Article:
Holding, E., Blank, L., Crowder, M. et al. (1 more author) (2019) Bridging the gap between the home and the hospital : a qualitative study of partnership working across housing, health and social care. Journal of Interprofessional Care, 34 (4). pp. 493-499. ISSN 1356-1820

https://doi.org/10.1080/13561820.2019.1694496

Journal of Interprofessional Care

ISSN: 1356-1820 (Print) 1469-9567 (Online) Journal homepage: https://www.tandfonline.com/loi/ijic20

Bridging the gap between the home and the hospital: a qualitative study of partnership working across housing, health and social care

Eleanor Holding, Lindsay Blank, Mary Crowder & Elizabeth Goyder

To cite this article: Eleanor Holding, Lindsay Blank, Mary Crowder & Elizabeth Goyder (2019): Bridging the gap between the home and the hospital: a qualitative study of partnership working across housing, health and social care, Journal of Interprofessional Care, DOI: 10.1080/13561820.2019.1694496

To link to this article: https://doi.org/10.1080/13561820.2019.1694496

Published online: 10 Dec 2019.

JOURNAL OF INTERPROFESSIONAL CARE
https://doi.org/10.1080/13561820.2019.1694496

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

OPEN ACCESS Check for updates

Bridging the gap between the home and the hospital: a qualitative study of partnership working across housing, health and social care

Eleanor Holding, Lindsay Blank, Mary Crowder, and Elizabeth Goyder

The School of Health and Related Research (ScHARR), The University of Sheffield, Sheffield, UK

ABSTRACT

Rising demand and financial challenges facing public services have increased the impetus for greater integration across housing, health and social care. To provide insight into the benefits and challenges of partnership, we interviewed 37 housing professionals and held a validation workshop with eight external agencies working within a new, integrated housing service in the United Kingdom. The strength of the initiative rests on the capacity of neighborhood officers to conduct home visits and refer tenants to support agencies. Yet this strength poses problems in partnership building because increased referrals threaten to overwhelm already stretched health services. Despite broadly supporting the initiative, officers expressed concern over losing specialist housing knowledge whilst filling in gaps for services. Tensions over professional role boundaries between officers and social workers, poor communication, lack of capacity in external agencies and difficulties in sharing information were identified as barriers to partnership. Whilst capacity issues were acknowledged, partner agencies welcomed the initiative and called for joint meetings and colocation of services. Lack of capacity of external agencies to respond to referrals threatens integrated housing and health initiatives. Greater interprofessional collaboration and further investment across the system is required to increase capacity and ensure referrals are translated into healthcare outcomes.

ARTICLE HISTORY
Received 6 December 2018
Revised 12 November 2019
Accepted 13 November 2019

KEYWORDS
Housing; health; partnerships; qualitative

Introduction

Joint working across public services has long been encouraged as a means of effective public policy and service development (Hudson, 2002). Growing financial pressures and demand for services has led to the development of policies to transform and integrate health and social care in the UK (Baxtor et al., 2018; Ham, 2018; Humphries & Curry, 2011; Pearson & Watson, 2018). The UK Government set out its vision through the 2014 Care Act and the NHS Five Year Forward View which placed a duty on local authorities and the health service to promote integration across care and support services (The Care Act, 2014; NHS England, 2014).

The 2017 Next Steps on the Five Year Forward View also sets out the importance of closer interagency working with housing support services (NHS England, 2017). The potential of housing services for providing preventative support in the community has been increasingly advocated as a means of alleviating demand on primary care (Chevin, 2014). The need for integration across housing and health was also a central feature of the Supporting People Initiative, a national policy launched in 2003 aiming to support vulnerable people in maintaining stable accommodation through a partnership of local government and external agencies (Cameron, Macdonald, Turner, & Lloyd, 2007; The House of Commons, 2012).

In response to this integrative drive housing services in the UK and internationally are pursuing holistic support to manage resources and tenant need more effectively. Some providers have adopted 'Housing Plus' initiatives to respond to the wider social and economic issues affecting tenants (Bratt, 2008). Although 'Housing Plus' activities vary, they typically involve tenant engagement to build community resilience and sustainability (Power & Richardson, 1996). Crucial to this agenda are partnerships across a range of professional groups including health and social care (Handy, 2014). Although such partnerships have long been encouraged, in practice the links between health services and housing remain weak (Cameron et al., 2007).

