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↑ ↑ ↑ championing better homes and communities



Health Creating Practices

Shining a spotlight on housing initiatives



Foreword



Hugh Broadbent, Chair, National Federation of ALMOs

ALMOs have a strong commitment to the communities which they serve and work hard to tackle some of the wider problems affecting their neighbourhoods. Working in partnership with the health sector to improve the health and well-being of their tenants is one of the ways in which our members continue to do this. We are very pleased to have worked with PlaceShapers to commission the New NHS Alliance to undertake this innovative piece of work. We hope that the whole of the social housing sector can learn some really useful lessons from

the case studies and the briefing will help promote further housing and health partnership work across the country.



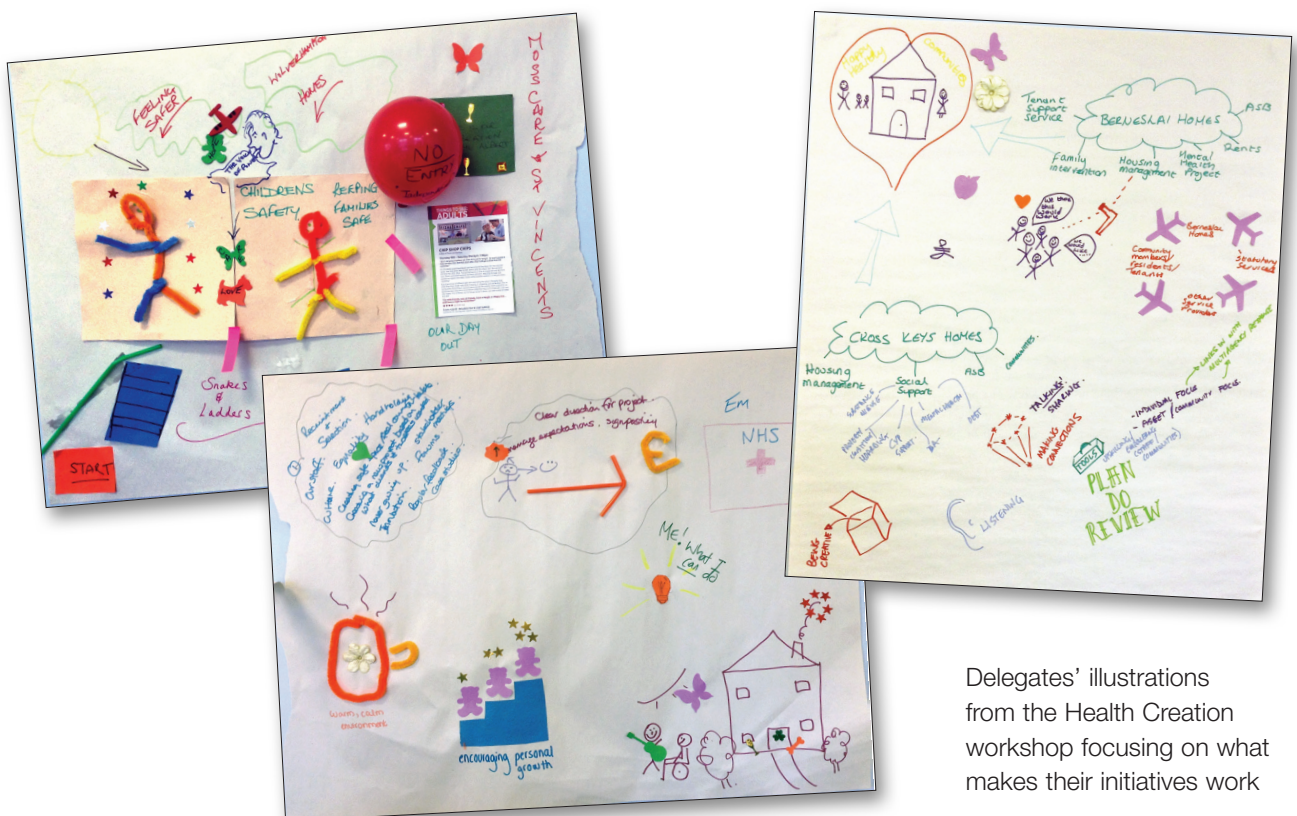
Sinéad Butters, Chair of PlaceShapers

We were delighted to collaborate with the National Federation of ALMOs and the New NHS Alliance on this important project. PlaceShapers take seriously their contribution to improving the health of communities and this collaborative project showcases what is possible.



Merron Simpson, Chief Executive, New NHS Alliance

Health Creation is a route to wellness. New NHS Alliance has an ambition for health creating practices to become common practice across the health system, enabling people and communities to live purposeful and meaningful lives. To that end, we have created a framework for understanding 'what makes us well' and tools to promote learning. I come across housing initiatives all the time that have elements of Health Creation within them and it has been a privilege to explore a few of these further through this project. It has been a moving and uplifting experience.



Delegates' illustrations from the Health Creation workshop focusing on what makes their initiatives work

Executive Summary

The National Federation of ALMOs (NFA) represents all local authority housing arms-length organisations. **PlaceShapers** is a national network for housing associations; together they have membership of over 130 housing associations and ALMOs. Both organisations have a shared agenda to support and promote the positive work that their members undertake to better the outcomes of individuals and communities, including around the health agenda.

Health Creation:
“The enhancement in health and wellbeing that occurs when individuals and communities achieve a sense of purpose, hope, mastery and control over their own lives & immediate environment”

The NFA and PlaceShapers have jointly commissioned **New NHS Alliance** to identify and assess good practice in Health Creation within health and wellbeing initiatives being delivered by their members. The New NHS Alliance is a growing UK-wide movement for action on health, social and economic inequalities through the widescale adoption of **Health Creation** (asset-based approaches) which enable people to become and stay well.¹ Both the NFA and PlaceShapers are partners with the New NHS Alliance and are supportive of their work.

Although there is a natural harmony between the initiatives that many housing associations and ALMOs undertake and the Health Creation agenda, this is the first time that the New NHS Alliance has had the opportunity to direct the lens of Health Creation onto social housing initiatives in its new **Health Creation Diagnostic** which focuses on the **5 features** of health creating practices.

The 5 Features of health creating practices:

- **Listening and responding**
- **Truth-telling**
- **Strengths-focus**
- **Self-organising**
- **Power-shifting**

It is an opportunity to understand and codify what is already being done, but also look for ways of further embedding **the principles** of health creating work.

To be well people need:

- **CONTROL** • **CONTACT** • **CONFIDENCE**



Methodology

The New NHS Alliance focused on seven place studies from NFA and PlaceShapers members which cover a range of initiatives. They studied literature on the initiatives and explored them through interviews with stakeholders, including people who experience the initiatives first hand ('service users'), frontline staff, and those at a 'systems' level within the organisation. A workshop was held to further explore how the place studies might go further in adopting health creating practices.² Each place study has been assessed against the five features of health creating practices and provided with feedback, which is summarised in this briefing.

¹ New NHS Alliance, A Manifesto for Health Creation: <https://www.nhsalliance.org/about-us/manifesto-2/>

² Delegates from 6 out of the 7 place studies attended the workshop in February 2018 to explore Health Creation and look at their place studies in further depth to compliment the work undertaken in the Health Creation diagnostic.

