

# *A foot in the door:*

a guide to engaging housing and health



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## Foreword



The relationship between housing and health is well established, with a growing evidence base for the role of housing in improving health outcomes. There are also many excellent examples where public health and housing colleagues have come together to tackle persistent health inequalities and deep-rooted issues around health and wellbeing. Despite this progress, the pressures that our health and care system faces remind us that these relationships can no longer be considered an attractive option, but a necessity.

The Government reforms currently passing through Parliament signal a new opportunity to learn the lessons of the past and prepare for the challenges of the future. The new health and wellbeing boards bring both old and new leaders together to start afresh and tackle the big issues that matter to local communities. Success will rely on pushing beyond the boundaries of traditional health and care to forge new partnerships with those who also exert influence over the wider determinants of health and wellbeing in our communities.

Whilst it is clear that partnerships of health and housing can produce exciting, innovative and efficient services, building strategic partnerships will be no mean feat. The link between housing and health is of course complex, often coexisting with multiple deprivation across education, employment, crime and social exclusion. Solutions to all our problems will not magically appear overnight. However, the new arrangements give us the opportunity to frame the agenda around building local relationships, trust, common cause – the hard stuff – that we know encourages innovation and shared risk in response to complex problems and makes all the difference in the long run.

This guide provides a timely opportunity for local housing providers to get together to consider the role they play in the health and wellbeing agenda. The Royal Society for Public Health encourages all partners to take up the challenges and get involved. It is an opportunity we simply cannot afford to miss.

**Professor Richard Parish**  
Chief Executive  
Royal Society for Public Health



## Sponsor Foreword



We see the profound impact of good housing on health and wellbeing on a daily basis, particularly in those communities facing multiple disadvantages. Housing services offer quality and value for money in several ways; they support vulnerable people to live independently, and the provision of good quality and affordable housing provides stability in peoples' lives and can act as a springboard to better health and greater life opportunities for all.

However, we recognise that we cannot work in isolation. To make a lasting difference to people's lives we must work creatively and collaboratively with our partners to meet and exceed people's needs and aspirations. The changing health and wellbeing agenda provides an ideal opportunity for housing organisations like Gentoo Group to get the conversation started.

I am therefore delighted that Gentoo Group has been able to sponsor the Northern Housing Consortium's new tool, 'A foot in the door: a guide to engaging housing and health'. This tool will help housing organisations and their partners work together effectively and productively, producing new and innovative solutions that recognise the common goals we share with our communities. It offers excellent guidance on the new health and wellbeing policy landscape, outlining what it actually means to the housing sector.

I know that as a sector we are ready for the challenge and look forward to realising new opportunities to work in a more collaborative way with our health and wellbeing colleagues.

**Caroline Gitsham**  
Director  
Gentoo Group



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## What the tool aims to do

This tool aims to help housing organisations build stronger collaborative relationships with the local leaders of health and wellbeing within a finite window of opportunity. It will help you understand the new health and wellbeing system; understand the roles and responsibilities of the new leaders, and use this knowledge to plan and execute an engagement strategy that will help place your organisation firmly at the heart of the new arrangements for health and wellbeing.

We hope this tool will be useful to a wide variety of audiences, but it has been created primarily for:

- \* *Strategic housing authorities*
- \* *Registered providers*
- \* *Local housing companies*
- \* *Arms length management organisations*

We recognise that, despite the well documented advantages of closer partnerships between housing and health, it has often proved an elusive goal. The real contribution of housing is often poorly understood by health colleagues who sometimes limit their view to bricks and mortar, oblivious to the depth and breadth of housing's role as service provider, intermediary, place shaper and community leader. The changes to the health and wellbeing system and the challenges of efficiency savings present an excellent opportunity for partners to revisit their relationships and highlight common ground for example, shared client groups such as vulnerable and complex needs users, and place based approaches supporting sustainable, healthy communities.

Here we set out a pragmatic and honest roadmap that places as much emphasis on navigating the people and politics in the new system as it does on providing the arguments and evidence to support the case for improved partnerships. We urge readers to build on the lessons of the past and develop an engagement strategy that is clear about why you are getting involved, and what you want to achieve. Don't expect change overnight and try not to get disheartened by early knockbacks. Relationships take time to establish and many colleagues find themselves in a period of great uncertainty. Remember that housing colleagues across the country have made their case, and won it, but only with patience, energy and commitment. It is crucial you understand the difference between building a business case and building a strategic relationship from the very beginning; if you want to be taken seriously you must be ready to embrace the language and culture of others, think about what matters in your area and not what matters to you.

You may find that much of the information we include is common sense, and you may have thought of many aspects of this tool yourself. However, we hope this tool is helpful in laying out your options. Regardless of the potential pitfalls, it is clear that the time to invest in building new relationships with health and wellbeing is now. This tool does not have all the answers, but we hope it encourages you to seize the opportunity to get started.

# Essential briefing

## An old problem, a unique opportunity

*The Government's reforms set out large scale change to the local, regional and national leadership of health and wellbeing. Without drawing on the details of new policy, a new generation of leaders are to be charged with driving existing partnerships across local government, health and wider agencies to tackle the most persistent health inequalities that are beyond the remit of any one agency.*

The interdependent relationship between health and housing is not new. Since Chadwick established a link between the appalling living conditions of the poor and their ill health in 1842, many of the most significant gains in health that followed stemmed from public health measures, such as clean water, sanitation, and reduced exposure to extreme cold and other factors associated with improved accommodation. The sector has made great strides in bringing homes up to standard but problems clearly persist. For example, 41 per cent of private sector homes remain non-decent; more vulnerable people live in private housing than in the social rented sector. People over 75 – the main users of health and social care services – are the most likely group to live in non-decent private sector housing.<sup>1</sup>

Many housing organisations work within communities facing some of the worst disadvantages. Alongside health inequalities, the challenges include higher rates of worklessness, higher levels of people categorised as not in education, employment or training (NEET), a less stable enterprise culture and lower levels of educational attainment. Considering multiple housing deprivation poses a health risk that is of the same magnitude as smoking and, on average, greater than that posed by excessive alcohol consumption, the case for action is clear.<sup>2</sup>

The housing sector has a strong and visible role in tackling health inequalities, reducing the burden on health and social care services<sup>3</sup> and reducing costs to the public purse. Research shows that investment of £1.6 billion in housing related support generated savings of £3.41 billion to the public purse, including £315 million of savings to health service in a year<sup>4</sup>.

Before developing your engagement strategy, it will be important to understand the issues foremost in the minds of your target audiences. This section briefly explores the main policy drivers facing both housing and health and wellbeing. We do not attempt to explore each of the issues in detail but rather set out the key points and headline messages for each, highlighting links and interdependency. For further information and more detail on each section, refer to the tools and resources section of this guide.

<sup>1</sup> English Housing Survey 2009-10, Department of Communities and Local Government

<sup>2</sup> Black D, Morris J & Smith C et al (1980) *Inequalities in health: report of a research working group*. London: Department of Health and Social Security.