In light of increased research and policy interest in joint working, evidence has emerged on the practicalities, strengths and barriers of interagency partnership. In relation to health and social care, research has highlighted a number of difficulties including conflicting professional perceptions (Hudson, 2002), lack of understanding of the roles and remit of external agencies (Fraser, 2019; Glasby, Martin, & Regen, 2008), struggles in delineating responsibilities (Reed, Cook, Childs, & McCormack, 2005), competing professional agendas (Drennan et al., 2005; Regen et al., 2008), problematic information sharing (Christiansen & Roberts, 2005; Ling, Brereton, Conklin, Newbould, & Roland, 2012; Sundari, Klein, McCluskey, Woolnough, & Diack, 2018), and lack of guidance for leaders and managers (Dickinson & Glasby, 2010). Similar challenges have been found in connection with housing and health (Cameron, Lloyd, Turner, & Macdonald, 2009; Cameron et al., 2007; Sharples, Gibson, Galvin, 2002) but there is a lack of more recent research exploring the impact of current approaches.

CONTACT Eleanor Holding e.holding@sheffield.ac.uk The School of Health and Related Research (ScHARR), The University of Sheffield, Regent Court, Regent Street, Sheffield S1 4DA, UK

Background

Council housing services in a major Northern City in the UK have recently adopted a city wide "Housing+" programme after initial piloting. Housing officers with a geographically based caseload of between 180–330 households undertake an annual home visit to discuss wider determinants of tenancy sustainability such as health, crime, community engagement and finances. Housing+ officers take a holistic, preventative approach by dealing with low level issues through signposting people to resources within the local community; and where necessary, referring to specialist services. Alongside increased health and wellbeing responsibilities Housing+ officers continue to manage traditional housing officer functions, such as ensuring rent payment, dealing with anti-social behavior and reporting repairs. The driver behind this change is to provide a more efficient, integrated and cost-effective service whilst also recognizing the need for joint working to address tenant need. The introduction of Housing+ poses interesting questions about changing occupational identities and relates to sociological research into professional boundary construction and conflict. Particular attention has been given to how professions exercise ownership over bodies of knowledge in order to protect themselves from competing agencies (Powell & Davies, 2012) and to maintain professional "boundaries" (Gieryn, 1983; Gieryn, 1999; Sanders & Harrison, 2008). The complexity of such boundary work is reemphasised by recent healthcare system integration (Hunt & Segrott, 2014). Organizational roles have emerged, such as the neighborhood officers in this study, but there is a lack of evidence on the evaluation of these new functions (Gilbert, 2016).

Given this paucity of evidence, the aim of this study was to explore the facilitators and barriers to joint working across housing, health and social care in the context of the emergence of a new role for housing officers.

Methods

An exploratory qualitative research design employing semi structured interviews with housing officers (n = 37) and a validation workshop with external agencies (n = 8) was conducted to determine views on interprofessional partnership.

Sample

A sampling frame for the qualitative interviews was developed by matching neighborhood "patches" across the city in terms of population age, ethnicity and property type. Contact details for the neighborhood officers (housing officers responsible for and operating in the corresponding patches) were shared with the research team by the council. They were then contacted for their consent to take part in a face-to-face interview with a researcher from the University of Sheffield (EH, LB or MC) at their place of work.

Data collection

Twenty five (n = 25) semi-structured interviews were conducted with a mixture of neighborhood officers and managers on their views and experiences of delivering the Housing+ programme in Year 1 of the evaluation. A further 12 interviews (9 repeat and 2 new interviewees) were undertaken in Year 2. Where neighborhood officers could not be followed up (e.g. due to moving job roles or "patch" area), interviews were undertaken with the new officer operating in the corresponding patch.

In order to understand the impact of the introduction of Housing+ on external agencies we conducted a validation workshop at the University of Sheffield with eight representatives across voluntary, community, health and social care sectors. We recruited by asking neighborhood officers to list the top three agencies they had the most contact with through the new service. We then contacted services by telephone and e-mail to request their attendance, prioritizing those which had the most frequent contact with housing. Verbal consent was taken on the telephone and then again at the start of the workshop. The structure of the workshop was guided by themes emerging from the preliminary analysis of interviews with housing staff. This included their views on the Housing+ service and its impact on working relationships, referral rates and overall tenant experience. Participants filled in anonymous feedback sheets and two researchers took detailed notes of the discussion. We also received feedback sheets from services that wished to contribute to the research but were unable to attend the workshop.