The Report Structure

The report has the following structure:

- **Part one – Setting the scene** – looking at housing, health and the concept of Health Creation (page 5)
- **Part two – The place studies:** an overview of each place study, with a spotlight provided on the features of health creating practices:
 1. **Stockport Homes** – refashioning the hospital to home pathway for homeless people (page 8)
 2. **Mosscafe St Vincent's** – supporting an over 55s group (page 10)
 3. **Berneslai Homes** – improving mental health through the Community Links scheme (page 12)
 4. **Cross Keys Homes** – The Connecting Families initiative (page 14)
 5. **Nottingham City Homes** – Hospital discharge and admissions prevention (page 16)
 6. **Wolverhampton Homes** – The Independent Domestic Violence Adviser (IDVA) service (page 18)
 7. **Rooftop Housing Group** – Walking football (page 20)
- **Part three – A summary of learning** from across the place studies and Health Creation workshop (page 22)

Key findings

Key findings are explored more fully in the final part of the report (page 22). A summary is provided below:

1. These housing organisations have **embraced Health Creation organically**, but the Health Creation diagnostic has enabled them to look more **systematically** at what they do and look at ways to improve their services and outcomes further.
2. It is harder to express **what makes something work** than where it can be improved, but actually **focusing on, and identifying, strengths** is a key part of working with clients.
3. There is sometimes a clear value in **having staff who are seen as independent** of mainstream service providers.
4. Working to shift power to clients/ service users involves **doing things differently** at a frontline and systems level; and power-shifting is expressed in different ways across the organisations.
5. **Active listening was fundamental** to the success of the place studies, but advocates are needed when systems don't listen well.
6. **Self-organising can develop out of a focus on strengths**. Where there is a focus on people's strengths, this can provide a route for people to reconnect, but it needs to feel natural to people, and this demands a high level of skill from professionals.

Part one – Setting the scene

Housing's offer to health partners

Social housing providers understand the value of building community resilience, empowering communities and preventing ill-health. Good quality housing is fundamental to people's wellbeing, and there is a weight of evidence showing the impact of poor – and good – quality housing on people's health outcomes.

Good condition, suitable housing and housing related support systems are, in themselves, necessary for healthy outcomes. However, in addition, PlaceShapers' and NFA members run programmes around health and wellbeing for what are often the most vulnerable individuals in society, and hence those who most suffer from health inequalities. This includes programmes around maximising income and employment, supporting with substance dependencies and mental health issues, promoting healthy living and eating, reducing social isolation, and supporting vulnerable families and older people.³

Perhaps most importantly for this, NFA and PlaceShapers' members are deeply embedded within their local communities, especially where the housing stock is geographically concentrated as with all ALMOs and many housing associations. They consciously take time and have systems in place to get to know their communities well in an effort to ensure that interventions and initiatives emerge from – and respond to – those communities.

Social housing providers have also taken considerable steps across the country to work with health partners including on hospital discharge, reablement, social prescribing programmes and multi-agency safeguarding hubs. Many of these projects make use of community assets to improve people's health outcomes and support health partners in achieving their outcomes (e.g. preventing delayed discharge). This is supported by a range of toolkits, research and best practice guides which look at the value of housing to health and supports organisations to evidence outcomes, for example:

- *The Housing Learning and Improvement Network (HousingLIN)* maintains **Health and Housing Intelligence pages** which pull together national policy and operational documents on the health and housing landscape and provide a range of case studies. They also have a **Health Exchange**, which is a free online resource for practitioners working across housing, adult social care, public health and primary care⁴
- *The Chartered Institute of Environmental Health* has a **Housing and Health Resource** which provides best practice case studies and advice and guidance⁵
- *New NHS Alliance* has a **Housing for Health website**⁶ – a web-based resource for strategic health leads
- *The National Housing Federation* maintains **a suite of resources** highlighting health opportunities for housing, and housing's offer to health, with advice for practitioners and case studies from their members⁷
- *SITRA Housing and Public Health* **Housing and Public Health Resources**, which studies the impact of the housing workforce on health outcomes, builds case studies and develops a suite of training resources to enable housing providers to develop their staff to become part of the wider public health workforce⁸
- **Developing your local housing offer for health and care: Targeting Outcomes**, a *HousingLIN* and *Chartered Institute of Housing* tool which provides a chart to help clarify and articulate how housing and housing related services can deliver the specific outcomes required of health and care partners through the national framework⁹

³ See for example, the NFA Best Practice Briefing, Improving Lives: <http://almos.org.uk/include/getDoc.php?did=7893&fid=9263>

⁴ <https://www.housinglin.org.uk/Topics/browse/HealthandHousing/>

⁵ <http://www.cih.org/healthandhousing>

⁶ www.housingforhealth.net

⁷ <https://www.housing.org.uk/topics/health-care-and-housing/>

⁸ <https://www.gov.uk/government/publications/housing-and-public-health-role-of-the-housing-workforce>

⁹ http://www.cih.org/publication-free/display/vpathDCR/templatedata/cih/publication-free/data/Developing_your_local_housing_offer_for_health_and_care

- **Standards of Evidence in Housing**, commissioned by *NHS England*, this *HACT* toolkit provides agreed standards that people can consistently use to produce evidence of the effectiveness of their interventions¹⁰
- **Housing: Just what the Doctor ordered**, a *SITRA* and *NHS Alliance* publication to support the housing sector in taking forward its work with clinical commissioning groups¹¹
- **Closing the Health Gap – a briefing on housing and health inequalities** by *NHS Alliance for Housing LIN*¹²
- **An integrated approach to delivering personalization... or a personalised approach to delivering integration**, *HousingLIN Viewpoint 44* (2013),¹³ Merron Simpson
- **Realising the Value**, *NHS England* with *NESTA* and various partners¹⁴
- *The King's Fund* and *New NHS Alliance* report on the **Economics of Housing and Health, the role of housing associations**, which looks at the economic case for closer working between the housing and health sectors, and shows case studies illustrating the economic benefits that housing associations can provide¹⁵

New NHS Alliance and Health Creation

New NHS Alliance brings together values-led professionals from across primary care, mental health, public health, social care, housing, local government and third sectors with communities to effect a wholesale shift in focus across the health system to 'wellness'. New NHS Alliance has an ambition to make Health Creation and health creating practices a core part of the UK health system alongside a greater focus on prevention. From deep lived experience, we know that working in equal partnership with communities is an effective way to reduce health inequalities and deliver a sustainable health service.

Health Creation is a route to wellness. It is also a route to a healthier economy. It comes about when professionals and local people work together as equal partners and focus on what matters to the community.

Health Creation requires 'asset-based' skills characterised by the five features of health creating practices. When these features are working, it provides the conditions for people to gain Control, make meaningful Contact with others and build Confidence. People need enough of the 3Cs of Health Creation to be well.

