**Asset Based approaches to Collaborative Care and Support Planning with tenants in ‘sheltered’ accommodation**

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April 2018

**Executive Summary: recommendations and actions**

**Project Outline**

Funded by Manchester Health and Care Commissioning (MHCC), the project was the initiative of the Chorlton, Whalley Range and Fallowfield Neighbourhood Group and was managed by Primary Care Manchester, the GP Federation for central Manchester. It focussed on people living in 3 older peoples’ housing schemes in South Manchester, including tenants with long term conditions (LTC).

The project team included a Community Facilitator (CF) and lead GP. Supervision and evaluation was provided by an expert in community development, via a local community organisation – the Whalley Range Community Forum. The project ran from May 2017 to March 2018 and had two elements:

a) asset-based group work to strengthen tenants' community identity and networks of mutual support

b) a pilot of the RCGP Collaborative Care and Support Planning (CCSP) toolkit with 10 tenants. CCSP is a 6-step process incorporating person-centred conversations with a professional in order to draw up a personal plan about making positive changes to stay well.

**Results**

The CF made 90 scheme visits, talked to 80 out of 125 tenants, met 58 tenants individually and facilitated 31 groups/meetings. 25 new agencies were contacted as a result of individual or group interests.

There was positive impact on:

* Tenants interactions within and between schemes
* Uptake of external activities and sessions, and activities
* The range of activities taking place, and ideas from tenants
* Tenants taking control of and planning activities
* Opportunities for tenants to share what was important to them particularly through one to one conversations
* Opportunities for coordinators to discuss their changed situation and the services they could offer
* Action taken over failed hospital discharges (people being readmitted to hospital soon after being discharged) and possibilities of action to reduce this.

Testing the CCSP approach in this contextindicated that:

* Thisapproach was highly valued by participants.For most tenants the quality of their relationships was most important to them. They valued neighbourliness, social activities and contact with their families.
* Although it can take several conversations before patients feel ready to commit to a plan, 4 of the 10 patients involved in initial interviews have already started advanced care planning with their own GP and 3 more are contemplating change.
* This work requires building trust and relationships, made much easier with a stable and constant workforce.
* Reading the notes, holding the conversation, writing a report and performing a review takes time - about 3.5 hours per patient. It is likely to be more time efficient if patients are known beforehand.

**Commentary**

*An asset-based approach is about focussing on people's strengths.* Supporting tenants to build social networks and signposting them to local community groups can improve health and well-being immeasurably*.*Scheme coordinators continue to have multiple roles, build knowledge of their tenants and gain their trust. The added continuity and familiarity can lead to more efficient working in relation to prolonging older tenants' independence. Consideration should be given to how all these values could be embodied in a “Modern Warden/scheme coordinator”.

*There is considerable added value to be gained from collaborative working between health professionals and the Community and Voluntary Sector (CVS):*This asset-based, community development approach has introduced GPs to new skills and refreshing ways of working which will empower people and facilitate change rather than create dependency.

*Some tenants need additional professional support:* It is clear that additional professional support has to be in place to enable older tenants, especially those with LTCs and at the end of their life, to stay in their home. Some service providers may presume a higher level of support is already in place in housing schemes which can lead to difficulties such as failed hospital discharges.

**Developments**

As a result of the work of the project and the insights given by the tenants the following actions are taking place:

1. **Strategic level change**. Highlighting the importance of housing to people’s health through:

* Meetings with Chief Executives of Housing Associations to enable joined up working.
* Meetings with Health and Social Care providers and commissioners (e.g. Public Health, Manchester Health and Care Commissioning) to increase the profile and role of housing in Health and Social care planning/delivery.
* Social Housing Providers should be a core member of the One Team: We propose that housing should be the 5th element of Manchester’s One Team, alongside Primary Care, community mental and physical health services, Social Services and Community and Voluntary services.
* Representatives of Health providers e.g. GPs have been invited to attend The Age Friendly Housing Strategy, and Older Peoples Housing Alliance meetings.

1. **Neighbourhood level change**: Joined up Health, Social Care and Housing services through:

* Neighbourhood meetings of Health, Social Care, Housing and the Community and Voluntary sector.
* Encouraging involvement in asset-based training programmes - to develop the community-focussed, asset-based work with groups in order to develop a strong sense of cohesion and belonging in a neighbourhood.
* Piloting Older People’s Teams at GP practices and closer working with housing schemes. As a result of the project Chorlton Family Practice is piloting an Older People’s Team focussing on care for older people. It will include a lead GP, a practice based Nursing Practitioner/Matron, Social Worker and community navigator working together to plan future care of older people,avert hospital admissions and reduce the risk of ‘failed discharges’. This could be coupled with reintroducing scheme-based services such as consultations, health visits and meetings eg falls and incontinence teams, and delivery of flu jabs.
* Enhanced partnership working with Community and Voluntary Sector groups - planning the use of their services during the roll out of Collaborative Care and Support Planning eg through volunteer advocates helping people to prepare for asset-based conversations.

3) **Scheme level change:**

* Recognition of the valuable and influential role of coordinators regarding tenants' health and wellbeing.
* Developing asset-based approaches - training for person-centred conversations through the “Person, Partner, Place” model is available to coordinators.
* Involvement in neighbourhood: access to community activity and information to be improved through practical means such as better digital access, transport to services and increased involvement with local Community and Voluntary services (e.g. Chorlton Good Neighbours, Age Friendly Chorlton and Whalley Range).
* Encouraging the use of shared spaces: housing associations will run events to raise tenants' awareness of group dynamics in order to improve social interaction and inclusivity.
* Tenants encouraged to apply for HA grants to support activities eg trips and social events.
* Practical support to maintain independence: tenants’ campaign for benches to be installed on the way to bus stops was acknowledged and supported, and has made progress.

**For more information about the project and for a copy of the full report contact Graham Mellors:** **graham.mellors@nhs.net**