<sup>3</sup> Bolton J. (2010) *The use of resources in adult social care: a guide for local authorities*, Department of Health

<sup>4</sup> CapGemini (2008) *Research into the financial benefits of the Supporting People programme*, Department of Communities and Local Government

## Health inequalities - understanding the scale of the challenge

The Marmot Review of Health Inequalities in England post 2010<sup>5</sup> - one of the most comprehensive pictures of health and wellbeing - reveals a picture of entrenched and growing inequalities. The scale of disadvantage is breathtaking, currently costing the UK £31-33 billion in productivity losses; £20-32 billion in lost taxes and higher welfare payments, and £5.5 billion in additional NHS healthcare costs.

Behind the figures is the more shameful story of lost opportunity and preventable disease and disability. For example, in around half of the local authorities in England Disability Free Life Expectancy (DFLE) - the average number of years a person could expect to live free of an illness or health problem that limits their daily activities - between richest and poorest varies by 9 to 10 years within the local authority. In some areas there are even greater extremes - the Wirral currently has the widest level of inequality in DFLE for both sexes; 20 years for men and 17 years for women.

### What it means at the local level:

it is too early to gauge the full influence of Marmot however improving health inequalities is a duty for the new NHS. Measures of health inequalities will appear in performance management and outcomes frameworks and a 'Health Premium' will be paid to areas that reduce inequality. Marmot is accepted by many as one of the underlying principles behind the current direction of travel for health and care services.

**66** *The housing sector has a strong and visible role in tackling health inequalities* **99**

## Efficiency savings - there are no easy choices

The public sector is facing unprecedented efficiency savings and a reduction in the financial settlement, including £20 billion NHS efficiency savings over 4 years; a £1.66 billion cut in the local authority settlement in 2010/11, including £311m from childrens services; an 11.5 per cent cut to the Supporting People budget with a removal of the ring-fence, as well as cuts to most local authority revenue and capital grants; and a cut to the 2011 police grant of £125m, with central funding reduced by 20 per cent to £8.8 billion by 2014.

### What it means at the local level:

the demands of efficiency savings on the public sector are huge and leaders are faced with tough choices on investment and disinvestment. The outlook for funding is uncertain. One thing is certain - cost-neutral and low cost investments will be most appealing to health and wellbeing commissioners.

<sup>5</sup> Marmot, M (2010) *Fair Society, Healthy Lives*



## New systems - understanding broader changes

The **Health and Social Care Bill** proposes the biggest shake up of the NHS since its inception. The proposals abolish Primary Care Trusts – the local commissioners of health services – and strategic health authorities or SHAs, and give responsibility for local health commissioning to the tune of £60 billion to clinical commissioning groups. Public health moves back to the local authority which now assumes the duty for local health improvement and the reduction of health inequalities. However, current system changes and reorganisations are not limited to health and social care as the reform agenda also includes the Localism Bill and Welfare Reform Bill.

The **Welfare Reform Bill** introduces the Personal Independence Payment in the place of Disability Living Allowance, and sets out reforms to housing benefit and employment and support allowance that will save £5.5 billion in welfare payments over the next five years. It is the biggest reform of the benefit system since the founding of the welfare state.

The **Localism Bill** sets out changes to social housing policy and the planning system, including new approaches to cross-boundary local authority working and strategic planning; the decentralisation of spatial planning and development to neighbourhoods, and an enabling role for retaining and transferring local service and facility provision to local control through the Community Right to Buy scheme.

### What it means at the local level:

the cumulative changes of the three agendas have huge implications for local partners both in terms of how and what type of services they deliver. It is also worth bearing in mind the scale of organisational change and uncertainty faced by many working in health and wellbeing.



## Personalisation, care, and independent living - a steep learning curve

By 2026, the number of 85 year olds is projected to double. Increasing life expectancy is a good thing, but it often comes with an increasing need for care and support. The Government is currently considering the recommendations of the Dilnot Commission - an independent commission set up to consider funding of care and support - that centre on personalisation, choice and quality. These concepts are not new to health and social care but increased focus on them marks a culture change towards running a single, multi-agency care planning process around the individual, where the individual them self is recognised as the real expert in their own quality of life and wellbeing.

### What it means at the local level:

many health commissioners are still getting to grips with personalisation, independent living and what it means for the services they commission. Some are yet to get a handle on their role in stimulating and supporting growth in local markets and, to date, 'personalisation' is often used to describe an abstract principle as well as very specific policy initiatives such as Individual Budgets in social care and personal health budgets pilots in the NHS. Expect debate about how far the boundaries of 'personalisation' go.

### Follow the direction of travel

It is clear the new policy is beginning to recognise the contribution of wider partners such as housing and the role they play in tackling persistent health inequalities. It will be incumbent on all partners to build a clearer picture about the nature and causes of multiple deprivation in their area. And, as Marmot reminds us, whilst policy will frame the debate, the solution to these problems is local: *'National policies will not work without effective local delivery systems focused on health equity in all policies.'* The time has come for local health and housing professionals to come together to devise local effective delivery systems focused on tackling these deep-rooted issues.

# Demystifying health and wellbeing

*The health system can be difficult to navigate because of its size, organisational and accountability structures, funding routes and different professional cultures and languages. Many of those not intimately involved in health can find it difficult to identify the appropriate organisation or individual they need to talk to.*

*This section aims to demystify health and wellbeing. It gives a broad and general overview of the key national, regional and local organisations and agencies, and sets out the assurance frameworks and performance management regimes that govern the system.*

*However, a health warning is attached: at the time of writing, the Government's reforms were still on passage through Parliament and some of the information here may be subject to change.*

## Local organisations

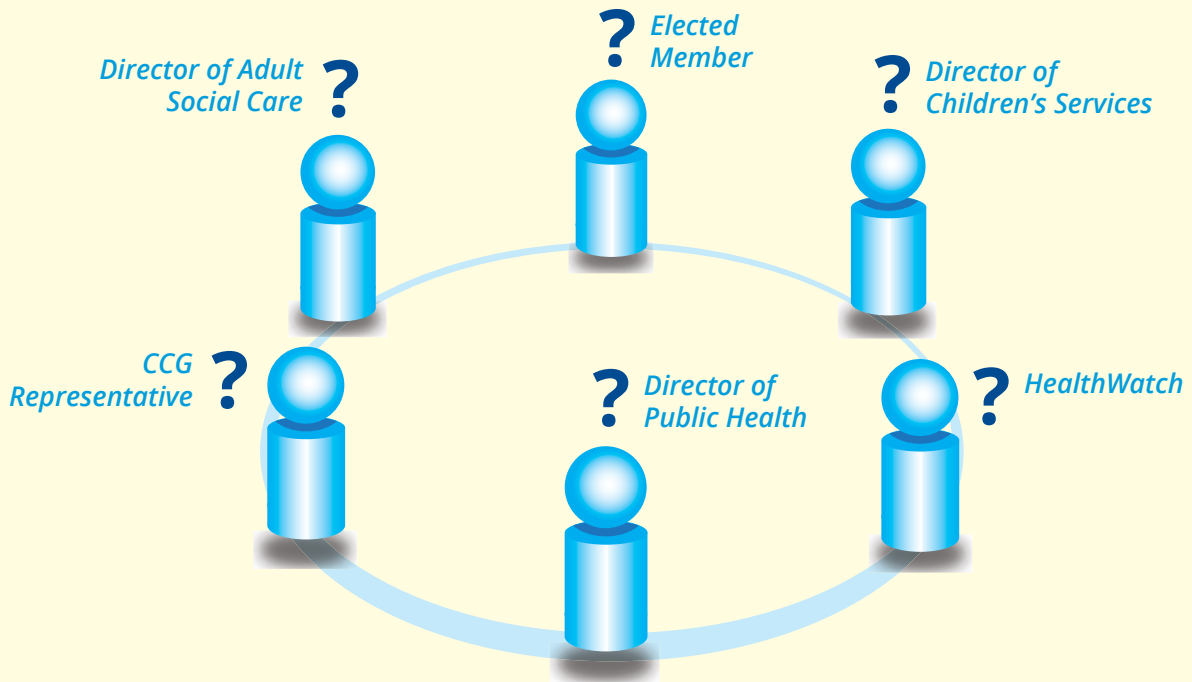
### Health and wellbeing boards and local authorities