The roots of Health Creation

Health creation as a concept brings together the wisdom gained from clinical and community leaders who have been working over decades to address inequality and support people to change their lives. In particular, it draws on the work of:

- Aaron Antonovsky, an American sociologist who talked about helping people to manage and reduce chronic stress (and the impact this has on health). He put forward a theory called 'a sense of coherence' which said that people could stave off the worst effects of stress if their lives are comprehensible, manageable and meaningful;
- Viktor Frankl, a psychiatrist who sought to understand why some people had survived the German concentration camps during the Second World War, concluding – by quoting Nietzsche – "He who has a why to live for can bear with almost any how"- i.e. the importance of a life with meaning;
- Sir Harry Burns, the former Chief Medical Officer for Scotland, who spoke often about his experiences of working at Glasgow Royal Infirmary as a surgeon, observing that his working-class patients healed more slowly than others. Absorbing the work of others, such as Frankl and Antonovsky, he thought that some of what he saw was down to a lack of resilience, meaning and purpose in men's lives when the shipyards of Glasgow closed;

¹⁰ <http://www.hact.org.uk/standards-evidence-housing>

¹¹ <https://www.nhsalliance.org/wp-content/uploads/2015/10/sitra-what-the-doctor-ordered-brochure-print-1.pdf>

¹² <https://www.nhsalliance.org/wp-content/uploads/2016/01/Housing-health-inequalities-paper.pdf>

¹³ https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Viewpoints/HLIN_Viewpoint44_IntegrationPersonalisation.pdf

¹⁴ Finnis A, Khan H, Ejbye J, et al. *Realising the Value: Ten Key Actions to Put People and Communities at the Health of Health and Wellbeing*. London. NESTA. 2016

¹⁵ <https://www.kingsfund.org.uk/publications/economics-housing-health>

HEALTH CREATING PRACTICES

Shining a spotlight on housing initiatives

- The Young Foundation, in 2008, studied how neighbourliness strengthens community resilience. They found the strongest communities are those in which residents are able to influence decisions affecting them and their neighbourhoods, where there is regular contact between neighbours and where residents gain the confidence to exercise control over their circumstances. It is this work that led New NHS Alliance to articulate the 3Cs of health creation – control, contact and confidence – and to test them further with people with lived experience.

In essence, the health creation framework is a new way of conceptualising and drawing together a range of theories and approaches that have long been expressed in the health world by different names.

At the NHS Alliance Health Creation Action Summit in December 2015, more than 95% of delegates from a range of voting backgrounds, including housing, said they believed that if they adopted health-creating practices, there will be a positive impact on cross-professional working.

The features

The five features of health creating practices are:

- **Listening and responding** – effective, genuine listening to the reality of people’s and communities’ lives, and acting differently upon what is heard;
- **Truth-telling** – When people and practitioners face the truth, and own up to what holds them back from creating health, they can start to get to the root causes of problems;
- **Strengths-focus** – Paying attention to what people can do for themselves or others; building on people’s strengths to unlock their potential and build confidence for creating health
- **Self-organising** – Connecting with other people in meaningful ways, rather than being socially isolated, enables people and communities to work out and find ways of getting hold of the things they need and they become less reliant on statutory services
- **Power-shifting** – a power shift from practitioners to people and communities, when people and communities are the experts, they can make decisions.

The five features lead on from each other: if you effectively listen and respond, this promotes truth-telling and a focus on people’s strengths; this in turn leads to self-organising and power-shifting within communities, which ultimately creates health.

The Health Creation diagnostic looks at these five features in the place studies on the following pages, before drawing together the main learning points from across the place studies. The diagnostic uses a scoring system and each place study was scored on how well it is practising each of the five features.



Part two – The place studies

Place Study One – Stockport Homes – H4 Hospital Discharge Service

The H4 Hospital Discharge Service has been running in Stockport since 2013, originally funded by the Department of Health and now by the Big Lottery Fund. The project is a shared initiative between Stockport Homes (an ALMO with nearly 12,000 properties) and H3 – Helping the Homeless into Housing, which was set up by homeless people living in temporary accommodation. A key ambition has been to re-fashion the pathway for homeless people into an integrated health and housing pathway.

The place study

The project is focused principally (but not exclusively) on addressing the health and housing needs of homeless people leaving hospital, particularly the barriers to accessing health services. Referrals are received from a range of partners, but usually come from the Stepping Trust NHS Foundation Trust that provides A&E and general wards, and Pennine Care, that provides mental health wards.

Given that in Stockport the mental and physical health services are in separate pathways, a key ambition has been to re-fashion the pathway for homeless people so that there is integrated care coordination. The service aims to ensure that homeless people:

- Have a suitable place to stay which is ready for them when they are discharged from hospital
- Are supported to access long-term settled accommodation after dealing with their immediate homelessness issue
- Have access to the health services they need including a named GP
- Report a reduced use of crisis services in the future
- Are enabled to volunteer with the H3 and give something back, as well as developing new skills
- Report that they feel improved wellbeing and confidence to manage their health and housing independently.

The H4 Hospital Discharge Service employs two staff. The Hospital Advocate works from the Integrated Discharge Team and supports individuals in hospital, undertaking assessments and ensuring an effective discharge into appropriate accommodation. Once discharged, the Health Advocate works with the individual intensely for up to 28 days to ensure long-term stability; working on everything from practical support (e.g. registering at a GP surgery or attending outpatient services) to accessing community-based services (e.g. therapy services, mental health and substance misuse services).

The service is also developing Peer Supporters who have used the service and can provide support to individuals. The service sits alongside H3's wider engagement and wellbeing activities, including a therapeutic programme, volunteering and sport.

The advocates also provide training and upskilling for hospital and community-based health professionals to ensure they understand the issues around homelessness.

Evaluating the project

An end of year two midway project report was undertaken, based on data from 285 customers who were supported in the period May 2015 to January 2017. This showed a clear shift from critical and emergency care to planned community-based care. Highlights of the analysis, undertaken using the New Economy tool included:

- Overall savings to health services of **£720,182** for these individuals based on benchmark data for six months prior to the intervention. This included a significant reduction of ambulance call outs and A&E visits (with no investigation, with treatment and with admission);
- A shift of costs to planned intervention, including outpatients appointments, GP appointments and community nurse visits. These are significantly more cost effective than emergency intervention; the analysis found a saving to emergency care of over £720,000, but a cost to Primary Care of £7,100, the majority of which was the cost of increased GP visits.

Alongside the cost-benefit analysis, a range of outcomes are being measured on the project, including ensuring homeless people have a suitable place to stay when discharged from hospital; homeless people have access to a named GP and other health professionals in the community as needed; a reduction in the number of homeless people reporting a use of crisis services; homeless people in long term settled accommodation; homeless people volunteering through H3; and homeless people self-assessing that they feel improved wellbeing and confidence to manage their health and housing independently.

Highlights from the Diagnostic

The scheme (and H3) came about through a history of organisational **listening and responding**. Good practice includes:

- There are many routes for people to have a voice and to be heard by others, both individually and in groups;
- Practitioners are non-judgemental and are experienced in active listening through a two way conversation rather than through direct questions;
- Staff understand the importance of acting on what they've heard, of keeping people informed and providing feedback;
- They also understand the power of peers – people who have had similar experiences – as listeners.

The organisation observes 'reflective practice' and colleagues are expected to emulate the listening among each other that they are expected to employ with service users.

There is a very big emphasis on focusing on people's **strengths**. There is an understanding that people need to 'build something for themselves' (beyond just meeting their needs) and that giving or helping others gives them a purpose and makes them feel good.

There is an awareness of the routes people who have been through a major crisis take to rediscovering their strengths and themselves, and that everyone needs to define that route for themselves. The initiative starts by helping people find meaningful things to keep them occupied, and through that they discover/rediscover things they enjoy. Learning and developing new skills is encouraged and in time people start to plan their futures.

Self-organising is a key aim of the project. Every client is put in touch with a peer mentor early on, so they have someone to talk to who has been through similar experiences. After a while, there is an opportunity to become trained as a peer mentor, which provides a route to connecting with and giving to others.

