by Boards learning and sharing information on how any new arrangements work in practice.

3.30 At all levels, better knowledge and understanding on all sides – housing, health and social care – is critical to joint working. This ranges for the basic knowledge e.g. who to contact (easily) in "xx" to help an individual, to a better understanding e.g. of respective roles, how organisations work, and what can be done for people. It tends to happen more where co-location is involved but there is scope and need for more joint training and continuing professional development activities to play a part.

# Appendix: Projects/Developments

**"Closer to Home"**
**First Choice Housing Association**

First Choice provides housing throughout Wales and Shropshire to enable adults with a learning disability to live independently in the community with support. "Closer to Home" was established in 2011 to reduce the number of people with a learning disability and/or challenging behaviour being placed in institutions The aim was threefold: to enable people with a learning disability and challenging behaviour living out-of-area to move back to their local area in Bridgend, Neath and Swansea, to prevent further out of area placements; to reduce the need for admissions to acute services.

The development was not "top down" but was spearheaded by like-minded individuals committed to joint working for the benefit of people who need accommodation and support. A Framework was established comprising the 3 local authorities, Abertawe Bro Morgannwg University Health Board ("UHB"), 2 registered social landlords and, via an open tender / framework opportunity, 5 support providers. The framework ran to 2015 but relationships between individuals in the Association, the NHS and relevant local authorities continue for commissioning purposes. Discussions have now commenced with Hywel Dda and Carmarthen to try and replicate the joint commissioning arrangements.

First Choice undertakes the landlord function, providing ongoing housing management. In conjunction with partners, it sources and develops the type of accommodation needed with Local Authorities commissioning appropriate care and support. The latter is contracted out to specialist providers. It has delivered 11 schemes under the Closer to Home Framework, providing suitable homes for 39 tenants. Discussions on 2 more homes in Carmarthen are in hand with Abertawe Bro Morgannwg UHB. These are supported by the Integrated Care Fund and bids for similar provision are with Betsi Cadwaladr UHB. Developments are based on a front-end agreement - 50/50 funding split with the local authority and NHS.

First Choice Housing has 850 tenants. It works across 19 local authority areas and this year will developing 19 new homes in 10 areas. The complexity of individuals' needs varies, with the most complex requiring, for example, tracking hoists, specialist baths, and a wide range of features which assist with managing challenging behaviours.

The savings on the cost of out-of-area placements can be considerable. For example, an out of area placement cost of £311,000 per annum compared to an annual cost of £90,000 under a "Closer to Home" arrangement would generate a saving of £221,000 per annum. The savings in some cases could be even more. here is a lead in time before these come through e.g. not necessarily in the first year or so given the set-up costs. However, when in place, the savings can be realised on an ongoing basis and, importantly, it is also possible to respond to changes in the support needs of individuals and their families.

Over and above cost savings, having suitable specialist housing options locally is preferable to someone being accommodated far away from their community and family. It produces better health and well-being outcomes for all. The benefit of supported living accommodation is that is also promotes an individual's right and independence to live in an ordinary home in the community, with a property adapted to meet their personal needs and appropriate care and support.

**The Lighthouse Project - Reducing delayed transfers of care**
**Taff Housing Association**

The Lighthouse Project was developed with Newport City Council's Supporting People team. Floating housing-related support is provided to vulnerable adults to enable them to live independently in their own home (funded via Supporting People programme)

A tenant support worker based in hospital was the result of a request from Newport Social Services via its hospital social work team. Discharging patients is a challenge, particularly where housing issues create difficulties or delays in achieving discharge. Third sector providers already worked to assist people with poor mental health and social services are involved automatically for patients of a certain age. The Lighthouse Project allowed assistance to be given to younger people and people with specific problems such as substance and alcohol misuse. The needs of all patients are considered and actioned as necessary, not just social housing tenants. And all housing matters can be addressed, not only adaptations to homes.

The prime aim was to reduce delays in people leaving the Royal Gwent as a result of referrals, paperwork and liaison, and a more comprehensive support package. However, over and above faster discharge, desired outcomes for the project included the arrangement of ongoing floating support, preventing the need for re-admissions to hospital, and cost savings for health and social services.

There is one support worker – a housing/homelessness professional - based in the Royal Gwent hospital but also covering St Woolos. He/she works on wards as part of hospital teams and proves the benefits of co-location. Their knowledge and experience facilitated pre-discharge action such as arranging for adaptions to someone's home. However, it extended to challenging housing and housing decisions e.g. someone being discharged back to same block of flats to mix with same people which can result in a cyclical problems and readmission, or a homeless situation. Similarly, it helps avoid problems associated with rent arrears and possible eviction, the risks of which can now be higher where Universal Credit is concerned.