Data analysis

With participants' consent, interviews were digitally recorded and lasted between 30 to 90 minutes. Interviews were transcribed verbatim and anonymized before coding in NVivo 11 software. Framework analysis was employed using a 5-step process to organize and analyze the data: 1. Familiarization, 2. Identifying a framework, 3. Indexing, 4. Charting, 5. Mapping and Interpretation (Srivastava & Thomson, 2009). An initial thematic framework was derived from the in-depth reading of a small number of transcripts before being modified to reflect the emerging themes (Step 1). The research team met regularly to ensure the validity of the thematic framework and to discuss any disagreements before a final coding framework was agreed (Step 2) and applied to the transcripts (Step 3). Indexing was undertaken to identify sections of the data which correspond to the existing themes and codes (Step 3) (Srivastava & Thomson, Gale, Health, Cameron, Rashid, & Redwood, 2013). Once coded, data was charted in a spreadsheet under each theme (Step 4) to aid summary and interpretation of the data (Step 5) (Gale et al., 2013). Data was then analyzed to map linkages and patterns between phenomena (Ritchie, Lewis, Nicholls, & Ormston, 2014). Constant comparison, combining simultaneous coding and analysis of the data was used to review the quality of our approach (Taylor & Bogdan, 1998).

Feedback sheets and notes from the workshop were thematically analyzed in order to identify any patterns within the data (Bryman, 2012). Themes were then compared with data from the qualitative interviews to understand any commonalities or differences between professional groups.

Ethical considerations

This research was commissioned by external funding acquired by senior management in housing, but our interviews took place with housing officers/managers who had been directed onto the service by top-down decision making. Despite assurances over anonymity, it is unknown how much officers self-censored their responses out of fear of identification. Ethics approval for this project was granted by the School of Health and Related Research (ScHARR), University of Sheffield's ethics committee on 19th July 2016 (008603).

Results

Interviews with neighborhood officers

Participant characteristics and professional background

The ages of the neighborhood officers ranged from 28 to 61 years (mean age: 41). Their work histories varied; the longest serving officer had worked in housing for 28 years, the newest member of staff started a year before their first interview. The majority of participants had worked within housing for a long period of time (+10 years), moving between different functions, job roles and teams. Before working in housing participants held a variety of roles including within teaching, retail and customer service.

The integration of housing, health and social care: the changing role of housing staff

The majority of neighborhood officers discussed how health and wellbeing had become a central responsibility for housing under the new service and within the housing sector more widely. While tenant health and wellbeing was acknowledged as "*a big issue*", in part reflecting the prevalence of mental health and other complex vulnerabilities, there was less agreement on whether preventative support was an appropriate role for housing staff.

Some neighborhood officers expressed concerns that by taking on increased responsibility for health and wellbeing they were unable to focus on the fundamentals of housing management such as repairs and maintenance. There were also concerns over losing specialist-housing knowledge by becoming a "*jack of all trades but a master of none*". Some officers felt that lack of funding and inadequate provision within health agencies was the main driver behind this integration. Consequently, they referred to themselves as *"poorly paid social workers"* providing *"social work on the cheap"*:

> We're being ruled more out of housing and more into social care and I think we're losing the bigger picture on housing a little bit. So there's things now that's not being picked up that were being picked up before … we're losing taking our eye of the ball really on to any issues that might come back at some point. (HO 101, Year 1)

> We fill a gap in services. So, we're ideally placed, we're in community, we've got access to tenants … we kind of fill that gap a little bit at very low cost … So, we're cheap labour, we've got some experience, we've got perhaps enough experience to scrape through. (HO 119, Year 2)

Others questioned whether they were qualified to deal with the issues identified through home visits, particularly complex mental health problems. One neighborhood officer was concerned about missing something important such as child neglect or abuse due to lack of experience and training:

> We're not trained in social work, and obviously there are a lot of issues at the moment where, you know when you hear the stories in the news where the council have been into a property and they've not picked up … I don't know, like child abuse or neglect, and I think there's a lot of worry from people, not that they're missing out on purpose, but if they do miss it, would we be held accountable because we've been into that property, albeit we're not trained in social work. (HO 115, Year 2)

In contrast, some officers felt that they were having a positive impact on the health of their tenants. Uncovering hidden tenant need, identifying vulnerable people, improving housing conditions, dealing with social isolation and loneliness and increasing knowledge of tenant problems were positive examples arising from the increased responsibility of health for neighborhood officers under Housing+:

> And, you know, then you do come across a lot of vulnerable people that we've never come across because we haven't done Housing+ before … I've had a few where been under the radar and once you've gone inside the property and you think, wow, you know, there's some serious need of support. So, we get support in place which is one thing about Housing+ it does highlight these kinds of issues. And which is very good because we wouldn't have known anyone living in them conditions. (HO 118, Year 1)

Partnership working with health and social care: benefits and challenges

Many neighborhood officers acknowledged partnership working with external agencies as "*one of the main functions*" of the new service. Most felt joint working had improved since the introduction of Housing+, including with the police, community support workers, drug and alcohol services and homeless charities. Examples of good practice include joint drop in sessions between the police, food banks and neighborhood officers. Increased information sharing with community support workers was seen as particularly positive:

> Previously, I said that customers get pushed from pillar to post, whereas my one point of contact for all enquiries, then that customer knows what's happening, with the support and I do, and [each service] can relay that back to one another, and if I've got concerns I just go straight to their support worker, so I think yes, it does promote better joint working together. (HO 121, Year 1)

Some officers gave specific examples of tenants who had benefited from joint working, including a 63-year-old tenant with complex health and financial issues who had their debts lifted and adaptations installed in their home.