The Government's Health and Social Care Bill 2011 introduces the new health and wellbeing board which is charged with improving local health and social care, and reducing health inequalities. It sits within the local authority, although responsibilities for delivering many of its functions are to be shared between agencies. The Bill allows local authorities to delegate any of their functions into the Board, which means its influence could extend over all locally commissioned public services.

The membership of the board is to be determined locally but must include one elected member, a clinical commissioning group representative, the directors of public health, adult social care and children's services, and HealthWatch, as a statutory minimum. As a board, they have a statutory responsibility for the delivery of a local Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), for joining up commissioning across health, public health, social care and wider services that they agree are directly related to health and wellbeing, and for delivering value for money. The Bill specifies that Boards will have a say in NHS performance management regimes, including for clinical commissioning groups.

### **What this means for you:**

*for many in housing, this will be a first port of call for building strategic influence, although not your only option.*



### Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) will be led by local general practitioners (GPs) and will take over from former NHS Primary Care Trusts (PCTs) as the commissioners of local health services by April 2013. They will be public bodies which will not be able to delegate commissioning to private companies or normally cross local authority boundaries. The CCG will be required to hold their meetings in public, publish minutes and related documents, as well as the details of contracts with health services. The board of a CCG must have a secondary care specialist and a registered nurse as well as at least two independent members – one of whom must be a champion of patient involvement. CCGs will commission most, but not all local NHS services – a notable exception being pharmacy, dental and primary care services (e.g. the services the GPs themselves provide).

#### What this means for you:

*you will need to understand the professional terminology, perspective and culture of GPs if you want to do business with local NHS commissioning.*

### NHS Providers

NHS Foundation Trusts hospitals - run by local managers, staff and members of the public – are big providers of NHS services. They sit within the NHS and its performance systems but have greater financial and operational freedom than other hospitals. Other providers of NHS services include Acute Trusts, Ambulance Trusts, Care Trusts and Mental Health Trusts. Expect to also see other types of NHS organisations, such as social enterprises, and where staff detach themselves from the NHS to form separate not-for-profit organisations closely, but not necessarily wholly, aimed at providing NHS services.

#### What this means for you:

*whilst they are providers and not commissioners of health services, expect the large hospitals – either Foundation or Acute Trusts – to continue to have considerable influence over your local NHS.*

### HealthWatch

Local HealthWatch builds on the foundations of the current Local Involvement Networks (LINKs) and is to champion the views and feedback of patients, services users and carers, and ensure that they play a central role in local health and wellbeing planning. They will be funded by and accountable to local authorities but will report their concerns through the national body, HealthWatch England, which will sit within the Care Quality Commission (see over)

#### What this means for you:

*although they will have to find their feet, local HealthWatch could be a useful ally around the health and wellbeing board.*



## National organisations

### Public Health England

Public Health England (PHE) is to be established as an integrated public health body that brings together the Health Protection Agency, National Treatment Agency, Regional Directors of Public Health, Public Health Observatories, and National Screening Committee and Cancer Screening Programmes. PHE will be an executive agency of the Department of Health and will be responsible for emergency preparedness, health protection, screening and immunisation, as well as a number of nationally designated public health functions such as infant health and specialised sexual health services. The national budget for public health has been estimated at around £4 billion.

The local Director of Public Health (DPH) will be the principal adviser on health to local elected members and is charged with delivering key new public health functions. Whilst employed by the local authority, the appointment process will be done jointly with PHE. The DPH will also have an obligation to produce an annual report on the health of the population - in practice, this could either be aligned with the JSNA or kept independent, depending on local arrangements.

#### What this means for you:

*DPHs will be highly useful advocates of your case, given their central and continuing role within intelligence and assessment processes such as the JSNA, and their role as commissioners of services in their own right.*

### Monitor

Monitor is the independent regulator of NHS Foundation Trusts. It is accountable to Parliament and responsible for determining whether NHS Trusts are ready to become NHS Foundation Trusts with greater financial and operational freedom. Monitor ensures foundation trusts comply with the conditions of their authorisation and are financially robust, as well as supporting NHS Foundation Trust development. The Government reforms propose new powers for Monitor as the sector's economic regulator for health with the core duty to protect and promote patients' interests.

#### What this means for you:

*Monitor is a useful source of information about your local Foundation Trust, including compliance and performance.*

### Care Quality Commission

The Care Quality Commission (CQC) is the independent health and social care regulator for England and registers and licenses the providers of care services. The CQC regulates providers of medical and clinical treatment and care, providers of care services for adults in residential homes, in the community and in people's own homes and providers of services for people whose rights are restricted under the Mental Health Act. The CQC will also eventually regulate primary care such as GP and dental practices.

#### What this means for you:

*CQC special reviews on different aspects of care are a useful source of information and best practice.*

### NHS Commissioning Board

The NHS Commissioning Board (NHS CB) will be nationally accountable for the outcomes achieved by the NHS and will provide leadership for the new commissioning system. The Board will have overall responsibility for a budget of £80 billion, of which £60 billion will be allocated directly to clinical commissioning criteria. The NHS CB will directly commission a range of services including primary care - the GP 'day job', pharmacy services, dental services, and specialised services where patient populations mean it makes sense to do this at a national or regional level. Although an independent, statutory body that is free to determine its own structure and ways of workings, the Board will be accountable to the Secretary of State.

#### What this means for you:

*if you want to work closely with clinical commissioning groups it will be helpful to know the priorities and views of the NHS Commissioning Board.*

### National Institute for Health and Clinical Excellence

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. They make recommendations to the NHS on new and existing medicines, treatments and procedure and develop and define Quality Standards which indicate efficacy, cost effectiveness, safety and patient experience.