The Integrated Care Fund did allow another support worker to be based on the hospital to cope with demand and to maximise the benefits of joint working and the prevention of delayed transfers of care and future problems. However, the funding from the ICF was not renewed so assistance is currently provided by one support worker.

**Remodelling Sheltered Housing – Penl Llew Court, Aberdare**
**Cynon Taf Housing Association with RCT County Council**

Sheltered housing has been a good home to many people. However, over time, the needs which underpinned the concept have changed. People are living longer and prefer to stay in their own homes. Adaptations and, where necessary, social care support packages help them to do this and to live safely and as independently as possible for as long as possible. Consequently, there is now lower demand for sheltered accommodation in RCT.

Cynon Taf Housing Association experienced low demand for its Penl Llew Court property in Aberdare. Thirty per cent of the property was always void and could not be filled. Financially, and socially this was unsustainable as the need to let the scheme had historically meant that some client groups not ideally suited to communal living had been offered properties at the scheme. After considering alternative uses and as a result of close working with Rhondda Cynon Taf County Council, the property is being remodelled.

The 34 homes (14 flats and 20 maisonettes) are being converted into 19 one-bedroom flats to house adults with learning difficulties. This means people will not being living in just one bedroom but will have their own front door, a living room and bedroom, kitchen, and adapted shower. Support will be available on site 24/7. The goal is for individuals to be able to live in a community not an institution. Reinforcing this concept, a community hub is part of the design. This will reduce the need to move people out to day centres. The hub will also be open for schools, communities, IT facilities, cooking available for everyone locally not just people with learning disabilities.

The property is owned by Cynon Taf Housing Association The costs of remodelling is £2.3 million of which £1 million is funded by the Integrated Care Fund and a £1.3 million loan to the association from RCT. The timescale for the loan and for the guaranteed rent over 15 years for the provision of accommodation provides the basis for prudent financial decisions. An efficiency in social care is envisaged which can be reinvested in frontline service provision as a result of the development. Accepted tender – delivery by end of 2019.

The Association is considering a similar scheme for Oxford Street in Mountain Ash town centre. It has also developed respite accommodation for use by RCT in Treforest. The development, which was handed over on 21 December, takes advantage of reducing student demand for houses in multiple occupation. A large property has been renovated without the need for grant and a long-term arrangement agreed with the local authority for 4 spaces plus sleeping accommodation for support workers.

**Remodelling sheltered housing**
**Trivallis**

Two of the Association's sheltered housing schemes (out of 27) were assessed as having no future due to lack of demand. Alternative use was explored with Cwm Taf UHB and RCT Council. The Health Board and Council had undertaken an analysis of the accommodation needs of 2 vulnerable client groups - those with a learning disability and with mental ill health. This identified need for a supported housing project for people with low level ongoing support needs and for crisis accommodation.

A scheme was developed to accommodate vulnerable people with a social care need aged 18 and over. Two buildings were remodelled to provide high quality self-contained apartments (Penygraig – 15 properties; Ynysybwl – 18 properties) with communal space being open and welcoming. Trivallis met the cost of the refurbishment and agreement reached for a minimum period for the use of the scheme. 24-hour support was commissioned by RCT. Each scheme has a part-time Manager, and suitable cover, including sleep-in cover where needed. Ynysybwl uses one property as emergency accommodation and one property for staff sleepover.

The buildings were handed over in 2013 and a support provider contracted. Homes were allocated by a panel. Tenants who were allocated a property experienced a range of needs including mental health, learning disability, and brain injury.

**Training flats**
**Trivallis**

Social landlords in RCT Taf provide one-bedroom accommodation to young people leaving care via an application to the Common Housing Register. It was apparent that many tenancies were ending, with reasons including abandonment and eviction for rent arrears. Investigation revealed the failure of tenancies was simply due to young people being unable to deal with the realities of everyday life such as paying bills, prioritising expenditure and ultimately facing the reality of living alone.

Joint working between Trivallis (or RCT Homes as it then was) and the Council sought to address the problem. A training flat was set up as a pilot in Aberdare in 2009, and another in Rhydyfelin in May 2010. The flats are aimed at young people (17+) in residential or foster placements. Young people are referred if their social worker believes that the experience would be valuable as a step towards independent living.