However, neighborhood officers shared common concerns over relationships with health and social care professionals including making contact with GPs and social workers. Accessing important tenant information when making a referral was also challenging due to data sharing restrictions between professional groups:

> GPs won't disclose information unless … I've had two occasions where I've had to contact GP. He didn't address any issues that were causing this person to have problems … I don't know whether that is something that we could perhaps work on in future. (HO 119, Year 2)

Others discussed internal "*tensions*" and poor working relationships with social workers due to similarities in the Housing+ job role and concerns over job security:

> It's moving more from housing into social care and social work … so and I can understand why it's moving that way but obviously our colleagues in social services are a bit wary of it … its money. Because at the end of the day we provide more services it means that we'll get more funding and take more services away from social care. (HO 101, Year 1)

> I must admit personally I've never, with regards to social workers, I've never been able to get in contact with them. Working wise it's very difficult with social workers. (HO 118, Year 2)

Long waiting times between making referrals to social workers and actual tenant contact was cited as a common issue. This was particularly problematic as these referrals were only usually made when the tenant was perceived to be in crisis. For one neighborhood officer this tension was not surprising due to housing being seen by other agencies as "*bottom of the pile*"

> When I [first started] … Housing+ was all about liaising with doctors, social workers, police … . And then when you actually get into the job and doing it, it is really hard to get anything from anybody … . But then if you get through to them, it's really hard for people to share information with you because of data protection. (HO 128, Year 2)

While relationships with social workers were particularly problematic, referrals to other external agencies also resulted in difficulties. Officers discussed the lack of capacity and resource, long waiting times between decisions on referrals and high thresholds for acceptance of support. Often services would have a 10 week waiting list before the client could be assessed, leaving vulnerable tenants without support for an extended period. This has implications for the relationship between officer and tenant that is seen as essential for the success of the intervention:

> Well, when you make referrals you always get, for certain agencies, a ten-week waiting time, and that's just for an assessment to be carried out. So, during that ten weeks, you've got two and a half months of someone still being vulnerable, still having health issues. Then great, when that ten weeks is up, we might get some positive news and they'll take them on and help them. But it's just obviously, we've got vulnerable tenants that might need support quicker than that. (HO 115, Year 2)

> [Agencies] can take on more, but they haven't got the staff there to pick the cases up, again because of funding issues … everybody's so stretched, and for us to be dabbling our toe, which is about referring to a specialist, because we're never going to be able to deal with it ourselves, but they're not out there to be referred to. You tell somebody you can refer them on, and then there's a three-month waiting list. You've lost the moment. You've lost the opportunity. (HO 120, Year 1)

> Or they don't hit, like, a criteria that they have to hit. So, they could be, I don't know … they could be a drug user, but unless they've got mental health problems, you can't get them in anywhere. Or the other way around. (HO 110, Year 1)

Referrals to mental health services raised issues due to tight eligibility criteria for acceptance of cases funding constraints, lack of services and the short term length of intervention. Officers would usually refer to community support workers in the first instance but support is only available for three weeks. If the tenant is still vulnerable they would then be referred to mental health services where support is usually available for a further six months. The tenant would then become the responsibility of the neighborhood officer once again after support had ceased. The complex nature of mental health often means that tenants do not engage or see housing as a line of support. This makes a joined up approach and information sharing across different agencies particularly valuable. One neighborhood officer gave a specific example of inefficient joint working where a vulnerable tenant with mental health problems was left unsupported and resumed previous unhealthy behaviors:

> I've signposted them on but I've seen like maybe 18 months down the line, they're not getting that support anymore and they've gone back to either one of them before. So for one guy in particular he were living in a squalor, it were terrible, so we got social services involved … But I visited him a few weeks ago and he's back to how it used to be because there's mental health issues … and I know it's difficult when tenants don't let people in but when I spoke to social services it's like they've not had no involvement with him for months and months so now I just think if they'd have still been involved they might have been able to try and find a solution before he got that bad again. But I've seen a few people like that where they seemed to be working with services when I referred them on but they're like going back downhill again. (HO 104, Year 2)

It was suggested by some officers that they would benefit from further opportunities to network and attend joint appointments with external agencies. For example, two officers suggested that joint briefings between housing and social work are particularly beneficial, while another discussed the benefits of co-location to better understand what the other does and increase face to face interactions.

