Under one roof? Housing and public health in England

What is the case for housing as a keystone of local public health strategies across England in the next two years? What is the state of play in linking the two sectors, and how can we strengthen such partnerships to improve health and wellbeing across our homes and communities?

With an increasing focus on integration, this viewpoint set outs to develop a rapid initial assessment of these questions and highlights key issues to stimulate further debate.

Written for the Housing Learning and Improvement Network by
Ed Harding, Partner, HKC Health

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1. Introduction

What is the case for housing as a keystone of local public health strategies across England in 2014 and beyond? What is the state of play in linking the two sectors, and how can we strengthen such partnerships to improve health and wellbeing?

These questions have been asked many times before over the last two decades, but arguably warrant a renewed focus in light of service pressures, efficiency drives, and the major and ongoing changes to the NHS and public health in England. For example, poor strategic linkages between housing and health were directly referenced in the recent and high profile acute care crisis of early 2013, where delayed hospital discharge acted as a bottleneck across the whole system, driven largely by a shortage of suitable specialist accommodation.

This viewpoint sets out to develop a rapid initial assessment of these questions, and highlights key issues from the Housing Learning and Improvement Network (LIN) to stimulate further debate. Development was primarily via desk research and a series of 14 telephone interviews with leading commentators from both public health, environmental health and housing sectors, including Directors of Public Health, representatives of Public Health England, social housing providers and care providers, academics and other opinion leaders and innovators working at the housing / health interface.

2. Summary of key issues

Few readers will be surprised that the first question of the case for partnership invoked a heartfelt belief in the enormous potential for housing-based approaches to improve health and wellbeing, particularly from those in the housing community but also within public health. Almost all colleagues we contacted in the preparation of this viewpoint were of the view that the research and evidence base was sufficient to justify close collaboration, and felt strongly that gaps in evidence should be treated as 'work in progress', not an excuse for inaction.

Beyond this, however, consensus proved elusive, with attempts to summarise the current state of play between (and within) each of housing and public heath often running into heated debate. As logically follows, it was also difficult to distil a clear picture of the drivers behind successful partnerships (or lack of them). The major factor behind this dichotomy was the apparently enormous variation in individual experience of working relationships at the local level. For example, the value of partnership was reported to be patently obvious amongst pace-setting localities where public health, local authority housing teams and housing providers are reported to enjoy a rich back history of successful collaboration, mutual appreciation and strong lines of communication. Conversely, a larger group of colleagues in housing and public health felt that progress in bringing the two sectors together was underwhelming in their experience, that barriers to progress needed to be better identified and overcome, and that the changes introduced in 2013-14 (explained in section 3) are a timely moment for renewed energy, focus and determination in building such partnerships.

To be candid, it became clear that this viewpoint would not be able to provide a narrative that reconciled these different views. Nor was it possible within the scope of the work to accurately assess whether this balance of opinion was representative of the wider national picture, and this poses an interesting research challenge for 2014, as does further segmentation of the state of play and distillation of successful models to support joint working.

Nevertheless, a number of useful issues surfaced in discussions and are summarised here. As such, readers are advised this viewpoint will likely cater better for those at an earlier stage of relationship building where a rehearsal of the case for partnership, identification of barriers to

progress, and mutual demystification may be a helpful contribution to starting new discussions. It is recognised that in those areas where partnerships are well established and work to the satisfaction of both housing and public health such commentary may not be as helpful, and indeed may smack of a misdiagnosis of the key issues necessary for consolidating success and moving matters forward. In any case, it is assumed readers will judge the state of play in their own locality, organisation or areas of business, and thoughts and comments on the issue will be much appreciated in the attached discussion forum.

3. The case for partnership

A renewed policy imperative

However difficult such questions might be, now is certainly a timely moment to ask them. As all will be aware, the 2013 Health and Social Care Act has moved public health out of the NHS and into local authorities, established new duties upon NHS and local government to lead integration, enhance local joint strategic planning and tackle health inequalities, and sparked a comprehensive restructure of the NHS which seems far from settled. Alongside this, the NHS and local government face considerable ongoing challenges in their strategic preparedness for demographic ageing, efficiency, failure scandals, poor lifestyle behaviours, growing chronic disease and changing models of prevention and care – i.e. a 21st century 'perfect storm' for health, care and wellbeing.