The initiative also provides mediation to help people to reconnect to family members they may have lost touch with, as well as introductions to a range of agencies and groups in the community.

There is a recognition that this process of connecting and developing relationships needs to feel natural to the person, and that this can develop from finding the things that they enjoy and are good at, and meeting like-minded people through these activities.

The organisation has a very good attitude to **truth-telling** and high level professional skills in drawing out the truth. Good practice includes:

- A recognition that people need to feel safe to open up. The environment is important, so the system allows meetings to take place wherever the person feels most relaxed
- The independence of H3 (from both housing and health services) gives people confidence that they will be helped and not judged;
- Practitioners are honest and clear with people about their role, the limits of what they can do, and about their safeguarding duties;
- The organisation puts significant effort and skill into building trust and carefully manage the line between friend/confidant and professional

Truth telling also takes place at a systems level. One of the aims of the initiative is to reshape care pathways, which requires a degree of challenge to health colleagues, and reframing of the issue and potential solutions

The service has **power-shifting** at its heart as a route to enabling people to regain control over their lives and situations.

There is an understanding that equality comes through listening and making the right things happen together. Staff seem to genuinely like being equal partners with clients and seeing people's lives change for the better. They also try to bring this ethos of equal power to mainstream services (which service users see as hierarchical). A number of staff members and charity trustees are former service users

"We work hard to protect the user-led nature of it. It's easier not to... to write a strategy and implement it, but you'd never get the same engagement. It doesn't work if nobody engages. It's about co-creation, building proper relationships, wrap around support"
– A Senior Manager

Place Study Two – over 55s scheme – Mosscafe St Vincent's Housing

Mosscafe St. Vincent's Housing (MSV) is a community-based landlord working across the North West of England. The over 55's Group is a shared project between the Neighbourhoods and Supported Housing Team at MSV.

The place study

The over 55's group came about as a response to reports of social isolation among MSV residents in 2013 and was officially launched in May 2014. Tenants were very clear that they did not want a structured group with formal processes (as there were other residents' groups for this) but wanted the focus to be on the social interaction and social activities. From this, it has grown organically around the choices of the tenants who are involved and now has around 57 members, a third of whom are not MSV tenants.

A good relationship has developed with MSV which provides the administrative support (maintaining the database, mailouts, advertising leaflets etc.), spaces to meet within their schemes, and a small amount of funding to subsidise some of the activities so that they remain accessible and the group can be as inclusive as possible.

Although the group is primarily a social club led by its members, it also serves as a useful connection point between the older members of the community and local services, providing a two-way flow of information, for example local benefits services, and health and wellbeing services. This hub helps people to make connections and improve their own wellbeing.

The group is made up of people living in private homes in the community as well as MSV tenants. As a sign of its success, it has started to receive referrals from social workers who see the value of the group for reducing social isolation in the wider community. MSV has also trained its Direct Labour Service staff to identify people who may benefit from the service as they deliver the repairs and maintenance service, and refer them through to the Housing Officer who can undertake an assessment.

MSV supports the over 55's Group because they believe that it helps to keep people healthy, happy, involved and well. It reduces the number of management problems and improves trust levels within the community by creating mutual respect.

Evaluation

A Value Calculator & Impact Valuation statement used HACT social value methodology to calculate that the total social value of the events listed in the scheme per annum is £67,433. Testimonials from group attendees indicated that as a result of the club, people were less isolated, they were developing new friendships and felt happier.

Highlights from the Diagnostic

This organisation understands the importance of **listening**. There are many vehicles for listening to residents including through direct means – to gain feedback on a specific matter – and also through indirect means, e.g. through drawing competitions for children and regular walk-about. MSV tailors the communication vehicle to the group and issue.

The over 55s scheme is a beneficiary of that listening culture and staff are clear with residents that ‘you need to tell us what is best for you.’ The residents involved in the group feel that they are listened to, and that the organisation responds well.

The organisation has very good systems and structures for **truth-telling** to take place. There is flexibility over where meetings take place, translation services are offered. People know how to gain resolution for issues if they feel that they are not being taken seriously.

The over 55’s scheme is open, inclusive and organic, so relationships are built over time. They actively seek out people who they think may be isolated and invite them along. It provides the possibility for people to get to know others, and deep friendships have emerged between group members.

There is a big focus on **strengths**, both in the place study and in terms of MSV service design. For example, the police have asked MSV to survey people on their behalf, and this group was involved in that work. People are encouraged to use and develop their strengths and are connected to sources of information and expertise to help them.

For example, MSV helped the group to bid for funding for ten music sessions with Manchester Camerata. The over 55s group promoted it among the sheltered housing schemes and each scheme wrote a verse of a song. They performed it at the Royal Albert Hall with the Camerata Orchestra.

Power sharing: Considerable effort is put into enabling residents to have control of the scheme, and residents feel that the relationship with each other and with MSV is equal. In the past, the offer was made for residents to run the scheme themselves, but they asked MSV to continue to run it because they did not want any individual or group to take over.

Both MSV and group members see the group as a vehicle for information transfer, so that people are equipped to lead their own lives well and also to contribute positively within their community.

There is a strong element of **self-organising** in the group. The way the group works is very flexible and it is a vehicle for many things. Alongside the initial agreed activities, the group cooks meals together and has information sessions where they invite speakers in. Sometimes the group acts as a springboard for a smaller group to do something they organise themselves, which is outside the support of MSV.

There is clearly an emphasis on having fun, sharing information, helping each other. The group will try and make sure the food is halal so that it is inclusive and people can come and enjoy it.

Areas for consideration: To take more steps into health creation, the organisation might like to consider how the group can go further in terms of using their own strengths to become less reliant on MSV. The organisation might also consider how MSV or the group be encouraged to be a place where isolated people can gain trusting friendships where they can start their journeys to wellness.

Place Study Three – Mental Health Scheme – Berneslai Homes

The Community Links (Mental Health) scheme arose from a pilot which was developed in partnership with Community Links, a support provider based in Leeds. The project provides low level support for those who fall below the threshold for help and support from statutory agencies and the third sector. Originally a pilot, the decision has been made to bring the service in house to grow on the scheme's success.

The place study

Berneslai Homes has a significant and increasing number of tenants and households who are affected by short and long term mental health problems, many of whom fall below the threshold for help from statutory agencies and the third sector. These problems impact on their ability to successfully sustain their tenancy, the wider community, and the workload of staff who do not always have the skills to provide appropriate support.

The service provides two specialist Mental Health Support Workers who provide people with support in areas which are affecting their tenancies, including accessing the correct services, preventing isolation, integration into the community, managing tenancy and finances, improving physical and mental health, and support with practical skills and tasks.

The purpose of the service is to support individuals to maintain their tenancies successfully and independently, and through this, improve quality of life. The service also helps to reduce homelessness.

The pilot has demonstrated a holistic approach which addresses the current and future needs of the individual and their family, and not just the symptoms. The support they provide is both practical to resolve immediate issues together, with forward planning to aid the integration of the individual back into the community. There is a commitment to providing ongoing and interactive support for the individuals, and not to be 'just another referral service'.

The performance management tool is based on outcomes not client volumes, which reflects the approach that the project is based upon a collaborative relationship between service user and provider.