The referral is for up to one week initially with an option of a 4-week placement. The young person is expected to produce a portfolio of their experience to record life skills developed during their stay, to develop their learning and support needs and to evidence their ability to live independently on referral to the Move On Panel. The Panel will give additional priority to those having had successful stays in the training flat when allocating suitable general needs housing. If the first stay is not a success, the young person can return to their former residence and can then be offered a second period later. This helps promote sustainable long-term tenancies following Move-On. When the young person has completed their stay(s) at the training flat, they return to their former residence before making a more informed decision on whether to pursue supported accommodation or independent living

**Wellbeing 4U**
**United Welsh**

As a specialist housing and support service provider, United Welsh has long provided opportunities to improve people's health and capacity for selfcare, which align with aims of other agencies. Improving people's well-being is inherent in its strategy. It works with people experiencing social challenges and lifestyles that affect their health.

Wellbeing 4U was launched in May 2016. It was developed as a result of a tender issued by Cardiff and the Vale University Health Board. The tender was broad in terms of the need – social prescribing – with the emphasis on developing a service to test what works and what doesn't. The 2-year contract was retendered in 2018 with the specification being more detailed as a result of experience and practice in the first two years. United Welsh securing a further 2 years plus a one-year possible extension.

The service (team of 11) works across 3 GP clusters covering 25 surgeries in the Cardiff and Barry areas. The Association's team delivers support to help patients to overcome situations affecting their health and wellbeing. This may be managing health or lifestyle issues but could be broader matters e.g. debt; rent arrears, which can be the root cause of low -level mental health problems. The approach builds on people's strengths rather than deficits to help them take control of their lives and to achieve goals. People are referred by their GP or other primary care staff but can self-refer. The approach is flexible enough to be adapted to work to different locations and needs. For example, the service delivered in the Vale is different that of the City. It is aligned with the needs identified by each GP cluster thus helping them to deliver to their plans.

The service has evolved. The model now is quite different to the original. While originally interventions discussed and agreed with patients could last as long as needed, there is now a greater focus on achieving behavioural change and avoiding support becoming an ongoing counselling service. Interventions range from signposting people to wellbeing and community activities, arranging home adaptations and other support through to therapeutic approaches on issues such as substance misuse or depression. The medium-term approach is now 1-4 sessions with a longer-term intervention option to the Association's "Healthful Network", which delivers courses and other assistance on matters such as stress and anxiety control, and nutrition/healthy eating (Foodwise, which is linked to the local Dietetic Team). The Association also has a means of allowing people to engage again with the support and to keep in touch with others they met while on courses. The manager of the service has also introduced measures to ensure the resilience of the team members. This is particularly important given the nature of some cases encountered.

1,749 referrals were made to the service in the first 2 years (includes an additional 252 referrals made by the South-East Cluster from Oct 2017 – March 2018, the support for which was funded by the cluster itself). The results are positive and wide-ranging and the decision by a cluster to invest some of its own budget to extend the service is proof of this. Detailed information is available. It has allowed more support and options to be provided to people presenting to their GP. It has also reduced pressure on GPs' time.

Early challenges were getting GPs on board as the service depended on referrals. Now, in its third year, it has proved its worth in the eyes of GPs; word has spread. More practices are requesting support which is a challenge as funding and thus capacity of the service is limited. Encouragingly, two GP clusters have funded support from their own budget albeit on short-term funding when budgets permit. This is of some concern as people can be wary of short-term funded projects which may at some point disappear leaving gaps in provision and the support people can access.

**2025 Movement**
**Various organisations across North Wales**

The 2025 movement is a strategic development which has stimulated joint working on several themes. The following text summarises the Movement itself. Some workstreams involved housing associations and local authority housing departments working with the NHS and/or social care. These are featured in more detail in separate descriptions in following pages.

The Movement comprises senior leaders and practitioners from North Wales local authorities, four housing providers; (Cartrefi Conwy / North Wales Housing Association, Cartrefi Cymunedol Gwynedd Cyf, Canllaw (Eryri) Cyf), Betsi Cadwallader University Health Board (BCUHB), Public Health Wales, Wrexham Glyndwr University, North Wales Police, and North Wales Fire & Rescue Service.

