# Guest editorial

Patricia Dearnaley

## Health, social care and housing: facing a wicked problem

Patricia Dearnaley is Managing Director at the East Training and Consultancy Ltd, UK

This special issue of *Housing, Care and Support* echoes the theme of the Housing Quality Network conference in May 2018 which considered the contribution of housing to the new integrated health landscape. The papers offer not only a range of thought-provoking perspectives on how integrated services may be improved through the incorporation of housing into local health structures, but also provide some useful learning for other organisations with ambitions to make a wider impact.

So why do we consider health and housing a wicked problem?

Wicked problems are causal issues with connections to many other issues. In that respect, wicked problems are difficult to define, socially complex and require a whole-system, multi-agency response. Indeed, what makes wicked issues "wicked" is that they cannot be solved using traditional linear problem-solving techniques and evidence-based solutions. These approaches fail because often a number of different organisations and people with competing priorities are involved and disagree about what exactly needs to change and how. Both the process of health system transformation and many of its current goals (e.g. achieving health and social care integration, shifting resources from the acute sector into prevention) are classic examples of wicked issues (Johnston and Wilson, 2017).

Whilst this definition is clear in drawing out some of the features of the issues facing integrated health and social care, and if every wicked problem "can be considered to be a symptom of another problem" (Head, 2008), then we may view and understand the issue in the context of a network of interrelated public service systems unable to meet the population's needs within available resources. We might further conclude that reduced resources are not the only cause, and that increasing expenditure may serve only to mask far more fundamental structural problems. As such, the NHS, social care and social housing jointly serve an ever-changing constituency of some sections of the population: some maybe once or twice in a lifetime; some on a temporary or intermittent basis; others permanently, potentially with duplicated and sometimes contradictory efforts and almost certainly replicated administration and structural costs.

## Fragmentation

A common theme found in both Brown's contribution and Van Doorn and Dearnaley's discussion concerns the fragmentation of personal services across government departments and funding streams.

Brown's paper considers the evidence for the wider contribution of housing to health and social care within a mixed economy of provision, citing the better health outcomes delivered through social housing and the potential long-term savings to the NHS following investment in bringing all homes in the private sector up to a satisfactory standard. He warns, however, that despite widespread recognition of housing's contribution to better health and social care outcomes and calls for greater integration since the 1960s, policy and practice are still in their infancy, with only 30 per cent of health and wellbeing boards having housing representation. Whilst local social services departments and health have been working together in numerous forms since reorganisation in the 1970s, housing has only ever played a part on the margins, and almost exclusively limited to small-scale, local and time-limited initiatives. Brown goes on to argue that the success of large-scale programmes can be undermined by uncertainty caused by central

government policy, the immediate pressures faced by different partners and practical issues such as differing geographical boundaries of local authorities and NHS groupings.

In their paper, Van Doorn and Dearnaley reflect on Nye Bevan's aspiration for housing and health's shared purpose in rebuilding the nation after 1948 and the need to revisit and strengthen that vision. They suggest that one way to realise this vision would be to establish a national system for ringfencing the disposal of excess public land and property to the social housing sector through joint ventures with NHS Trusts, following the lead of the London Estates Board. This, they contend, will yield greater returns and ensure that additional asset-based health services are able to emerge, while also enabling an increase in the supply of affordable homes for NHS workers. In making this policy prescription, Van Doorn and Dearnaley are acknowledging and critiquing the limited success of Section 106 agreements in delivering affordable homes. The paper analyses the affordability of London postcodes for different grades of NHS staff and finds that some low-paid workers working in high property value postcodes may face a long commute at an annual cost of more than £1,000. With all staff below Band 4 earning less than the London Living Wage, it is likely that a proportion of NHS workers will be in receipt of in-work benefits, though the Department of Work and Pensions advise that employer data are not collated by its Data and Analysis service.

Whilst Van Doorn and Dearnaley offer a reasonable and worthy proposal, the qualification within the Naylor review "negotiating affordable housing quotas and maximising value for the highest value sites in London" (Naylor, 2017) suggests that there is by no means any certainty that long-term benefits will outweigh the lure of short-term capital benefits, particularly when "23% of the NHS is declared as not fit for purpose" (EC Harris, 2010, p. 5) with capital budgets at a historic low (Naylor, 2017).

## The mixed economy

A significant contributor to the complexity and wickedness of the problem is the mixed economy of supply of health, social care and of housing across a wide range of different ownership, funding and regulatory systems. Coupled with that, government reluctance to interfere in the operation of the private market does, to some extent, contribute to the challenge if coordinated improvement is to be achieved.

For instance, much focus has been directed at the role of social housing in supporting the NHS in managing health delivery to an increasingly demanding population within the context of shrinking public resources. However, government understanding of the co-dependent inter-relationship between housing, health and social care needs to acknowledge and implement practical measures to optimise the contribution of all housing tenures in preventative, as well as clinical healthcare. As a result, all the focus and efforts to date have been on only 18 per cent of the market represented by the social rented sector, which is already largely playing its part in providing secure, warm and dry accommodation that does not endanger its occupiers' health. The private rented (6 per cent) and owner-occupied (76 per cent) sectors have no less of a contribution to make but are currently largely unsupported by central government to make this happen. We thus welcome the introduction of the Homes (Fitness for Human Habitation) Bill 2017–2019, particularly the requirement that private landlords are responsible for maintaining safe property standards. But a far more significant issue relates to the fitness of properties owned by older people in poor health and poverty, and the lack of a consistent and strategic policy response. Whilst many home improvement agencies are reliant on local government revenue funding, this is by no means universal, with only 71 per cent of local authorities funding services (Foundations, 2018), and delivery of support to asset-rich, cash-poor older and vulnerable owners, though proactive and committed, needs a unified and centrally funded programme of support to this vulnerable group.