While most neighborhood officers felt joint working had improved since the introduction of Housing+, the process and speed of referrals remained unchanged. One manager felt that the referral process had actually slowed due to reduced capacity within external agencies. Most neighborhood officers follow up on the outcomes of referrals but expressed disappointment at having to constantly "*chase*" external agencies for information. Despite these issues, some neighborhood officers acknowledged the difficulties facing external agencies due to reduced capacity, cuts to budgets and lack of tenant engagement.

Consultation workshop with partner agencies

Interaction and relationship with housing services

Eight representatives from health, social, community and voluntary organizations attended the consultation workshop held at the University of Sheffield. Feedback forms were also received from two further organizations who wished to contribute but were unable to attend the workshop

The organizations reported varying levels of involvement with housing services, ranging from daily interactions to one organization having little contact due to misunderstandings over the remit of the new service. A number of organizations including food banks, drug and alcohol services and multi-agency support teams had regular joint meetings with housing since the introduction of the service. Food banks and multi-agency support teams also attended joint home visits with

neighborhood officers to encourage interagency working and avoid the duplication of tasks.

Overall, relationships and joint working had strengthened since the introduction of the new service. One agency in particular felt that by providing holistic support housing services were "*more human*" and receptive to the needs of tenants rather than them being a *"name on a list"*.

Capacity and resource

Most agencies felt they were working at near capacity and were concerned about an increase in referrals due to the introduction of Housing+. However, they felt that the increase in demand from the new service was part of a wider trend of service referral increase and they continued to prioritize tenants in terms of need. One health and social care agency felt that the increase in referrals was positive as it demonstrates housing services are taking increased responsibility for the health and wellbeing and a need to support tenants holistically. Some agencies stated that it was the personal responsibility of the officer to follow up on the outcomes of referrals. If a tenant is referred this does not mean *"job done"* and further work is required to understand and support that tenant's issues. For example, a referral from housing services to a food bank does not deal with the underlying issues of financial hardship.

All attendees acknowledged the increasing complexity of tenant problems and the need for joint working as a means of managing population need. Joint meetings and home visits alongside further networking opportunities were encouraged to facilitate interagency working.

Discussion

Despite impetus for joint working between housing and health, research on the barriers, facilitators and impact of such partnerships remains underdeveloped. This study presents the views of both housing staff and external agencies on the integration of housing, health and wellbeing.

Most neighborhood officers acknowledged their increased responsibility for health and wellbeing under the new service. Despite outlining a number positive benefits such as uncovering hidden need and identifying isolation and loneliness, officers encountered a number of difficulties in partnership working such as poor communication, difficulties with information sharing, infrequent acknowledgment of referrals, staff tension and notable challenges when engaging with social work and mental health services. These difficulties are consistent with findings from previous studies into attempts to integrate health related services, particularly in terms of issues with information sharing due to concerns over appropriateness and patient privacy (Drennan et al., 2005; Ling et al., 2012). The findings also echo specific research into mental health and housing partnerships where referrals from housing to mental health were rarely accepted or deemed successful (Secker & Hill, 2001).

Officers were concerned about losing specialist housing management knowledge whilst filling in gaps for health and care services without appropriate expertise and training. It was recognized that the specific strength of Housing+ is based on the ability of officers to enter the homes of tenants. This raises the possibility that they will encounter serious issues such as abuse and neglect that require the legal intervention of social workers and the police. Failure to identify and report such issues potentially puts officers in the position of being held responsible for failures to intervene, threatening their professional livelihood. In these circumstances, it was worrying that some officers described themselves as "*poorly paid social workers*" but the interviews were characterized by absence of examples of effective joint working between them. Through discussions of the cause of these problems, the interviews posed the possibility that social workers were threatened by a potential blurring of professional boundaries threatening their job security.

In identifying tensions due to overlaps in job role, the interviews reveal practices prevalent in the health care field whereby professionals seek to protect job roles by maintaining existing professional boundaries (Finn, 2008; Gieryn, 1999). Adult social work services increasingly emphasize referral instead of direct work with individuals (Blewett, Lewis, & Tunstill, 2007) creating a gap in support that housing departments are well positioned to fill (Cameron, 2010). The interviews made it clear that Housing+ is indeed a top down technology designed to amplify the officer role in areas traditionally monopolized by social workers. Based on research by Carmel (2006), tensions over areas of responsibility are likely to arise where professional roles overlap, including in professional-client encounters such as home visits (Hall, Slembrouck, Haigh, & Lee, 2010).