As a major a case in point, the recent high profile A&E crisis in early 2013 established a clear picture of an acute-dominated health system still out of touch with the housing drivers behind service usage; with hospital spare capacity now cut back to the bare minimum, the lack of appropriate accommodation into which older patients could be safely discharged from hospital was identified by Parliamentary Committee as a major bottleneck behind bed shortages.[1]

Against this backdrop, the government has issued a call to arms for the NHS and local government to innovate, integrate and prevent our way out of a crisis. Public Health England's Chief Executive Duncan Selbie recently called for a comprehensive rethink of health and wellbeing in a system where we will increasingly live with ill health rather than die from it, stating, "*we think that healthcare is how we will get improvement, but whilst it matters, and it does, it remains marginal to length of life and life lived without disability…. we need to get much, much earlier and work with people before things get difficult.*'[2]

This and other key policy statements represent a clear challenge to public health teams to operate in a strategic capacity and leverage their new position within local authorities to build new community alliances for health and wellbeing. The policy language is still perhaps slow to name check housing-based approaches as a profitable option, but it is reasonable to argue the overall mood music has significantly changed and now is as opportune a moment as any to lead new conversations or push existing partnerships further.

The high cost of poor housing to health

The evidence base linking housing and health remains the subject of ongoing debate, reflecting the different expectations and cultures between sectors as to how evidence is best distilled from observation, whether the right questions are being asked, and how findings can ultimately be used. Nonetheless, few could doubt that the causal links between the housing condition and health are now well established. To quote the Chartered Institute of Housing, '*the exact relationship between poor housing and health is complex and difficult to assess*'[3] yet an increasing number of authoritative reports over the last few years have set out to do exactly this. WHO reports, and the 2010 Marmot Review of Health Inequalities in England, have also

lent greater scientific credibility to the psychological, social and environmental determinants of health than perhaps ever before.[4-6]

Readers are encouraged to view these for themselves, however, the headlines are a useful reminder of a growing and compelling evidence base; that housing's role as one of the major determinants of health is widely accepted, and that poor housing is linked to a variety of conditions such as respiratory diseases; rheumatoid arthritis; depression and anxiety; nausea and diarrhoea; infections; allergic symptoms; hypothermia; and physical injury from accidents.

In England, established estimates of the direct costs of poor housing to the NHS are based mostly on physical aspects of housing and stand at £0.6bn per year,[7] but other estimates run as high as £2.4bn.[8] Higher end figures would seem perfectly credible, given, say, that cold housing is a major factor behind the UK's 25,000 or so excess winter deaths each year,[9] and falls amongst older people alone cost the NHS £2bn per year,[10;11] and have a proven linkage with housing.[11] If such linkages are powerful today they will be even more so tomorrow; commentators have warned that the UK's ageing housing stock is poorly suited for an increasingly geriatric population where 2.9 million people are expected to be living with 3 or more long term conditions by 2018.[12;13]

Housing as strategic partners for healthier communities

Such figures cannot express the complex but fundamental relationship between housing, health and wellbeing across the entire population, and the value this would place on much broader strategic alliances between housing and public health teams.

Beyond the immediate home, housing developments and estate improvements are a major opportunity to get the built environment right, for example designing age-friendly streets, facilities and neighbourhoods, or making sure that estate design capitalises on evidence linking green space and trees with stress, blood pressure, cardiovascular disease, heat management, air quality and anti-social behaviour.

Local authority housing teams and housing providers promise to be highly relevant strategic partners in the context of the much heralded 21st Century 'chronic disease epidemic',[14;15] and in particular diabetes, cardiovascular disease, stroke and their costly co-morbidities. Chronic diseases typically account for 70-80% of health spend, yet the vast burden of disability and premature death is avoidable and driven by the 'big four' negative behaviours of poor diet, insufficient exercise, smoking and alcohol abuse.[15] Globally, a public health consensus is emerging that 'corrective' efforts to tackle these behaviours will fail unless we tackle their underlying social and environmental causes, of which housing conditions are often cited as a major factor.[5;16;17] The social and age gradient of health and indeed chronic disease is well-established, and this should continue to make social housing providers an attractive partner in helping to meet and anticipate the needs of vulnerable and high needs groups.

Similarly, wellbeing approaches promise to significantly enrich talking points between public health, health and housing. Such approaches aim to promote health and wellbeing in contract to 'reactive' medical treatment and care of ill-health or disability, and are based on the evidence that mental and physical health are inseparable. Wellbeing approaches maintain that investment in individual quality of life, independence and resilience are a simultaneous investment in prevention, self-management, health outcomes and reduced service usage.[18] Some of the supporting evidence is remarkable. For example, one meta-review of 148 international studies proved loneliness to be comparable with smoking as a risk factor for mortality, and even to exceed obesity and physical inactivity.[19]

4. State of play: very varied

As noted in the introduction, this viewpoint was unable to find an early consensus as to how consistently public health teams, local authority housing teams and housing providers work in close strategic collaboration. More representative research across England is needed.