#### What this means for you:

*NICE has system-wide influence on health commissioning, so be sure to use any NICE quality standards and evidence that support your business case.*

## Performance management and quality assurance regimes

*Although many details of performance management arrangements were still in development at the time of publication, here we provide an overview of the main mechanisms and agencies involved in the performance management and quality assurance of health services.*

### Joint Strategic Needs Assessment

The health and wellbeing board will lead a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS). The JSNA will be the primary process through which local partners identify and agree a comprehensive picture of local health and wellbeing needs and priorities, providing a robust evidence base on which to base local commissioning plans. JSNAs should provide useable intelligence around complex needs and multiple deprivation.

Using the JSNA, the board will agree a high-level JHWS. The JHWS will document an agreed local strategy by capturing the needs and priorities identified in the JSNA and translating into a plan of action. Both processes span the NHS, social care and public health, and can consider wider health determinants such as housing, or education. The commissioning plans of CCGs and the NHS CB must align with the findings and priorities identified through the JSNA and JHWS processes.

#### What this means for you:

*look to the JSNA and JHWS as a place to contribute data and intelligence to the local strategic agenda; a source of data and intelligence to inform your own strategic planning; and as a way of identifying potential common ground with health and wellbeing leaders.*

### NHS, Public Health and Social Care Outcomes Frameworks

Three new Outcomes Frameworks – NHS, Public Health and Social Care – are the primary indicators by which the performance of the health system will be measured. The outcomes frameworks move away from centrally driven targets around what a particular service should or shouldn't do, and instead look at what has been achieved overall for health and wellbeing outcomes in the area. Despite being independent of each other, the three frameworks are intended to overlap and interconnect, allowing agencies to work towards common goals. For example, although health is tasked with recovery following injury, and social care with delaying and reducing the need for care and support, both will share the common indicators of emergency re-admissions within 28 days of discharge from hospital, and the proportion of those aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. Public Health England and the NHS will share indicators for life expectancy and mortality, for example, the under 75 mortality rate from cardiovascular disease, and under 75 mortality rate in people with serious mental illness.

#### What it means for you:

*outcomes frameworks set the 'bottom line' agenda for commissioners. Consider how your offer will help them evidence local improvement to the people who hold them to account.*



## Payment by Results

Payment by Results (PbR) provides a transparent, rules-based system for paying NHS trusts. It is intended to reward efficiency, support patient choice and encourage activity for sustainable waiting time reductions. Payment is linked to activity, with the intention being to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual commissioners.

### **What it means for you:**

*it may be a useful way for you to interrogate local NHS commissioning and spot opportunities for housing-led services that are cost effective in relation to institutional, emergency or acute care.*

## Quality, Innovation, Productivity and Prevention

The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large scale transformation programme that aims to deliver up to £20 billion of efficiency savings by 2014-15. QIPP comprises a range of initiatives that span many areas of NHS activity and aims to improve productivity and eliminate waste while maintaining clinical quality. For example, the Long Terms Conditions QIPP seeks to reduce unscheduled hospital admissions by 20 per cent, reduce length of stay by 25 per cent and maximise the number of people controlling their own health through the use of supported care planning. There are around 15 million people living with a long-term condition in England who account for around 70 per cent of overall health and care spend in the NHS. The idea is it is not about cost improvement plans, i.e. getting the same or more for less, but making quality gains through financial efficiencies.

### **What it means for you:**

*expect NHS commissioners, both in outgoing PCTs and incoming clinical commissioning groups, to talk about QIPP as a major agenda for them.*

## Quality Outcomes Frameworks

The Quality and Outcomes Framework (QOF) is part of the General Medical Services contract for general practices. The QOF rewards GP practices for the provision of quality care and helps to fund further improvements in the delivery of clinical care. QOF is based on national quality standards covering four domains:

- **Clinical** – managing common chronic diseases such as asthma, diabetes
- **Organisational** – how well the practice is organised
- **Patient experience** – how the patient views their experience
- **Additional services** – the amount of extra services offered, such as child health, maternity and weight management services.

In 2011/12, a maximum of 1,000 points are available to practices across QOF and practices will be paid on average £130 for each point they achieve. Practice participation in QOF is voluntary but most practices do take part.

### **What it means for you:**

*QOF may help you spot opportunities where GPs are financially incentivised to develop new services and initiatives in primary care.*

# Journey to Engagement

*This section will help you build your offer and plan and execute your engagement strategy.*

*As you go through the following worksheets, it is an idea to bear the following hints and tips in mind...*



## **You already have an agenda**

You have a clear, unambiguous agenda for change: the Marmot Review and its six priorities set out a comprehensive challenge for all partners in health and wellbeing to consider how they could work together better. Efficiency savings and new policy means that leaders need to think again about how and what services they commission.



## **Delivery is everything**

The challenging backdrop of rising demand for services, changing demographics, growing health inequalities and unprecedented public sector spending cuts mean significant pressure will be placed on health and wellbeing leaders to do more with less. The new policy aims to increase public accountability and transparency to the process of health and wellbeing commissioning, upping the ante considerably for those across all public agencies with responsibility to deliver. Start with services where you know you can add value. Develop a reputation for delivering and solving problems and people should quickly become receptive.



## **You will need a clear plan**

You are dealing with complex problems made even more testing by the politics of prioritisation, decision-making, politics and power struggles. It is essential that you are clear about who you are targeting and why. The hurdle is not putting an offer together that demonstrates the value of housing to health and wellbeing; it is targeting the right people, at the right time with the right intelligence and information.



## **Waste no time**

The housing sector is very well placed to work in partnership with health and wellbeing leaders. Housing has a valuable contribution to make to delivering better outcomes and savings to the public purse. The new policy arrangements provide the carrot and the stick for health and wellbeing leaders to develop meaningful and effective partnerships across the system to help foster a culture of integration and joint working. Remember, there is only a short window of opportunity to influence - waste no more time and get started on your engagement strategy today.

# Step 1

## Set out what you want to do

*Develop a core mission statement to keep your engagement strategy on track. Before you start to engage with health and wellbeing leaders, it is crucial that you agree and understand what you want to achieve. Be honest with yourself about how much you are prepared to invest. Do you want to be an active participant in setting the overarching strategic health and wellbeing agenda, or do you want to engage leaders only on certain issues such as supported living, or advice and advocacy?*

### Key issues

- \* Who in your organisation will be involved and what does your organisation want to achieve? It may seem obvious, but leaders may be put off if you cannot summarise your aims and objectives succinctly from the start.
- \* What is at the top of your wish list? Which goals are crucial, and which are nice to have? This clarity will be valuable later on.
- \* Are you confident you have a mandate for an engagement strategy or are colleagues talking about winning business? A business case and engagement strategy are two different things.