Tensions were also indicated in the workshop with external agencies which reported that Housing+ increased referrals at a time they are already operating at full capacity. This lack of capacity to receive referrals threatens to undermine initiatives such as Housing+ because officers are unable to move their tenants onto effective onward provision. Having effective services available for referral protects the relationships between housing staff and tenants which is integral to the success of the Housing+ intervention (Blank, Holding, Crowder, Ferrari, & Goyder, 2018).

Attempting to overcome these tensions, both officers and external agencies made recommendations to improve joint working, such as colocation and joint briefings. Such methods have recently been employed by Wakefield District Housing in order to strengthen a newly established housing, health and social care partnership (Roxby, 2018). Colocation of officers within multidisciplinary teams and attendance at joint meetings embedded housing partners in care planning whilst improving understanding of external roles and responsibilities (Roxby, 2018). In order for the potential of housing/health partnerships to be realized, housing professionals must invest time and resource to gain buy in and drive progress (Roxby, 2018).

Despite some positive views on the potential of housing and health partnerships in this study, it remains the case that Housing + cannot achieve its objectives unless resource capacity is increased throughout the wider healthcare network. In the context of severe constraints on NHS and local authority budgets, the efficiencies potentially arising from closer partnership working may not be realizable.

Limitations

At the time of Year 1 interviews the intervention was in the process of being rolled out across the city and some housing

staff were very new to the role. The stress associated with starting this new job may have amplified some of the concerns expressed. Those new to housing may not have yet established appropriate links with health and social care services. However, repeat interviews took place over a year after the roll out of the intervention in order to compensate for this unsettled period.

Although housing staff identified mental health and social services as key referral agencies we were unable to recruit a representative of either service to the workshop despite several attempts to contact. This is not surprising given that these professional groups were the most difficult for housing officers to engage with. Their views would have provided context and understanding to some of the views expressed by housing officers in this study.

Conclusion

Increased attention is being given to the potential of housing services to provide preventative support to reduce demand on primary and secondary care (Chevin, 2014). Housing+ is one such approach which aims to provide holistic support for tenants before they reach crisis point. Similar preventative strategies are being employed across the country to manage resources and tenant need more effectively. The success of such programmes is dependent on effective interagency partnerships across housing and health, yet research on its facilitators and barriers remains undeveloped.

This study has presented the views of both housing staff and external agencies on joint working between housing and health. The results reemphasise difficulties surrounding information sharing, communication and problems over professional boundary construction. Further opportunities for networking and joint meetings to understand each other's job role may be beneficial, alongside colocation of services. Housing providers wishing to have a positive impact on the health of their tenants through interventions such as Housing + need to be aware of these potential difficulties. Further development work should be undertaken to ensure effective partnerships are in place or being developed prior to the roll out of such interventions.

Housing+ has the potential to substantially increase referrals across increasingly complex healthcare networks because it is based explicitly on home visits to large numbers of tenants. However, by increasing referrals it simultaneously exposes resource limitations in the wider network as well as highlighting the complexities of inter-professional relationships. In order to realize its potential, further investment across the system is required to increase the capacity of external agencies to ensure referrals are translated into healthcare outcomes.

Acknowledgments

We would like to thank our participants for taking part in this research, our project Advisory Group for their advice which contributed to its successful completion, and our practice partners for supporting this evaluation.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

Funding

This study is funded by the National Institute for Health Research (NIHR) School for Public Health Research (SPHR) (Grant Reference Number PD-SPH-2015). The views expressed are those of the author(s) and not necessarily those of the the NIHR or the Department of Health and Social Care.

Notes on contributors

Eleanor Holding is a Research Associate in the School of Health and Related Research (ScHARR) at the University of Sheffield specialising in qualitative methods and evaluation. She has worked on a number of evaluations of complex interventions in the areas of housing, welfare reform and loneliness. Her research interests include evaluations of interventions which seek to reduce health inequalities, particularly in relation to the impact of housing related issues on vulnerable populations.

Lindsay Blank is a Public Health Research Fellow of 18 years experience, with a variety of research interests broadly in the areas of health inequalities and public health evidence synthesis.She is currently funded to deliver policy relevant systematic reviews for the National Institute of Health Research (NIHR) Evidence Review Centre based in the School of Health and Related Research (ScHARR). Lindsay is also currently involved in two primary research projects funded by the NIHR School of Public Health Research which consider housing and health.

Mary Crowder is a Research Associate in the School of Health and Related Research (ScHARR) at the University of Sheffield. Her research interests include using qualitative and participatory methods to evaluate community-based health interventions. She is currently involved in a project for the national School for Public Health Research funded by the National Institute for Health Research, examining children and young people's health.