The group first came together in 2015 with the aim of enabling organisations to take a new approach to working together to address shared challenges to end avoidable health and housing inequalities across North Wales. A Programme Management Group meets bi-monthly and oversees seven work areas or 'Just Do' teams;

- Flint Regeneration (currently focusing on youth physical inactivity and food poverty)
- Healthy Homes – Healthy People
- Mental Health & Hoarding
- 'Made in North Wales' Social Prescribing Network
- Public Services Leadership Programme supporting the aims of 2025 in conjunction with Wrexham Glyndwr University
- Tackling Health Inequalities for Homeless Rough Sleepers
- Facilitating Improvements in Hospital Discharge

**Mental Health Pathway**
**Isle of Anglesey/Ynys Mon County Council / BCBU**

A Pathway has been developed to improve the way in which support and accommodation can be provided to people with mental health needs who are either accessing services via Betsi Cadwaladr UHB Mental Health Services, primary care or Housing's Supporting People secondary services. Embryonic – 3 months old. It developed from discussions triggered by the 2025 Movement. The overall aim is to help people to find and maintain a tenancy. and to ensure accommodation is available for individuals with low level mental health and enduring mental health needs. It offers offer choices to the individual to help them to move on towards full independence.

People with mental health needs will have access to short-term preventative and recovery services. The services provide a mixture of accommodation based short and long-term services as well as floating support services. In addition to the short-term prevention and recovery services, there is a need for long-term support and accommodation-based services.

The 'pathway' will provide support as service users' needs change. It facilitates early intervention / prevention by ensuring housing needs assessments are completed to prevent someone becoming homelessness, including a Mental Health Needs Assessment within the procedures. It also helps build closer working relationships between Housing and Health Workers including the Community Mental Health Team and to develop robust Information Sharing Protocols

When someone is admitted (to any hospital in the area), the unit will be informed which allows planning for discharge to begin, this is reassuring for the individuals concerned particularly those with no accommodation. Came about as a result of a member of the local authority's Housing Department was once a service manager in Social Services. The development was informed by personal experience of cases where individuals were discharged only for temporary accommodation arrangements to fail. The person then re-presented to housing without any notice. The arrangement allows three key public services – health, housing and social services - to focus on providing co-ordinated support for an individual to prevent cyclical problems as far as possible. Working relationships and mutual understanding of roles has improved as a result of the development. behaviour.

A Stakeholder Panel has been established to ensure the Pathway is successful. It also facilitates communication and information sharing between all agencies and key stakeholders, helps ensure people have access to primary care services and secondary support services via Supporting People to help them maintain their tenancy. It will also inform future planning and commissioning arrangements and where required and appropriate to inform and make recommendations. The group includes representatives of the local authority's Supporting People, Community Support, Community Safety, Children's Services and Housing Options teams, the NHS Community Mental Health and Substance Misuse teams

**Hospital Discharge Project**
**Conwy County Borough Council (project lead)**

The Hospital Discharge Project was established in December 2016 after discussions triggered by the 2025 Movement. It works across Conwy and Denbighshire in partnership with Betsi Cadwaladr UHB, Conwy Housing Solutions, Denbighshire Housing Solutions and Conwy & Denbighshire Care & Repair Agency. A Housing Officer is based full-time in Ysbyty Glan Clwyd. The postholder works with patients and partners to address any housing issues which enable timely discharge from hospital to home or, where necessary, to temporary accommodation. The role has been piloted within the Step-Down team since the end of December 2016. Initially funded to run for 3 months, positive outcomes saw an additional 6-month extension. In November 2017, the Health Board confirmed permanent funding for a full-time Officer.

The role evolved and developed during the first six months to establish. The Officer endeavours to attend all board rounds, which was particularly important in the first months as it was an opportunity to meet with ward and therapy staff and discuss the benefits of the role to support discharge planning. The service was promoted on all wards in acute and community hospitals and in the emergency quadrant with posters, and education pack and contact details. The education pack also contains helpful housing-related prompts for staff when completing the 'what matters' conversation with patients.

The housing officer initially visited each hospital site weekly but as more case are identified within the acute site, the necessity of visits to community hospitals has reduced. The officer endeavours to attend community sites within 24hrs of a patient being transferred from acute where the patient is already known to them. This provided valuable reassurance to staff within the community setting that plans are in place and that the patient's referrals need not be re-started. This has aided and developed trust.