Evaluation

The purpose of this project is to improve wellbeing and quality of life. For this reason, the Outcome Star is used as a measure of success. The Outcome Star is a nationally recognised tool for measuring movement on a client journey, with self-assessed scores given on a range of measures. Looking at scores over time enables the individual client to track distance travelled, but also enables the overall project to be evaluated. Evaluation shows that the service is making people more resilient and improving their wellbeing and quality of life.

Highlights from the Diagnostic

Listening is at the heart of what this organisation does, and the expectation that staff will listen is embedded in its culture. There are many vehicles for listening to take place – between residents and the organisation, between frontline and senior staff- and staff also know how to hold conversations in the right way that enable people to express themselves. When specialist skills were required (such as listening to and understanding people with health conditions) Berneslai Homes sought these from outside the organisation and is now embedding these skills within Berneslai Homes. Sufficient time is built in to enable proper listening and to co-produce solutions. Where necessary, staff will act as an advocate to enable people to be heard by other parts of the system.

Truth telling flows well from the listening – it is clear that trust is being built consistently throughout this organisation.

Most meetings take place in people’s homes, but there is flexibility which ensures people can meet staff in a place where they feel comfortable. Staff know how to be personable and to develop close relationships with people and earn their trust.

Support planning is undertaken in a way that helps to maintain the professional boundaries and maintain a focus on the client. There is an appreciation that it takes time for some disclosures to emerge and that this requires patience on behalf of the practitioner.

Strengths-focus: Both the support worker and the organisation find ways to focus on what people can do for themselves, and also on enabling the person to do more for themselves. This can happen in small steps and may involve asking the individual to do something for them- in one case the support worker asked the client to make a bracelet for her, and she had felt a sense of achievement and value as a result. The strengths-focus can be indirect and subtle, and this allows strengths and skills to emerge and develop over time. People become aware that they can do much more than they thought and this helps them to develop a different, much more positive narrative about themselves.

There is clearly a culture of **power-sharing** across the organisation, both on a personal level between client and support worker, and beyond the scheme.

Staff understand that the community is a vital source of information which is very useful for informing service design. The community runs a lot of activity supported in various ways by Berneslai Homes, for example, by providing buildings for meetings and activities.

Tenant scrutiny is applied to wider community issues – making the organisation responsive to residents and the wider community in relation to wellbeing as well as housing management issues.

Self-organising: There is some really effective connecting work happening in this project. This includes helping people to maintain connection (or reconnect) with family members, as well as helping them to find new people and activities that they can connect with.

The organisation goes out of its way to keep staff abreast of what is available for people to engage with in the community and matching people to this, and has an ambition to develop this into a social prescribing service.

“My support worker has made me realise that not everyone wants to be against you – there are people out there that want good things for you”

“She’s helped me to understand who I am, how to read it differently, to create a positive bubble.”

Place Study Four – Connecting Families Initiative – Cross Keys Homes

Cross Keys Homes is the largest social landlord in Peterborough, managing more than 11,000 properties. It is one of several local delivery partners for Peterborough's Connecting Families Programme, which has been operational since 2012 (initially as the Troubled Families Initiative). It is funded by MHCLG and Peterborough Council, and includes a Payment by Results element.

The place study

Clients are offered assistance through the programme if they are currently below the threshold for social care/ children's care, and it is designed to support them and prevent cases escalating to the point where statutory services need to intervene. It is a voluntary programme that clients are invited to join. In addition to housing support, Cross Keys Homes are able to deliver on some parenting interventions, including the 'teen triple P' positive parenting programme, an evidence based parenting programme for teenagers and parents of teenagers.

Support provided by the Specialist Intervention Team under the Connecting Families remit are received by referrals through a multi-agency panel chaired by Peterborough Council that decides which agency should manage the elements of different cases. CKH takes on cases that have a significant housing/ tenancy component, and most are vulnerable families who are also their tenants.

Cross Keys Specialist Intervention Team have been operational since February 2015. It comprises seven posts, including Service Manager, Neighbourhood Delivery. Tenancy Support Connector caseload is around 15- 25 families at any one time.

Evaluation

As a Payments by Result service, there is a fundamental emphasis on individual and service outcomes, linked to national frameworks. In the period 2016-2017, the service managed 19 connecting families cases; of these, 84% achieved their outcomes (with a further 16% declining support or not engaging with the service). The most successful area was with school attendance, where 100% of cases achieved their outcomes.

Highlights from the Diagnostic

It is clear that Cross Keys Homes really understands the importance of **listening and responding**:

When the caseworkers start to work with a client they undertake a comprehensive 'Early Help Assessment' with the person that takes in everything to do with the family, their background, money, health etc. This is considered to be a vehicle for listening to make sure they have covered everything which might be causing concern.

One caseworker said: *"It is definitely more about listening than talking in this role."*

The frontline workers have a very good understanding of some of the barriers that get in the way of trust-building and **truth-telling** for their clients.

They are skilled at creating the conditions for people to open up, including using humour, 'just being there', being honest and reliable (doing what they say they are going to do) and allowing people to become comfortable in sharing their confidences.

As one case worker said: *"I don't ask for too much information, they don't like social care professionals – they think it leads to their children being removed. They will always be on the defensive if you keep asking them for information."*

The caseworkers also know how to maintain professional boundaries and handle safeguarding issues when they arise.

"There's a deal going on all the time... 'I'll do this for you and you have to do this for me' – then they realise how easy it is. Cross Keys will do the things they can't do" – A case worker

Strengths-Focus: The case workers use a wide range of techniques for building self-confidence and self-belief.

Outcome Stars are used as a positive reinforcement vehicle. For example, they might ask the parent/family to rate themselves, and the conversation that follows will pick up on the positives they have identified. The case worker said: *"They need to hear they are doing some things right – to encourage them to do other things right!"*

There is a very good understanding that the service is not about solving people's problems for them (which creates dependency) but rather enabling them to solve their own issues.

"When you're not listened to, it feels as though you're constantly fighting but getting knocked back. When (my caseworker) came along, I was able to open up more and slowly got my confidence back" – a service user in interviews.

Power-Shifting: The scheme is very good in terms of the equality of relationship between frontline professional and service user, helped by the fact that it is a non-statutory service which means people engage with it on their own terms.

Self-organising: The organisation has systems in place to find isolated people. Neighbourhood managers do regular visits to tenants and tradespeople are trained to spot the signs of vulnerability and isolation. These are then referred to the Specialist Intervention Team to look at.

People are helped to connect to relevant services and support, such as children's centres, Mind Mental Health Charity, medical services, through a directory of services. There is a significant focus on employees knowing what is available in the community and the support worker acts as a connector to make people aware of what is available. They also encourage clients to attend courses such as life skills and confidence building courses that they didn't have the confidence to access on their own. These could be offered by Cross Keys' Communities Team.

Areas for consideration: Like the other place studies, there is potential here to further enable people to build on their strengths by creating conditions for people coming through the scheme to connect to each other and other community members and to support them to do things together. Also, further enabling people to build their futures out of their strengths, for example through volunteering or employment?

Place Study Five – Hospital to Home Service – Nottingham City Homes

Jointly commissioned by Nottingham City Homes (an ALMO managing 27,000 properties in Nottingham City) and Nottingham CityCare Partnership, the Hospital to Home project works to support people who are discharged from hospital with housing related solutions.