Elizabeth Goyder is Professor of Public Health in the School of Health and Related Research (ScHARR) at the University of Sheffield. She leads a number of research programmes with a focus on research that can directly inform policy and practice, including projects co-produced with practice colleagues and evidence synthesis. Her research interests include interventions to tackle health inequalities and the evaluation of the effectiveness and cost-effectiveness of complex community interventions.

References

Baxtor, S., Johnson, M., Chambers, D., Sutton, A., Goyder, E., & Booth, A. (2018). The effects of integrated care: A systematic review of UK and international evidence. *BMC Health Services Research*, *18* (350). doi:10.1186/s12913-018-3161-3

Blank, E., Holding, E., Crowder, M., Ferrari, E., & Goyder, L. (2018). Taking preventative health messages into the wider caring professions: The views of housing staff and tenants. *Journal of Public Health*, fdy175. doi:10.1093/pubmed/fdy175

Blewett, J., Lewis, J., & Tunstill, J. (2007) The changing roles and tasks of social work: A literature informed discussion paper. Retrieved from https://www.kcl.ac.uk/scwru/pubs/2007/blewettetal2007changing.pdf

Bratt, G. R. (2008). Viewing housing holistically: The resident-focused component of the housing-plus Agenda. *Journal of the American Planning Association*, *74*(1), 100–110. doi:10.1080/01944360701816071

Bryman, A. (2012). *Social research methods*. Oxford, UK: Oxford University Press.

Cameron, A. (2010). The contribution of housing support workers to joined-up services. *Journal of Interprofessional Care*, *21*(1), 100–110. doi:10.3109/13561820903012065

Cameron, A., Lloyd, L., Turner, W., & Macdonald, G. (2009). Working across boundaries to improve health outcomes: A case study of a housing support and outreach service for homeless people living with HIV. *Health and Social Care in the Community*, *17*(4), 388–395. doi:10.1111/j.1365-2524.2008.00837.x

Cameron, A., Macdonald, G., Turner, W., & Lloyd, L. (2007). The challenges of joint working: Lessons from the supporting people health pilot evaluation. *International Journal of Integrated Care*, *7* (18). doi:10.5334/ijic.219

Care Act. (2014) UK government legislation. Retrieved from http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

Carmel, S. (2006). Boundaries obscured and boundaries reinforced: Incorporation as a strategy of occupational enhancement for intensive care. *Sociology of Health & Illness*, *28*(2), 154–177. doi:10.1111/shil.2006.28.issue-2

Chevin, D. (2014). *Housing associations and the NHS: New thinking, new partnerships*. London, UK: The Smith Institute. Retrieved from http://www.smith-institute.org.uk/wp-ontent/uploads/2015/09/Housingassociations-and-the-NHS.pdf

Christiansen, A., & Roberts, K. (2005). Integrating health and social care assessment and care management: Findings from a pilot project evaluation. *Primary Health Care Research and Development*, *6*(3), 269–277. doi:10.1191/1463423605pc247oa

Dickinson, H., & Glasby, J. (2010). 'Why partnership working doesn't work' Pitfalls, problems and possibilities in English health and social care. *Public Management Review*, *12*(6), 811–828. doi:10.1080/14719037.2010.488861

Drennan, V., Llife, S., Haworth, D., Tai, S. S., Lenihan, P., & Deave, T. (2005). The feasibility and acceptability of a specialist health and social care team for the promotion of health and independence in 'at risk' older adults. *Health and Social Care in the Community*, *13*(2), 136–144. doi:10.1111/j.1365-2524.2005.00541.x

Finn, R. (2008). The language of teamwork: Reproducing professional divisions in the operating theatre. *Human Relations*, *61*(1), 103–130. doi:10.1177/0018726707085947

Fraser, W. M. (2019). Elephant in the room: Inter-professional barriers to integration between health and social care staff. *Journal of Integrated Care*, *27*(1), 64–72. doi:10.1108/JICA-07-2018-0046

Gale, K., Health, N., Cameron, G., Rashid, E., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13–117. doi:10.1186/1471-2288-13-117

Gieryn, F. T. (1983). Boundary-work and the demarcation of science from non-science - strains and interests in professional ideologies of scientists. *American Sociological Review*, *48*(6), 781–795. doi:10.2307/2095325

Gieryn, F. T. (1999). *Cultural boundaries of science: Credibility on the line*. Chicago, US: University of Chicago Press.