The officer contributes to the weekly delayed transfer of care meetings. This has provided valuable information to the housing officer and a weekly link to discharge liaison nurses working in community hospitals, it has improved their knowledge of housing options. A file system has been developed for the Emergency Quadrant. A staff member who believes that there may be a housing-related concern that could delay discharge simply places the patient's G number sticker in a designated file in their area. Files are checked daily by the housing officer who approaches the patient and establishes what options/services may be available to them. This has been of real benefit where a patient's medical needs have seen them admitted onto a ward as the housing officer can effectively 'track' their case and ensure that where appropriate, support is offered. The results are positive with 47% of cases identified within the Emergency Quadrant.

The support provide to the Acute Mental Health (Ablett) Unit and attendance at weekly meetings allows early intervention in cases. This is particularly important when dealing with patients who are being treated for mental health conditions as their cases tend to be complex with several underlying factors which can mean housing options are more limited.

In the first 6 months, 80 patients benefited from the service. Further analysis was undertaken in October 2017 to capture the total notional savings to BCUHB using a formula developed by Nottingham University. Applying Nottingham University's formula, the early intervention of the housing officer role saved BCUHB 1,293 bed days. This does not include potential front-door savings from avoiding readmissions and staff time savings knowing where to refer/signpost and support for the "What matters" conversations. Other benefits include increased knowledge and understanding of housing matters and options

**Tackling Health Inequalities for Rough Sleepers**
**North Wales Housing Association (Project lead)**

Triggered by discussions from the 2025 Movement, a project group was set up to focus on the Gwynedd area. This was agreed based to North Wales Housing's expertise in working with rough sleepers in Gwynedd through their outreach and resettlement services. Key goals were to meet rough sleepers in Gwynedd, to record their experiences of living with poor health and the barriers they encounter to accessing health services (22 interviewed January to March 2017). Also, as a means of ensuring the project made a difference, to identify one thing that's not working in terms of rough sleepers accessing healthcare.

Ensuring positive engagement with a group which is traditionally difficult to engage with is a challenge. One-to-one working with rough sleepers was required thus the action was labour intensive

As a result of the project. rough sleepers in Gwynedd can now access GP services as a result of the team's liaison with GPs in the area. They are now offered flu vaccinations (at the GP surgery) as they are considered health vulnerable as a group within the general population. They can also access emergency dentistry (information provided to all rough sleepers) and they have improved access to mental health services both in the community and in hospital.

The Project has had a positive impact so far in Gwynedd with health outcomes integrated into the Services delivered by North wales Housing's Outreach and Resettlement Team across Gwynedd. They are currently engaging with all 45 or so rough sleepers in the Bangor area and regularly engage with rough sleepers in Porthmadog and other towns in South Gwynedd. Most of the rough sleepers need support with mental health, drug or alcohol misuse issues. The stronger partnership developed with BCUHB has had some positive impact in encouraging rough sleepers with mental and physical health issues to engage with services. The team ensures that the hot meals prepared daily are balanced and nutritious, as well as providing ready prepared sandwiches and cakes as available. To a certain extent the service depends on the generous donations of businesses such as Greggs and Marks and Spencer.

A further 2025 project has now been agreed to explore and support the development of homeless day centres and night shelters in two geographical locations in North Wales, to look at offering a one stop service for rough sleepers, under one roof.

**CARIAD Scheme**
**LINC**

The CARIAD scheme aims to ensure patients who no longer require a medical bed are provided with an alternative pathway that supports and facilitates their long-term care needs.

It is a means of enabling people to 'step-down' from hospital when their treatment has finished, and they no longer need to be there, but may require a further period of assessment in an alternative setting. The acronym stands for "Collaborative Assessment Reducing Interventions, Admissions and Delayed transfers of care".

The scheme aims to prevent unnecessary admission to hospital due to short-term illness or injury, to reduce the risk of admission/ re-admission to hospital, and to shorten the length of time someone who is medically stable and needs help with rehabilitation is in hospital. The aim is to rehabilitate people to be able to return home or to another appropriate care setting. Circumstances in which it can help include issues affecting mobility e.g. plaster cast; to allow time to establish the level of care needed and to consider housing options, to manage delays in returning home because of delays in setting up home care, the lack of a carer for a time, and obtaining equipment or carrying out repairs or adaptations.

The project has 4 locations, which include Extra Care, Residential Care and Sheltered Housing. Support is provided by the Blaenau Gwent Community Resource Team, which comprises Social Workers, Intermediate Care Consultant, Occupational Therapists, Physiotherapists, Rapid Response Nurses, Health and Wellbeing Support Workers. While part of the CARIAD scheme, the support provided is tailored to an individual's needs and any goals or outcomes that he/she may have are discussed and support provided to enable them to be achieved.