Statements on your aims and objectives	Do you agree? Is this essential? <i>Note your thoughts and further comments here</i>
<i>We want to understand how services connect so we can plan and deliver quality integrated services for our communities</i>	
<i>We want to understand what the health and housing needs in our area will be in twenty years time</i>	
<i>We want to lead a culture change moving housing from physical decency to tackling multiple disadvantage, e.g. benefit dependency, skills, poor mental health and anti social behaviour</i>	
<i>We want commissioners and budget holders in health and wellbeing to understand the value of housing-led services</i>	
<i>We want a specific audience to engage with us – e.g. GPs and CCGs, elected members, social care, public health, other providers, planning</i>	
<i>We want more involvement in 'big issue' community decision making around health and wellbeing – e.g. service reconfiguration, regeneration, and planning</i>	
<i>We want to put housing at the heart of the health and wellbeing agenda and be recognised as equal partners</i>	
<i>We want housing to have a seat at the health and wellbeing board</i>	
<i>We want housing to come together to have a single voice for the sector</i>	

## Step 2

### Do an audit of what you have got

*Effective partnerships are built on mutual trust and support. Look at what you can bring to the table; you may be surprised at what you actually have. Stating this clearly could make the difference in being recognised as a legitimate health and wellbeing leader.*

#### Key issues

- \* Start with the simple stuff: residents, physical assets, homes, green space, business units, community centres.
- \* Review your services; do you provide advocacy, support, befriending and community support and development, adaptations, homes and building maintenance, environmental services, infrastructure? How do you work with your clients and service users?
- \* What and where are your networks? Which agencies do you work with, who do you know and how can these relationships be aligned to the strategic agenda? Do you need to strengthen your partnerships with other housing providers?

<b>Asset</b>	<b>What have you got? How can it be helpful? Who would be interested?</b>
Homes and buildings	
Trust of the community and residents	
Shared public spaces: estate offices, community centres, parks	
Amenities	
Services	
Existing partners, networks and influence	
Long term investment, plans and aspirations	
Other assets?	

## Step 3

### Plan your strategy

Once you have agreed on your aims and objectives and have reviewed what you have got, take the lie of the land. Consider your local health and wellbeing leaders, and how you might build effective relationships. There is no single way to do this – you are free to approach the people in a way that makes the most sense to you.

#### Key issues

- \* Who is involved in the new health and wellbeing board, and what are the new formal roles and responsibilities of its members?
- \* Who do you think has the most influence? Where do you think there is common ground?
- \* Putting the health and wellbeing board aside, does it make sense to start building relationships with other partners, such as acute trusts, mental health trusts, voluntary and private sector providers and community organisations? How about other housing providers?

<b>Potential partners</b>	<b>Who do you know already? Who would you like to build relationships with, and why?</b>
Health and wellbeing board	
GPs and CCGs	
Adult social care	
Children's services	
Public health	
HealthWatch	
Elected members	
Acute trusts	
Mental health trusts	
Voluntary sector providers and advocates	
Community organisations	
Other housing providers	
Other private sector providers	
Others (e.g. local planners, police, education, skills and training)	
Other national (e.g. NICE, professional bodies)	

## Step 4

### Build your case

Now that you have established who you know, who you don't know and who you would like to know, it is now time to focus and build your case for strategic engagement. Consider whether you are going it alone or will work with partners in the housing sector.

#### Key issues

- \* You will have to clearly set out your health and wellbeing credentials. Can you give a succinct big picture report card, with examples of your existing contribution to health and wellbeing?
- \* What do you know about your target audience and how does this shape your offer? What are their professional outlooks? What does the world look like to them?
- \* Be careful not to confuse a business case for your services with a case for recognition as a legitimate strategic partner. Building trust and credibility is paramount at this early stage.

Issues	Note your thoughts here
<p><b>Issue: set out your credentials to your target audience</b>  <b>Rationale:</b> start with who you are – how many, how much, who and where – and clarify your overall local contribution; is it one of a commissioner, provider, local community leader, all of them? Give a value statement about who you are and what you are about; are you about people, are you about place, are you about community?</p>	
<p><b>Issue: be ready to demonstrate added value</b>  <b>Rationale:</b> you will need to show how your existing services improve health and wellbeing and help partners realise efficiency savings. Be ready to provide specific local examples and case studies. It will be tempting to try to cover everything and include volumes of data to support your case, don't.</p>	
<p><b>Issue: set out a strategic offer for health and housing going forward</b>  <b>Rationale:</b> look beyond traditional boundaries at the big problems facing your partners and how you can help. What would be different if you were involved as a strategic partner? Use evidence in the JSNA and other strategic plans to set out a clear offer around shared and common issues. Remember, there must be something in the deal for existing health and wellbeing leaders; what is their incentive to change? What is the risk of doing nothing?</p>	
<p><b>Issue: prepare to put a deal on the table</b>  <b>Rationale:</b> set out what you really want from your partners and what you are prepared to give. Revisit your answers to the questions in step 1. Effective partnerships are based on mutual trust and benefit. Give the details about your potential contribution; talk about the data, capacity, access, assets, needs, and networks that you could bring to the table.</p>	



## Step 5

### Get stuck in

Once you have agreed your aims, planned your strategy and built your offer, it is time to get stuck in. The way in which you do this will depend on your answers to the previous four steps but below we set out some general tips for engaging decision-makers. Remember, if plan A isn't working, don't just bang your head against the wall, try a plan B or a plan C.

#### Key issues

- \* Failure often comes down to talking to the wrong people at the wrong time. Pick your timing carefully for your initial approach.
- \* What approach makes the most sense - formal or informal channels? A universal approach or targeted one? Think about where you might meet resistance and how this can be overcome.
- \* Progress will require a degree of trial and error, testing the waters, and thinking on your feet. Be ready to adapt.

Practical tips for engagement	Does your strategy do this? Can you improve it?
<p><b>Tip: expect people to be people</b>  <b>Why:</b> it's easy to focus on the merits of your case, on what you think ought to happen, as opposed to what actually does. If someone just doesn't get it, then don't bang your head against the wall, move on and come back to them later.</p>	
<p><b>Tip: understand the system and procedures</b>  <b>Why:</b> health and wellbeing leaders will have their own assurance regimes, targets, quotas and incentives foremost in their minds. Make sure you know about them and how your offer might help them realise their priorities.</p>	
<p><b>Tip: make a case using real examples</b>  <b>Why:</b> use real examples where possible to support your offer as they often help people understand the impact of their decisions.</p>	
<p><b>Tip: know your facts</b>  <b>Why:</b> make sure that you use the latest up-to-date data and intelligence in your offer and make sure it is accurate. Stay clear of ambiguous quotation and make sure modelling and projection is explained clearly with sound methodology.</p>	
<p><b>Tip: have one point of contact</b>  <b>Why:</b> make sure that you use the latest up-to-date data and intelligence in your offer and make sure it is accurate. Stay clear of ambiguous quotation and make sure modelling and projection is explained clearly with sound methodology.</p>	
<p><b>Tip: use plain English!</b>  <b>Why:</b> different professional groups use different languages, often using different words to express the same thing. Make sure you are familiar with acronyms and terminology but if in doubt, stick to plain English - incorrect terminology could undermine your message.</p>	

# Step 6

## Evaluate your progress

*Evaluating your engagement strategy is essential if you want to understand your impact. You will have to set your own indicators of success but be realistic about what you can achieve. Real change takes time and can only be effected through building sustainable relationships and a culture of co-operation that will outlast progress made by strong leadership and forceful personalities.*

### Key issues

- \* How do you know if your engagement strategy is working?
- \* What will do you do if it's not working? Will you try to engage and influence someone else using the same approach or will you take a different tack?
- \* How do you measure 'success'; is it outcomes for individual service users, access to decision-makers, funding opportunities?