Anecdotally at least, regional groupings of well-developed partnerships and excellent working norms were reported around the country. However, contrary to this, stark and enduring frustration was also evident amongst some colleagues, not least amongst housing providers, who felt that their broader potential offer is undervalued by 'health' more often than not. Some, but not all, public health colleagues acknowledged a historical deficit in the attention and energy devoted to housing in years past, but it is important to note that all expressed enthusiasm for further collaboration and partnership with housing, albeit from different points along a journey.

However, other sources provide a useful indication of progress made, and overall many indicate that strategic collaboration remains a cause for concern across England. For example, dementia is a good example of a condition posing major structural challenges to health and care services and their readiness to work closely with the housing sector. Prevalence is expected to increase by about 22% over 2007-2020 (or more than 130,000 people)[20] yet a National Housing Federation report has stated that there is an undersupply of specialist housing, care and support options so crucial to managing the condition.[21]

Changes to the benefit system warrant a specific mention. With increased pressures on the poorest and most vulnerable populations to move home, strategic planners in housing and public health should ideally be considering the impact of significant social and economic disruption on those populations already suffering a highly disproportionate burden of ill-health, financial exclusion and disability.[22] Yet it was unclear from our interviews what best practice models exist in this area, nor how commonplace such linkages might be. Commentators such as the Northern Housing Consortium have already challenged local public health teams to adopt a more urgent focus on the issue.[23]

As for housing-based wellbeing approaches, again it was unclear in developing this viewpoint how commonplace and established such approaches might be. Many excellent local case studies exist. However, a key NHS Confederation position statement from 2011 maintains that the adoption of wellbeing approaches by the NHS is far from widespread, and indeed many cultural and other barriers will need to be overcome if this is to be reversed.[18] By extension, this and other anecdotal evidence would suggest that many areas will face a learning curve where public health, local authorities, the NHS and housing providers wish to work together to pioneer such approaches.

It also seems reasonable that the fortunes of public health and housing partnerships would be tied to those of local health and wellbeing boards, where the main statutory levers lie in terms of duties to lead integration, preparation of JSNA and agreement of joint health and wellbeing strategies. Boards would also seem the most likely vehicle to realise the elusive goal of redirecting NHS acute spend into wellbeing, preventive and community-based approaches. A 2011 national survey of Directors of Public Health revealed that most reported local authority housing teams were well engaged in JSNA processes, but that housing providers were largely absent.[24] More crucially, a recent Kings Fund report stated that there is still too little evidence of health and wellbeing boards grappling with the immediate and urgent strategic challenges facing their local health and care systems, and highlighted the looming danger of irrelevance if they do not.[25] This is perhaps one of the most tangible threats to public health and housing partnerships, and all the more so as neither side may be able to do much about it.

Clearly, there can only be concerns as to the consistency with which the NHS and public health have engaged with strategic housing market enablement functions, understood the potential for housing-based wellbeing approaches as a key area for investment and set out to embrace housing and care providers in close collaboration and partnership. Progress is eminently possible however in any localities that find themselves lagging behind, and ideally such concerns should prove a useful focus for action and meaningful change.

5. Barriers to progress, and how we overcome them

There are complex reasons for inconsistent progress, however some key themes emerged. Fundamentally, the state of partnerships reflect a broader and well-established consensus that progress is still too slow in recalibrating the health system away from the traditional, reactive 'medical model'. Those who remember the 2002 Wanless Review will doubtless reflect this can only be an evolutionary process demanding accumulative pressure over the long term, for example via professional (re)training, structural reinvestment, realignment of incentives and wholesale cultural change. However, in the short to medium term, national policy could certainly be more proactive in articulating the role of housing in public health business and as a focus for local strategic planning between the NHS and local government. It is noticeable that despite the PHE's work on the wider built environment, the words 'housing' and 'home' barely appear in key documents in their current statement of priorities 2013-14, or the National Institute of Clinical Excellence's 2013 public health-orientated Summary of Actions to Prevent Premature Mortality. This is despite both documents emphasising the importance of child and early life wellbeing, dementia, mental health, troubled families, and many other areas regarded as classic housing territory by the sector.