The place study

The Housing to Health scheme was originally run as a pilot from November 2015 to March 2017, and following successful outcomes, has been jointly commissioned. The project funds two Housing and Health Coordinators (HHCs) at NCH to take referrals from health professionals in the hospital or in the community, to act as a key worker, responding to concerns, sourcing suitable accommodation and ensuring the person is set up to live independently in their new home. Although there is a prime focus upon housing support for people at the point of discharge from hospital, the scheme also promotes prevention of re-admission and has developed support for people with seriously adverse home conditions as well as, more recently, solutions for people with long-term mental health issues.

Referrals can be for a range of reasons, including assisting with transition to supported living environments, supporting with poor or inappropriate housing, improving health and wellbeing through the home, and ensuring homes are suitable for people to be discharged to, such as through aids and adaptations. Coordinators also work closely with Environmental Health to ensure people are supported who live in sub-standard private rented accommodation.

The scheme has recently expanded to a new hospital post, which will work within an Integrated Discharge Team to support individuals in hospital, undertaking housing assessments and ensuring an effective discharge into appropriate accommodation. The intention is that this greater involvement in the NHS team will further increase the numbers of people supported and enable earlier identification of housing need.

The starting point for referral on mental health grounds is that people are already in mental health NHS care, but under this project, they transfer into mainstream housing. Previously the majority of people in this category were homeless or not in fixed accommodation, and the Housing to Health approach gets people into a secure accommodation base rather than returning them to the cycle of temporary offers or supported placements.

Evaluation

Evaluation of the pilot demonstrated a clear financial return on investment for the local authority and the NHS by comparing outcomes with hypothesised 'counter-factual' scenarios; as well as looking at positive outcomes for individuals, measured by the Wellbeing Valuation developed by HACT and Daniel Fujiwara.

The evaluation found that for every £1 invested there was a saving of £6.40 to NCH, the NHS and Adult Social Services. The 129 people who had been successfully rehoused over the 17 months had gone through the process in 39 days compared with an average letting time of 129 days for people with medical needs on the general housing register. 31 people had been referred as delayed transfers of care from hospital and the number of days released back to the system was 2,642.

94% of people said they would not have been able to move without the support of the project and its staff. Six months after the move, people reported a 24% improvement in self-reported health, a 20% increase in health-related quality of life, and carers reported a 48% improvement in their own quality of life. The project saved an estimated 2,642 bed days and prevented in the region of 48 unnecessary hospital admissions.

The project has worked to build a different set of relationships between health and housing professionals. It has shown it can be successful in this ambitious aim, and the project is continually developing and is now stepping out into new areas and ways of working. It offers people a return to wellness that evaluations show has lasting impact and is deploying many of the features of health creation to this aim.

Highlights from the Diagnostic

Listening: The project develops a very personalised view of what matters to people about their house, supporting them with new housing or with remaining in their current home. It specifically recruits staff who understand the unique nature of the work, and their high levels of skill in listening and understanding are really appreciated by people in the service. There is a very strong sense that the project cares about what really matters to people and takes the time to find this out. It is also clear that the project has influenced the whole organisation, not least in improving the use of housing stock, but also through developing new relationships with stakeholders.

In interviews, one person reported that she was alive because of the move and the way which this had been done: the project 'got a very personal picture of me.' Another stated that it was like the staff had 'known me forever.'

Strengths-focus: The project is clearly focused on supporting people to develop their own strengths and go on to live independently.

Follow up evaluations of people after they have been re-housed show significant gains in self-reported health and quality of life measures. For example, there was a 24% improvement in self-reported health; 20% better quality of life and 85% better contact with others; while 97% of people felt safer in their own homes.

An above UK average score for mental wellbeing is impressive confirmation of the way in which the scheme has built up the personal strengths of people, based in large part on the levels of engagement with them during their house move process.

Self-organising: People reported feeling 'in control' and also appreciated the quick nature of practical support, such as vouchers for decorating new houses.

Although there are clear time pressures on staff, these are not handed over to service users, so they have a strong sense of having control over decisions, pace and the organisation of their lives.

The opportunity to develop peer support was identified as part of this work, and the proposed peer mentoring from people with recent amputations represents a very significant step in this direction, with the opportunity for peer mentors to develop strengths/ awareness of existing strengths

Truth-telling: The project has a clear commitment to stepping in to walk alongside people who are at a point of great vulnerability. There is a commitment to supporting people to honestly assess their own situation and put in place a plan which they have control over that will prevent re-admission to hospital.

From a community point of view, the project has been very effective in building a reputation for housing locally and evidencing the contribution it can make. The evaluation highlighted the 'difference in culture and knowledge' between housing and health, and the project is clear and honest about some of those issues. It can show a positive trajectory for how these have been tackled.

Power-shifting: The project gives people back control and dignity in their lives by resolving and addressing housing issues, and the evaluation scores suggest that this work has a sustained and positive impact on wellbeing.

There are significant power imbalances in the wider professional systems which have shown in issues like funding and measurement (for example, the NHS' counting of 'bed days' is an uncomfortable fit with a person making life changing decisions about their home.) The project is conscious of these issues, and is managed and steered with considerable strategic skill to make an impact on them.

Housing to Health supported one service user with terminal cancer as she elected to give up her property and move in with a friend and carer. Six months on, she was clear about being alive today as a result of her move:

"A new house meant it was possible to start getting myself out of bed, washing and controlling my continence. Taking back control of these things has made a huge difference."

Benefits to NCH: The benefits of the Housing to Health project to NCH include a reduction in the void (empty property) rate and a fall in the number of empty independent living apartments – all of which contribute to more sustainable and thriving communities and allow NCH to reinvest more back into services for residents.

Place Study Six – Independent Domestic Violence Adviser – Wolverhampton Homes

Wolverhampton Homes has a range of programmes which focus on developing healthier communities, including programmes around home energy, fuel poverty, domestic abuse advocates and mental health counselling. Managing 23,000 homes across the city, the ALMO is well placed to support vulnerable customers with early intervention.

The place study

Wolverhampton Homes has a systematic approach to identifying and supporting people who are victims of domestic abuse, which has arisen out of findings from Domestic Homicide Reviews. This approach enables the organisation to identify people before they become tenants (or if they wish to move between properties) and provide the right support for them.

A question on whether the person wants to move as a result of domestic abuse is included on the housing application form, with positive responses followed up within a week with a personal call. Following a Safe Lives risk assessment, cases are rated high, medium or low risk. High risk cases are channelled immediately through to MARAC (multi-agency risk assessment conferences), while medium and low risk cases are given additional priority and signposting into support services. However, there is an emphasis on supporting people to fulfil their choices, including supporting them to stay within their own homes if they want to.

Wolverhampton Homes' Housing Independent Domestic Violence Advisor (IDVA) works with high level domestic abuse cases and at points of crisis, providing advocacy and support to ensure the voice of survivors informs every stage. The service recognises that people who are victims of domestic abuse have a more specialist set of needs, including around lettings, tenancy management and debt, and arose as a response to issues raised in domestic abuse homicide reviews.

The IDVA specialises in working with clients for whom housing and a risk of tenancy breakdown is a factor, making proactive contact and providing high quality advocacy and support based upon a client-led needs and risk assessment to victims. A question on domestic violence is included within housing applications with positive responses followed up within a week with a personal call. The emphasis is on supporting people to fulfil their choices, whether it is to stay in their own homes or move to somewhere more suitable for them.

The IDVA also advises on criminal justice and civil remedies and related matters, supporting victims to attend court where necessary, and coordinating the provision of multi-agency support. A key part of the post is to establish positive, proactive and innovative working relationships with other agencies.