Examples of quality statements	Note your thoughts here
<p><b>Statement:</b> we are better recognised as a legitimate partner in health and wellbeing.</p> <p><b>Measure:</b> colleagues agree they are now more actively involved in the strategic agenda for health and wellbeing than in the past.</p>	
<p><b>Statement:</b> we have a better relationship with our target audience, e.g. GPs and CCGs, elected members, social care, public health, other partners and providers.</p> <p><b>Measure:</b> colleagues agree they are better engaged with partners, and can demonstrate a track record of face-to-face and open contact, either through formal mechanisms such as reference and steering groups, or on an ad hoc basis.</p>	
<p><b>Statement:</b> we are more involved in 'big issue' community decision making around health and wellbeing – e.g. service reconfiguration, regeneration, planning.</p> <p><b>Measure:</b> colleagues agree they can evidence one or more major wellbeing plan or commissioning strategy that they have engaged with and successfully influenced.</p>	
<p><b>Statement:</b> we have reshaped peoples' attitudes and understanding of housing and its contribution to health.</p> <p><b>Measure:</b> colleagues can demonstrate examples where health and wellbeing leaders themselves have flagged the crucial role of housing in commissioning strategies and plans for health and care.</p>	
<p><b>Statement:</b> our organisation sees leadership for health and wellbeing as core business.</p> <p><b>Measure:</b> colleagues feel engagement with health and wellbeing is valuable. Senior colleagues support activity around engagement and allocate resources to support it.</p>	
<p><b>What quality statements make sense to you and how would you measure them?</b></p>	

# Case Studies

What Works...



*The following case studies illustrate the vital role that housing organisations can play in improving outcomes and delivering value for money.*

## **Early intervention in the community – Wakefield's health inequality workers**

Through their JSNA, the Wakefield public health team uncovered a large population with low to moderate health and wellbeing issues – problems like alcohol and drug dependency, physical health, obesity, and

poor mental health. Despite being currently 'off the radar' for health and care, many of these seemed likely to become complex and high needs service users in future. The public health team approached Wakefield and District Housing to explore what could be done to help identify these individuals out in the community, address their needs better and help prevent high-level dependency and crisis before it happened. Sue Perry, the Director of Public Health in Wakefield said that "Our analysis showed a sizeable population whose needs were not being met. We needed to find a partner who could help us identify who and where they were; housing seemed the most obvious place to start."

As a result, NHS Wakefield commissioned Wakefield and District Housing to run a pilot network of five Health Inequality Workers to run outreach, coordination and early intervention programmes through their existing housing services. Workers were recruited who had skills and experience in supporting vulnerable people and operate from housing area offices where they are well placed to work with local residents and other partners. Referrals are received from a range of sources, but predominately from Estate Officers and Debt Advisors. The team offer mentoring and intensive support based on a persons' individuals need, often referring people on to NHS and voluntary sector services such as counseling,

smoking cessation, benefits advice, GPs and others. The aim of the project is to support a person to make positive lifestyle changes within 6 months and enable them to manage their own health and wellbeing as they recover their independence. In their own words, the team see it as about being 'person-centred', a 'motivator' and offering emotional support after building up rapport and trust. The aim is 'To give people the opportunity to stop, think and rewind' and give them "an open door and support them through it'.

A recent evaluation by Bradford University demonstrated that whilst it was not possible to calculate the individual economic impact of the pilot, it clearly exemplifies the positive action demanded by the Marmot Review (2010) of health inequalities. Client feedback has been very positive. The evaluation report included a poignant comment from an individual talking about her experience of the service:

*"Oh, if you could've seen me... I don't think I'd have been here without her. I think I would have just, I know it's a silly thing to say, but I think I'd of just topped myself. I'd just given up..."*

"The service has made a difference to people lives in a way that could only have been done through housing. It is about embedding a service into real communities and building relationships with people that are based on trust" says Sarah Roxby, Service Manager at Wakefield and District Housing. "A recent example of the project was that of a pregnant mother with mental health and alcohol problems who was helped to manage her drinking through her pregnancy. Without the Health Inequalities workers project we wouldn't have found her until it was too late, and her child, who was born healthy, would have otherwise faced a much bleaker future." The programme has been considered a success – and funding has recently been confirmed until 2013.

## Housing-led hospital discharge teams in Newcastle



Newcastle established a multi-disciplinary team to address issues around hospital discharge and homelessness in the city. The need for an improved and integrated service was clear; preventing homelessness was a priority for

the local authority and improving independence, quality of life and health and wellbeing for vulnerable groups was high on the NHS agenda. Timely support and suitable housing maximises the chances of an individual recovering independence and quality of life post discharge, whereas homelessness or inappropriate housing can increase dependency, poor ill-health, continued service use and hospital readmission.

Newcastle Strategic Housing Service, Adult and Culture Services, Newcastle Hospitals NHS Foundation Trust and Your Homes Newcastle agreed a protocol for integrated working and commissioning housing-based services that prevents homelessness and ensures appropriate housing when they leave any of the hospitals in the city. The protocol signs all agencies up to a set of working principles about the way peoples housing needs are managed across services. For example, they agree to:

- \* make sure that patients' housing status and needs are assessed well in advance of discharge, and are communicated to housing colleagues within set timeframes to help them find the right accommodation and support;

- \* work together to share data in a timely and appropriate way through a Service Level Agreement;
- \* identify those at risk of homelessness during discharge, and work to secure appropriate accommodation for them as quickly as possible.

The multi-disciplinary team is made up of a Homelessness Prevention Officer specialising in hospital discharge, and an Advice and Support Worker who helps people with a move into independent and settled housing. The team is supported by a community psychiatric nurse who helps bridge the divide between health and social care. Ash Des-Forges, Advice and Support Worker for Your Homes Newcastle says, "Without access to NHS data, we would be hindered in our ability to assess an individual's true needs and prioritise their application appropriately."

The programme is a clear success; it has reduced the average wait for priority need cases from making an application to moving into appropriate accommodation from 179 days to 29 days. Although the programme is yet to be subjected to robust cost modelling, it is clear that reduced hospital stays and readmissions, along with increased sustainable tenancies and appropriate housing of vulnerable people, has realised substantial savings and improved outcomes across the system. Your Homes Newcastle is now looking to build on the success of the cross-agency, multi-disciplinary working and has developed an approach with drug and alcohol agencies.

“The programme is a clear success”



## Using JSNA to change the relationship between housing and health in Bristol

Housing officers in Bristol City Council used their local JSNA to build stronger partnerships with other public services. "We were determined to show what a difference our

work made to health and wellbeing and what more we could do" says Nick Hooper, Service Director for Strategic Housing at Bristol City Council.