## Delivering real change

It would be easy to focus too narrowly on the major, systemic issues that prevent cross-sector working. By way of contrast, Brown's paper highlights a number of local initiatives that have achieved real achievements and successful outcomes. In reflecting on these localised examples,

Brown calls for the development of a comprehensive database of local collaborative projects, which in turn would allow for a shift of focus from national large-scale initiatives to the allocation of support and resources by central government to local projects.

Our final three papers provide a more local perspective.

Owen's paper looks at inequitable healthcare for people with learning disabilities, and how one Essex-based initiative is underway to improve the experience of hospital outpatients whilst improving outcomes and reducing failed appointments.

Following a number of premature deaths of people with learning disabilities connected to their journey through the healthcare system, several reports from 2006 onwards highlighted institutional discrimination in healthcare. This included a lack of training in learning disability awareness, a poor understanding and response by healthcare workers to individual needs and a lack of progress in making "reasonable adjustments". The learning has been widely shared, and some recommendations enshrined in law, such as reasonable adjustments, though people with learning disabilities and their carers have suggested that more progress has still to be made.

Estuary Housing Association (EHA) delivers housing, care and support services across Essex to a total of 112 individuals with a range of complexities of learning disabilities in nursing, registered care and supported living services, with a further group supported in their own homes. In response to concerns in 2016 about the experiences of their clients at Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH), Estuary staff provided anecdotal feedback to Owen on a range of issues, including issues with access, lack of reasonable adjustments, communication issues with the hospital, lack of clarity around responsibilities of the hospital and care provider and unsafe discharges. Over the next two years, informal joint working and liaison greatly improved client experiences, and as a result of this, BTUH and EHA initiated a project with support from Skills for Care to develop a joint working protocol to benefit the wider learning disabilities population in the transition between social care and NHS hospital services. A wide scope of information gathering and discussion around key issues is underway and several initial recommendations have already emerged.

Owen's paper provides an initial overview of the project, and we will welcome the submission of the final findings of the project to a later edition of the Journal.

Roxby's case study of Wakefield District Housing's (WDH) participation within the local Health and Wellbeing agenda reflects some of the learning highlighted by Brown. As one of the NHS New Care Models Programme vanguards, Wakefield is co-redesigning a new approach to integrate services for people in care homes. From a similar perspective to Dearnaley and Smith's paper, Roxby shows how the Wakefield Health and Wellbeing Board were persuaded to extend the initiative to include some specialist social housing, which enabled greater shared understanding of the role of housing in meeting strategic health and wellbeing objectives.

This new partnership, locally known as the Connecting Care+ programme, has established co-located multi-disciplinary teams, which operate from two hubs and in doing so enables housing to participate in planning interventions for those referred to the hubs from primary and secondary care, GPs and hospitals. Joint funding of specialist posts, such as Wellbeing Caseworkers and Mental Health Navigators, has led to a reduction in delayed transfers of care, prevented tenancy breakdowns and provided additional support to individuals living in homes no longer deemed suitable for their physical needs.

Significantly, the secondment of the WDH Service Director to the CCG and the parallel establishment of a Housing, Health and Social Care Partnership are shown to be raising the profile of housing and embedding it within the architecture of the local health landscape. The inclusion of the CCG, Wakefield Council, WDH, West Yorkshire Fire and Rescue Service and the voluntary and community sector shows a breadth of inclusion and therefore serves as a model joint working for other areas to draw upon.

Dearnaley and Smith address another aspect of coordinated services; namely that of integrating local workforce strategies across health, social care and specialist social housing to ensure that the policy intentions of the Care Act 2014 are achieved. In the course of their discussion Dearnaley and Smith provide a model of how health, social care and specialist housing can work

together to form a continuum of intensity of service. They show, for example, the way in which services are linked to a specific location such as a clinical setting or specially adapted and equipped housing. Thus, by categorising specialist housing, social care and health within the same model, a pathway for greater integration emerges.

The core theme of the paper is the argument that in specialist housing for vulnerable adults and older people many of the functions complement those within an integrated model of health and social care, and that many of the new roles being developed by the NHS STPs are already delivered within specialist social housing. The risk, they argue, is that without integrated local workforce planning, different partners will compete for the same candidates. They conclude that retaining a full-time equivalent workforce of 1.11m in adult social care is a significant challenge, and predictions of a national staffing shortage from March 2019 after Brexit make effective planning vital.

So how to address this most wicked of problems? We learn from the authors that like the problem, the solutions are diverse, complex and nuanced. They can and often do involve buildings, people, culture, attitudes, partnerships, interagency relationships, separate funding streams, unaligned geographical boundaries, diverse legislative and regulatory demands. This diversity and complexity is exemplified by the existence of a fragmented market involving 12 special health authorities, 17 commissioning bodies, 22 commissioning support units, 185 shared services and support agencies, 13,946 GP surgeries, 1,579 private health providers, 14,607 registered care providers, 3,359 optical providers, 10,410 dental practices, 242 CCGs, 234 NHS Trusts, 4 care trusts, 1,699 housing associations and 34,903 voluntary health and housing charities operating in over 100 commissioning areas.

In this special issue, the authors have illustrated a microcosm of the vast diversity and range of solutions. These solutions encompass major infrastructural reforms predicated bringing health, social are and housing back together, to coordinated workforce strategies across a range of employers, through true and respectful partnership working, to caring on a one-to-one basis and the deployment of personalised support to address healthcare inequality for some of the most vulnerable members of our communities. They show us that if we really want to provide better, more personal and human services, we cannot just focus on the big issues: small acts of compassion are what turns regulation and policy and procedure into positive experiences for people who use our services.

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