Wolverhampton Homes have a co-located post in the multi-agency safeguarding hub, who attends the Barnados DV screening panel of low-level domestic abuse, ensuring cross-sector working.

Collectively, the introduction of a dedicated IDVA service has made a massive difference to how victims of domestic abuse are supported, with better systems for identification and response. The service is developing; for example, with the introduction of a counselling service that Wolverhampton Homes commissioned for tenants to respond to issues, including those arising as a result of domestic abuse.

Highlights from the Diagnostic

Listening and responding: Wolverhampton Homes' whole application process is designed around making sure that people who experience domestic abuse have the means to communicate this at the earliest possible opportunity. A Safe Lives risk assessment is undertaken over the phone, if that is appropriate, or in a way that the individual chooses where it is not safe for them to speak over the phone. Often victims of domestic abuse are not encouraged by statutory services to stay in their own homes if they rent, but this service listens to people and advocates for them to be able to do so if they wish, for example through a move to temporary accommodation or the provision of safe spaces in their homes.

The team has an Independent DV advocate based within it, which has been useful as a way of providing a step of distance from the landlord (e.g. allaying concerns that speaking to the service might have an impact on tenancies).

Truth-telling: Often this is the first opportunity that people have had to tell others about their abuse, and it is important that the service is delivered on their terms. People are given choices which enable them to make informed decisions about how they can be supported; they are also provided with signposting and information. For high risk cases, intensive support is provided over a period of months which looks at the whole situation and gradually empowers people to take back control over their lives. The organisation recognises the link between ASB and domestic abuse, and the ASB team is trained to flag up concerns with housing officers, which can then be sensitively explored.

Strengths-focus: There is a strong focus on supporting victims to recognise their strengths and build on them across all elements of the work that Wolverhampton Homes does around domestic abuse. Important for this is ensuring that people have a genuine choice around where they live; and gradually empowering them to take back control of their lives by recognising what they can do for themselves.

Power-shifting: Wolverhampton Homes has a clear commitment to working with tenants to shape services through all their engagement mechanisms. By catching individual cases early, the organisation is working in a preventative way to channel people into multi-agency services before their cases escalate.

Self-organising: Where possible, people who are victims of domestic abuse are supported to stay in their own homes and communities, preventing an uprooting from what they know and the networks that they have. This includes maintaining tenancies for victims while they move into temporary accommodation for a period of time. Although there is currently not a peer support network in place, this is something that the organisation may explore in the future.

Place Study Seven – Rooftop Housing Group, Walking Football

With roots in Wychavon, Rooftop Housing Group provides homes mainly in South Worcestershire and into Gloucestershire, and the group has over 20,000 customers.

The place study

Rooftop Housing Group (Rooftop) has always valued the place it has within the community and, like many housing associations, has a commitment to doing more than 'just housing'. With property spread across 46 towns and villages, the organisation has developed a high level of insight into the micro-nature of the communities where it works. This has led to an approach to community investment which has become a 'profit for purpose' methodology. The organisation employs a team of six staff who work in the area of health and wellbeing. The team have a clear brief to be an enabling and facilitating resource, rather than becoming involved in the provision of activities. This includes a programme of co-production with tenants and engagement of people as volunteers. This is supported by a strong strategic commitment from the Board.

The diagnostic focused attention on the Walking Football group, which was launched 18 months ago. The scheme arose from the skillset of the lead volunteer and tenant who had substantial past experience of running football clubs. It was designed to bring people together and improve health and wellbeing. The group has been evolving from the start, and now engages a range of older men in a number of different ways, including in running the group and supporting activities.

In the past, Rooftop has found it challenging to engage with older men, and this group has been so successful that it is running three sessions a week aimed at Rooftop residents and the wider community.

Evaluation

The organisation utilises an evaluation system based on the Warwick-Edinburgh methodology to evaluate the impact of its initiatives on mental wellbeing. All players have demonstrated an improvement in their mental wellbeing after three months of participating in the scheme. This comes from a range of factors, including the socialising and support network, the confidence building, the physical health benefits.

Case Study: *A man who had recently retired came to walking football at something of a loose end. He enjoyed playing and realised he could use some old skills and interests in new ways. He has gone on to help at the local junior football club and to complete coaching qualifications. He has also recruited another player to start helping out with the juniors.*

Case Study: *An NHS mentor made contact with the scheme to see if a younger man could play as part of his recovery from a breakdown. Not only was this possible, but the way that the scheme listened to the man meant that both he and his mentor came to play. The camaraderie and the experience of success are seen as key to assisting with a remarkable turnaround, particularly in starting to encourage and support new connections with other people. The lead volunteer thinks that the way the team clap every goal and the award of the yellow jersey to 'team player of the week' were key elements in giving the young man a sense of value. Recently, the man applied for a job. The NHS mentor puts all the progress down to walking football.*

The Walking Football project has clear health creating features and is having a significant impact on people's health and wellbeing. Of particular merit are the design of the scheme around the assets and talents of Rooftop tenants and its very positive impact on people who have not been easy to engage. This approach of facilitating rather than direct delivery has the added benefit of increasing the impact from Rooftop investment in the Health and Wellbeing team and sustainability and value of activity to the community.

Results from the Diagnostic

Listening and responding: The organisation has a deep commitment to ensuring the scheme is led and shaped by the voices of those involved and the wider community.

Rooftop have provided the group with the space and the support to develop, without being prescriptive about the shape that the group takes, and as a result, it is owned by its members. This is facilitated by a clear structural commitment to making a difference within communities led from the top.

Evaluation is designed around self-assessed views of mental wellbeing, with conversations used to further support the individuals involved.

Truth-telling: The lead volunteer thinks a big reason for the success of the scheme is that it allows people to find old skills expressed in new ways.

The scheme is very inclusive and has found ways to involve people with all manner of needs in walking football. It has also highlighted a new view of the needs of women. It acts as 'eyes and ears' by taking such an inclusive approach.

There is a very systematic approach to evaluation which starts with measuring the impact the players are finding in their lives. This offers prompts back to the players about ways to deepen connections and improve wellbeing. The results of the evaluations are also used by the whole organisation and feedback to the Board.

Strengths-focus: The scheme has a clear focus on recognising strengths and supporting people to build them; and walking football itself emerged out of the skills and talents of tenants. People are actively encouraged to join in however they like, with barriers broken down.

"Football is something I can do – I know what to do and how to use my background" – Lead volunteer.

Football is the facilitator to enable people to develop strengths, including increased confidence, mental wellbeing, social inclusion and sense of usefulness and value. The majority of this develops from peer support which makes it a more sustainable intervention than statutory support.

The organisation itself takes a deliberate strategic approach to building individual and community strengths, providing people with the tools rather than 'doing for' them.

Power-shifting: This example clearly shows how power can be shifted to communities and individuals, and balanced relationships can be developed and maintained:

Tenants and the organisation each bring their areas of expertise to the relationship. Rooftop has a clear strategic direction and provides the group with the tools and support to be self-managing. The group draws on the strengths of individuals, such as the lead volunteer and referees, to be able to run. The group is inclusive and is based on a methodology of 'activities for all'.

Football is a useful way of breaking down any perceived barriers between the organisation and staff, and the community; for example, through games played with staff (including the Chief Executive).