Bristol started with the data and intelligence gathered by the Housing Health and Safety Rating System (HHSRS) of which it was an early pioneer. Public health and housing then used HHSRH statistics, together with local NHS health profiles, the house condition survey and other local authority statistics, to predict where the worst housing conditions were to be found, and how they were impacting on health. Involving housing in the JSNA has helped to highlight the significant impact of below standard housing on the health and wellbeing of some of Bristol's most vulnerable populations.

The JSNA helped develop a shared agenda between 'big picture' housing issues and the strategic agenda for health. It provided the impetus for housing, public health and social care colleagues to see suitable, decent housing as a viable investment to improve outcomes such as independence, health outcomes and quality of life. This led to a partnership between the Private Rented Sector team and public health to run a programme of Home Action Zones (HAZs) which targeted the ten most deprived areas of the city where they believed the most significant impact could be achieved. The service offers a

range of home improvement and adaptations informed by the JSNA's analysis of evidence of effectiveness. This includes subsidised energy efficiency improvements, subsidised loans for home improvements, free home fire safety checks, and small adaptations and equipment such as bath boards, grab rails, WC pan risers and grabbers/pickers funded by disabled facilities grants. Bristol also offers support and advice to landlords managing housing for vulnerable people.

Overall, the programme is considered a success. Bristol City Council has used the Chartered Institute of Environmental Health's HHSRS Cost Calculator to demonstrate likely cost effectiveness. For example, the excess cold aspect of the initiative alone implies resultant annual savings to the NHS of £7.4 million. A satisfaction survey of Bristol residents also found that very high numbers of people who had received a home adaptation or improvement felt healthier, happier, and more comfortable.

"The last three years have completely changed the way we work with colleagues in health and care" says Nick Hooper. "Public health now recognise housing is key to strategic needs assessment and priority setting, and support us operationally in managing the home action zones." Bristol housing team concede that the future of housing services, such as the HAZs, are far from secure, but are confident that the relationships they have built through the JSNA will stand them in good stead in the years to come. "When the health and wellbeing board gets down to business, we are better prepared than ever to make an evidenced-based case for housing as an essential partner in driving cost-effective improvements in health and wellbeing across our community."

*66 The last three years have completely changed the way we work with colleagues in health and care 99*



## *Using cost neutral approaches to becoming an indispensable strategic partner in Doncaster*

Doncaster's local authority housing department believe housing is uniquely placed to develop cost neutral or low cost

opportunities to improve health and wellbeing across partners. Gary Wells, Assistant Director of Housing at Doncaster Metropolitan Borough Council (DMBC), said that "We realised that we could either fight over the bare cupboard of funding, or reposition ourselves as local facilitators and leaders, helping our partners use housing as a way to work together to design better services that deliver shared priorities and better health outcomes."

An early example of the approach was the Harmony House project, a partnership between housing, DMBC Children's services and North Ridge Community School. Harmony House is an 'off site' educational and social resource that allows children with disabilities to experience independent living in a safe environment. Housing identified the site, the Department for Education funds were used for the building refurbishment and North Ridge manage the project for schools, students and local community groups. "We get two large empty properties back in use and regeneration of a formerly empty site and our partners get better services for a vulnerable group. We all deliver at no extra cost by redirecting existing resources into a single, eventually self-funding project that achieves multiple objectives - so we all win", says Gary. The head teacher of North Ridge Community School says, "We have always promoted the need for a facility that provides young people with disabilities the opportunity to experience independence.

Harmony House is an exciting development and shows what can be done if people get their heads together - I am very proud to have played a part."

### **Developing an evidence base to gain influence**

Doncaster's Housing in an Ageing Population (HAP) Strategy has given the evidence base to pursue this vision much more broadly across the system. The HAP Strategy was developed in partnership with Adult Social Services, NHS Doncaster, Doncaster Metropolitan Borough Council Planning, Doncaster Age UK, Doncaster CVS, Doncaster 50+ group and DMBC neighbourhood teams. Councillor Ray Mullis, Cabinet Member for Housing said, "In the absence of housing market renewal capital funds, we had to work closely with partners to devise a new cost effective solution to deliver on our housing, wellbeing and regeneration priorities. We realised we had to make better use of the levers at our disposal, and the strategy has been a powerful point of departure in making these relationships happen."

A suite of initiatives aimed at housing markets and housing development has followed. This includes a set of exemplar accommodation standards for extra care and sheltered new build / refurbishment, which has now been extended to cover all developments for older people. Doncaster works with Registered Providers and developers to apply the Standard and help them develop the right tenure mix to ensure the schemes are sustainable in a climate of little or no funding.

The standards have also been more widely applied via a Supplementary Planning Document, jointly developed with planning colleagues. Ruth Winter, Project Manager for Doncaster's HAP

Programme says that, 'planning policy decisions are an enormous opportunity to shape your community, provided you can approach your colleagues with a clear, evidence-based agenda.'

Work is also ongoing with local estate agents to develop a 'Lifetime Assessed' scheme. It better identifies existing accommodation for sale and rent in the private sector that is suitable for an older generation with reference to key elements of the Standards.

### Local investment plans

Doncaster's housing team are thinking longer term about the role housing plays in overall strategic priority setting and decision making, in particular, getting involved in the Local Investment Plan (LIP). The LIP sets out how different plans and strategies such as children and young people, health and social care, and crime and neighbourhood priorities fit together with housing, planning and economic regeneration priorities. It does this through a process of data sharing and analysis to establish a robust, joint evidence base.

"Our latest LIP outlines how and where investment will be made according to Doncaster's priorities over the medium to long term" says Gary. "It identifies the shared vision, objectives and priorities for Doncaster; including the required resources and how partners will need to work together. We sought to embed health and housing outcomes into the heart of this process."

At the heart of housing's offer for the LIP is the success of the Neighbourhood Hit Squad project, which targets areas of Doncaster that have been identified as being the least sustainable using data such as the Sustainable Community Index, housing complaints database and prevalence of problem empty properties. Within each area, the initiative is tailored to react to local priority issues such as crime and anti-social behaviour, public health, and environmental nuisance, and to deliver a 'joined-up' service with partners. This approach maximises the value of housing and other investments into an area to avoid further decline and improve outcomes.

The Hit Squad initiative is being rolled out to other hotspot areas as part of the implementation of the 2011/14 Local Investment Plan priorities following positive evaluation by the Homes and Communities Agency, featuring as a case study in their best practice toolkit. The approach is also cited as national best practice by the Department of Communities and Local Government.

Gary Wells says, "Provided you have clear evidence about your role, local needs and your potential contribution, housing can be one of the key players at the table." Gary's advice is to build credibility through smaller initiatives that demonstrate value and help partners see the benefits and cost savings you can provide. He goes on to say, "I'm really looking forward to taking forward our ideas and ensuring that best practice around housing's offer to health is widely available."