Gilbert, H. (2016). *Supporting integration with through new roles and working across boundaries*. London, UK: The Kings Fund. Retrieved from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Supporting_integration_web.pdf

Glasby, J., Martin, G., & Regen, E. (2008). Older people and the relationship between hospital services and intermediate care: Results from a national evaluation. *Journal of Interprofessional Care*, *22*(6), 639–649. doi:10.1080/13561820802309729

Hall, C., Slembrouck, S., Haigh, E., & Lee, A. (2010). The management of professional roles during boundary work in child welfare. *International Journal of Social Welfare*, *19*(3), 348–357. doi:10.1111/j.1468-2397.2010.00725.x

Ham, C. (2018). *Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England*. London, UK: The King's Fund. Retrieved from https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems

Handy, C. (2014). Housing, health and social care – An introduction. *Journal of Integrated Care*, *22*(1), 4–9. doi:10.1108/JICA-08-2013-0032

Hudson, B. (2002). Interprofessionality in health and social care: The Achilles' heel of partnership? *Journal of Interprofessional Care*, *1*(16), 7–17. doi:10.1080/13561820220104122

Humphries, R., & Curry, N. (2011). *Integrating health and social care: Where next?* London, UK: The Kings Fund. Retrieved from https://www.kingsfund.org.uk/sites/default/files/integrating-health-social-care-where-next-kings-fund-march-2011_0.pdf

Hunt, B., & Segrott, J. (2014). Renegotiating inter-professional boundaries in maternity care: Implementing a clinical pathway for normal labour. *Sociology of Health & Illness*, *36*(5), 719–737. doi:10.1111/shil.2014.36.issue-5

Ling, T., Brereton, L., Conklin, A., Newbould, J., & Roland, M. (2012). Barriers and facilitators to integrating care: Experiences from the English integrated care pilots. *International Journal of Integrated Care*, *12*. doi:10.5334/ijic.982

NHS England. (2014). *Five year forward view*. London, UK: National Health Service England. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS England. (2017). *Next steps on the five year forward view*. London, UK: National Health Service England. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

Pearson, C., & Watson, N. (2018). Implementing health and social care integration in Scotland: Renegotiating new partnerships in changing cultures of care. *Health & Social Care in the Community*, *26*, e396–e403. doi:10.1111/hsc.2018.26.issue-3

Powell, A. E., & Davies, H. T. O. (2012). The struggle to improve patient care in the fact of professional boundaries. *Social Science & Medicine*, *75*(5), 807. doi:10.1016/j.socscimed.2012.03.049

Power, A., & Richardson, L. (1996). *Housing plus – an agenda for social landlords*. London: LSE Housing.

Reed, J., Cook, G., Childs, S., & McCormack, B. (2005). A literature review to explore integrated care for older people. *International Journal of Integrated Care*, *5*(e:17). doi:10.5334/ijic.119

Regen, E., Martin, G., Glasby, J., Hewitt, G., Nancarrow, S., & Parker, H. (2008). Challenges, benefits and weaknesses of intermediate care: Results from five UK case study sites. *Health & Social Care in the Community*, *16* (6), 629–637. doi:10.1111/j.1365-2524.2008.00788.x

Ritchie, J., Lewis, J., Nicholls, M. C., & Ormston, R. (2014). *Qualitative research practice: A guide for social science students and researchers* (2nd ed.). London, UK: SAGE Publications Ltd.

Roxby, S. (2018). Partnership in action: Forging a new approach. *Housing, Care and Support*, *21*, 99–107. doi:10.1108/HCS-09-2018-0024

Sanders, T., & Harrison, S. (2008). Professional legitimacy claims in the multidisciplinary workplace: The case of heart failure care. *Sociology of Health & Illness*, *30*(2), 289–308. doi:10.1111/shil.2008.30.issue-2

Secker, J., & Hill, K. (2001). Broadening the partnerships: Experiences of working across community agencies. *Journal of Interprofessional Care*, *15*(4), 341–350. doi:10.1080/13561820120080472

Sharples, A., Gibson, S., & Galvin, K. (2002). 'Floating support': implications for interprofessional working. *Journal of Interprofessional Care*, *16*(4), 311–322.

Srivastava, A., & Thomson, B. S. (2009). Framework analysis: A qualitative methodology for applied research. *Journal of Administration and Governance*, *4*(2), 72–79.

Sundari, J., Klein, S., McCluskey, S., Woolnough, P., & Diack, L. (2018). Interagency adult support and protection practice: A realistic evaluation with police, health and social care professionals. *Journal of Integrated Care*. doi:10.1108/JICA-06-2018-0041

Taylor, S. J., & Bogdan, R. (1998). *Introduction to qualitative research methods: A guidebook and resource* (3rd ed.). New York, United States of America: Wiley.

The House of Commons. (2012) The supporting people programme: Research paper 12/40. Retrieved from https://researchbriefings.parliament.uk/ResearchBriefing/Summary/RP12-40