There are considerable case studies emerging from this group which show how people have developed (or redeveloped) skills, interests; and even gone on to volunteering or employment. Like other projects of this sort (e.g. Men in Sheds), football is the enabler which drives other change in an organic way.

Self-organising: The whole purpose of this group is that it is self organising with support from Rooftop. An important factor is the fact that the lead volunteer is a tenant and has knowledge of running football clubs. This volunteer stays in contact with all the participants by text message, which means he can organise activities and make sure that people are okay. He acknowledges the 'absolutely tremendous' support and relationships developed with the Rooftop team which facilitate the activities of the group.

From the initial self-organising, the group has organically grown other activities, which are also self-organising. For example, three of the men have formed a group for watching amateur football. Connections have also been made with the local college which opens up other opportunities.

Part three – Summary of Learning

Assessing these place studies through the Health Creation lens has given us a number of insights that we would not otherwise have noticed, both within each place study, but also by looking at the examples together. These are summarised below.

These housing organisations have embraced Health Creation organically

There is clear evidence within these place studies of the five features of health creating practices in play. Frontline practitioners have embraced Health Creation organically and this probably reflects a broader trend across much of the social housing world towards the adoption of customer-oriented values and people-led solutions.¹⁶ All of the organisations are enabling Health Creation at the system level too to some degree.

The Health Creation framework has enabled them to look more systematically at what they do. It has enabled them to become more conscious of their health creating practice and to look for ways of improving their practices even further.

Self-organising was one of the less strong elements across the place studies. It was more likely to be interpreted as re-engagement with services than building connections among community members. This could have been in part because most of them are dealing with people at a point of crisis and they are focused on stabilising the individual in the short to medium term.

“When you’ve lost trust in a lot of people it’s hard to reconnect” Resident/Client

As a result of the diagnostic audit and workshop, several of the place studies are now exploring peer forums to enable individuals that have had similar experiences to connect and potentially bond. This will also help people to continue to support each other once the formal support networks have been removed. This seems to have provided a way of addressing a concern in some of the place studies.

It’s harder to express what makes something work than where it can be improved

During a workshop on Health Creation, delegates from across the place studies were asked to illustrate in groups what made their projects a success. They all found this difficult and it took some time before they were able to see the excellence in their practices. They found it easier to focus on things which are not going well, and this exercise showed how difficult it is to think about the strengths of ‘the day job.’ Doing this exercise helped participants to empathise with clients and to understand how difficult they must find it to think about and articulate their own strengths; and why it is important to develop skills in spotting strengths in other people and drawing attention to them.

“I always try to focus on strengths – even if there’s only one good thing [about a person’s situation] we’ll try to focus on that and how we can build out from there. They need to hear they are doing some things right” Support worker

There is sometimes a clear value in having staff who are independent of mainstream service providers

Within some of the place studies, especially those working with particularly vulnerable clients, it was noted that clients are often less guarded and more willing to open up and engage in truth-telling where their support worker is understood to have third party status. Staff who are independent from direct service provision (i.e. from mainstream

¹⁶ See: New era, changing role for housing officers: <http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/Frontline%20futures%20report%20final.pdf>

housing, health, social care services) are better able to act as an advocate for them. This might be especially important in the housing setting, where people are concerned that opening up might have an impact on their tenancy.

Those organisations which offer services that help people at crisis point demonstrate an especially strong commitment to ‘truth telling’. This is very important, since getting to the bottom of a matter is very often a key step towards good mental health and in supporting people to independence. Practitioners also described the need to explain the potential consequences of not telling the full truth in a relationship with service providers – to enable their clients to make informed decisions.

Enabling people to make meaningful connections with others, offering the potential for truth-telling between each other rather than with professionals is a route to lasting (rather than temporary) Health Creation.

Working to shift power to clients/service users involves doing things differently on a frontline and systems level

To genuinely shift power and engage in Health Creation, there needs to be flexibility on the part of frontline practitioners, and this requires a system to allow and support that flexibility. More often than not, this is about organisations having a culture of equality and ‘parity of esteem’ and systems in place to support that positive culture. There was some concern expressed in the workshop that working in a health creating way with people might raise their expectations beyond what the organisation could realistically meet. However, this anxiety is commonly held by staff who are not working at the frontline; those working closely with people and who have experience of people’s requests know that they are always modest and usually relate to helping them to get access to everyday things they need.

At least one delegate at the workshop expressed the view that what had thus far been seen as ‘risk’ to the organisation might be re-packaged as an ‘opportunity to work differently’. Others agreed that it is important to take some risks and to see failure as a learning exercise; in order to do this, organisations need to be emotionally intelligent.

Listening was key to the place studies

A common strength across all the organisations is ‘listening and responding’. These housing organisations do understand the power of listening, and of how much that means to people. Some have even adopted ‘listening’ between colleagues as the expected way of working, with senior staff trained to listen to frontline practitioners and to reshape services accordingly.

Advocates are needed when systems don’t listen well

The frontline practitioners were often providing an advocacy service: listening to the client, interpreting their requirements, speaking to services on their behalf, challenging services, and filling the gaps in order to find and connect them to relevant services. This may be because a number of the place studies focus on people who are in crisis mode, so advocacy is an expedient and appropriate short-term response to support people to move to independence. They were also building people’s confidence to enable them to make their case themselves, directly to services and to engage well with others. Ideally, services would become more responsive to clients directly through listening and responding to them appropriately and embedding all five features within their practices. If this were to happen, then the need for third party advocates would reduce.

“My support worker explains it better than me – for some reason they seem to respect her where they don’t respect me” Resident/Client

Self-organising can develop out of strengths-focus

All of the place studies have some element of focus on the individuals' strengths; some go further than others in terms of developing people's confidence by focusing both on what they are good at and what they enjoy doing. Where this is happening well it can provide a route for people to reconnect; by focusing on what people have done before and what they want to do to fill their time, they can settle on things they enjoy, get into a group that relates to that activity, develop their skills further, get to know other people who have something in common, and find their place in a community with others.

The process of bonding with others (apart from the frontline professional) needs to feel natural to people, and this demands a high level of skill from professionals.

Power-shifting is expressed in different ways

Power-shifting was evident in a variety of forms with different emphases in different places. For example, in the parity of the relationships which were formed between frontline workers and clients, in the willingness for senior executives to attend meetings and walkabouts, in the way that people and communities were helped to become better informed and equipped.

In some of the schemes, there is also a quiet education of health colleagues going on about the realities of some people's lives and the reasons behind some of the more negative behaviours people sometimes exhibit.

“They help you to find out information, even if you own your own house” Resident/Client

Where people are vulnerable, they often form a strong personal relationship with their support worker (whilst respecting professional boundaries) and this can lead to dependence if not careful rather than a shift in power. It is important to move quickly on to the 'self-organising' phase because it is when people make meaningful and constructive connections with others in a personal (and not professional) capacity that lasting Health Creation become possible. In at least one place study, clients are offered a peer mentor to buddy up with – someone who has had similar experiences and who can offer them deep understanding while helping them to rebuild their lives. Becoming trained as a peer mentor so that they can help others can be an empowering step for some clients.

“Sometimes the only person you can speak to is someone who's gone through it” Resident/Client

One of the place studies was very strong on power-shifting, the service having been established through full coproduction with clients.

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Requests for further information

For further information on the New NHS Alliance or the Health Creation Diagnostic, including how it can be used with your organisation, please contact Merron Simpson, Chief Executive New NHS Alliance: 07973 498603

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