66 *I'm really looking forward to taking forward our ideas and ensuring that best practice around housing's offer to health is widely available* 99

# Further information and resources

*As well as the briefings and publications available on the Northern Housing Consortium website, the Department of Health website is a good source of information for updates on policy and it will be worth keeping an eye there for further detail on the structures and assurance frameworks as and when they emerge.*

## Joint Strategic Needs Assessments

JSNAs have become the cornerstone of strategic planning and commissioning for health and wellbeing. JSNA: a springboard to action is a practical guide for emerging health and wellbeing boards to help them lead a new generation of JSNA. It helps all involved in the JSNA process ask the right questions, understand good practice and decide what is needed from the process. It offers a step-by-step guide in easy to understand language and takes readers through the JSNA process from agreeing the scope and mandate to evaluation and governance.



### JSNA: a springboard to action

[www.idea.gov.uk/idk/core/page.do?pagelid=26995274](http://www.idea.gov.uk/idk/core/page.do?pagelid=26995274)

The JSNA data inventory was developed by Paul Brotherton and John Battersby of the East Region Public Health Observatory to complement JSNA: a springboard to action. It is a useful reference that sets out the data and intelligence sources commonly used in need assessment and might help you identify what you can contribute to the JSNA and JHWS process.



### JSNA: Data inventory

[www.idea.gov.uk/idk/aio/29219234](http://www.idea.gov.uk/idk/aio/29219234)

## Commission on Funding of Care and Support

The Commission on Funding of Care and Support – more commonly known as the Dilnot Commission – was launched in July 2010 and was tasked by Government with reviewing the funding system for care and support in England. The Commission was an independent body chaired by Andrew Dilnot, with Lord Norman Warner and Dame Jo Williams as fellow commissioners. The analysis, advice and recommendations of the commission were published in July and are currently being reviewed by Government.



### Dilnot Commission

[www.dilnotcommission.dh.gov.uk](http://www.dilnotcommission.dh.gov.uk)

## Marmot Review of Health Inequalities in England post-2010

The Marmot Review explores how persisting inequalities across key domains – such as housing – are inextricably linked to persistent and widening health inequalities in England. The Marmot Review is clear disadvantage accumulates over a lifetime and is beyond the remit of any one agency. The Marmot team produce updates and new data sets and case studies that will provide a rich source of information that will help build your engagement strategy.



### Marmot: A strategic review of health inequalities in England post-2010

[www.marmotreview.org/](http://www.marmotreview.org/)

## Spatial planning and regeneration

The contribution of planning and development professionals to the health and wellbeing agenda is enormous. Decision-making on licensing, leisure services, transport, employment, economic development, housing, and green space are central to the wellbeing agenda. This publication by Hyde Housing and the Town and Country Planning Association was commissioned by the DH JSNA Development Programme as a practical guide to JSNA for planners and policy-makers in spatial planning, regeneration, housing, and development management.



### Spatial planning and JSNA

[http://www.hyde-housing.co.uk/client\\_files](http://www.hyde-housing.co.uk/client_files)



# Jargon Buster

*This section includes some of the terms commonly used in this tool. It is intended to complement explanation in the text and is not definitive, exhaustive or academic in its approach.*

## Commissioning

In health, commissioning is the process of ensuring that services are provided or arranged to effectively meet the needs of the population. Commissioning is a complex process that goes beyond procurement and contract management. Responsibilities range from assessing population needs, prioritising outcomes, procuring products and services, and managing service providers and evaluation.

## Enhanced Joint Strategic Needs Assessment (JSNA)

The phrase was first used in HM Governments 'Liberating the NHS: Legislative Framework and Next Steps' (Cmd 7993) which said: "In the reformed system, the process and product of the joint strategic needs assessment takes on much greater importance." (5.19). The phrase is used to distinguish the next generation of JSNA from those developed since 2007-2010.

## Health Inequalities

Differences in the health (and increasingly wellbeing) experienced by different groups in a community which are avoidable and therefore held to be unacceptable.

## Joint Health and Wellbeing Strategy

The health and wellbeing board must prepare a JHWS to meet the needs in the JSNA. The strategy must be published by the local authority although decisions about the length, style, content and detail is left to each local area to decide.

## Outcomes focused approach

An approach based on focusing on the results of investing in a service or providing it in a certain way rather than outputs. Commissioners can be clearer about the real benefits they are seeking by defining the outcomes being sought. (See also "Health inequalities")

## Personalisation

A principle that individuals should be recognised as experts in their own needs, and that care planning processes must orientate themselves around individual to the maximum extent possible, rather than the other way around. The Government has launched several major policy initiatives to promote personalised approaches, including Individual Budgets in social care, and Personal Health Budgets pilots in the NHS

## Wellbeing

The World Health Organisation defines wellbeing as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."



## **Closing Remarks**

For too long the housing sector has struggled to get the recognition it deserves as a wider determinant of health and a key partner in delivering quality and cost effective solutions that address poverty and multiple deprivation – the root cause of persistent health inequalities.

Housing organisations are not only landlords but commissioners, service providers, community leaders and innovators. We act as a hub sitting in the heart of the community, we are trusted by many, and are connected to some of the poorest and most vulnerable in the community, often those people typically categorised as 'hard to reach'. The case studies in this tool demonstrate how well placed housing organisations are to shape healthy and resilient places, promote independence and opportunity and help prevent ill health.

Through Health and Wellbeing Boards and Joint Strategic Needs Assessments we have a better opportunity than ever before to work in true partnership delivering better quality outcomes and cost savings. Change can be daunting, but if we pause there is a danger that opportunities will be missed. As a sector we must demonstrate a strong and compelling offer, and we must do so quickly and confidently.

I am delighted to launch this tool which sets out the very practical steps you can take to help build your offer and build stronger collaborative relationships with local leaders – putting housing at the heart of the health and wellbeing agenda.

I'd like to thank all the organisations that contributed to the development of this tool, I wish you all every success and look forward to working with you to promote your successes.

**Jo Boaden,**  
Chief Executive,  
Northern Housing Consortium

## About the Northern Housing Consortium

The Northern Housing Consortium is a non-profit making and non political membership organisation. Our full membership is drawn from local authorities, registered providers, ALMOs, and other organisations involved in housing, from across the three Northern regions of the North East, North West and Yorkshire & Humberside.

The Northern Housing Consortium's primary role is to support and represent our members, who, between them, are responsible for 86% of social housing in the North. We do this through the provision of a range of products and services aimed at ensuring that the interests of the North are fully consulted, represented and served at sub-regional, regional and national level.

Our position of independence; relationships with local and national government; support from our member organisations, and over 30 years of expertise & influence, has enabled the Northern Housing Consortium to develop unrivalled respect and credibility within the housing sector, and we thus believe we can legitimately claim our role as 'the Voice of the North'.



## About Gentoo Group

Gentoo Group aim to make a positive mark on the future by investing in people, the planet and in property. Consisting of a number of divisions who work collectively as one business, Gentoo ensures maximum efficiency and value and enables customers to achieve more; by do everything that they can to develop and deliver of a wide range of initiatives, aimed at inspiring and adding value to the lives of its customers.

From improving skills, enhancing employment prospects, promoting enterprise and encouraging good citizenship, the Group endeavors to positively improve their lives and inspire the communities in which it works.





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