Evidence and return on investment

The evidence base linking housing and health was mentioned by several as an issue worth careful discussion, where colleagues can work together to make the best use of available evidence and try to ensure different expectations do not hold back progress. For example, professionals from public health, social care and housing may have very different ideas of what constitutes an acceptable level of evidence of effectiveness to justify investment. Randomised Control Trials (the medical 'gold standard') are extremely difficult in housing for obvious ethical and logistical reasons, where the literature may be weighted more towards case studies, local research or qualitative feedback.

Like chronic disease models or integrated care more widely, progress to date may reflect the fact that releasing spend and achieving cashable savings are rarely a straightforward equation. Two major national programmes illustrate this point. On the one hand, the national evaluation of the Supporting People (SP) Programme showed excellent value in strategically planned housing-related services for vulnerable groups, estimating a £3.4bn benefit to the NHS against an overall investment of £1.61bn.[26] On the other hand, the national Partnerships for Older People Programme (POPPs) showed inconclusive returns in reducing emergency hospital admissions through a range of integrated and community-based prevention initiatives, much of which was built around housing care and support.[27] This is not to undermine the case for housing based approaches, which as mentioned earlier is credible and substantial. Rather, it is important to note up front that there are often complex reasons as to why such preventative or integrated models may not always provide the anticipated returns. Housing is by no means unusual in this regard, and does not warrant particularly cruel or unusual treatment from commissioners. For example, the art and science of navigating a mixed evidence base

should be highly visible as England's 130 or so Health and Wellbeing Boards up the ante on health and social care integration, a major new national priority. In such circumstances political courage and long term vision will be vital to releasing spend.

Defining 'housing', an enormous sector

A simple lack of mutual understanding was mentioned by several participants as a reason why health, housing and public health have not always found it easy to move partnerships forward. As any housing colleague will tell you, the sector is enormous and often difficult to define. 'Housing' is a term frequently used to summarise the entire housing stock, specialist accommodation, and the care, support and adaption services which are deemed to belong to the sector. Implicitly, it is often used to refer to representatives and officers from across the social rented sector, housing associations, home improvement agencies, local authority housing teams, and many others. Even within local authority housing the story can be complex, with 'housing' reportedly used to describe officers from a diverse range of teams such as strategy, planning, environmental enforcement, stock renewal and social care. Housing, care and strategic partnerships with the NHS are also split between County and District level authorities, adding extra complexity in some areas.

Definitions can get further complicated given the fact that care and support services often blur into the physical provision of housing. For example, it is entirely typical for larger housing providers to manage many tens of thousands of homes across the country, and within this thousands of supported housing units. In specialist accommodation, the overlap between housing and care may therefore be conceptual (e.g. adaptations, on-site support, wardens, telecare and other services are accepted as intrinsic components of accommodation for high needs groups such as older people, people with learning disabilities, frailty or dementia), financial (e.g. funding may originate from the individual, the NHS, social care, public health, other local authority budgets, or charities) and organisational (e.g. many housing providers will run a combination of housing, care, health promotion and support services, and as noted above, span mainstream and specialist accommodation.) Extra care housing is a classic example of this; care and specialist needs are literally hardwired into the design of accommodation, making it almost impossible to separate the two, and funding for places may also be through social care, self-funding, owner occupancy, or NHS Continuing Care.

Public health, meet housing…

Public health colleagues may find it helpful to reflect on the realities of working in local authority housing teams, where life is not necessarily easy. Many teams are reported to be short staffed and strained by immediate concerns like complaints and maintenance backlogs. Colleagues may also be struggling with outdated stock, despite the investments in recent years, and their traditional means of shaping homes and communities are likely to have suffered in the economic climate and the collapse of many public-private partnerships. Mechanisms such as Section 106[i] are now rarely used as developers' profit margins shrink, making it hard for the local authority to demand new community facilities or, say, specialist housing units as part of a wider development. Neither should public health teams be surprised if the strategic thread is hard to discern; housing teams may have been forced to chase grants across different programmes and priorities, leaving a patchwork of back projects over the years.

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[i] Section 106 agreements are a mechanism for local authorities to require 'developer contributions' as part of a development proposal. It is commonly used to provide for infrastructure or affordable housing, or financial contributions for community benefit, but there are many other examples and possibilities.
See: www.pas.gov.uk

Funding streams for housing-related care and other interventions may be a promising area to align investment, but public health teams should not expect to find much spare capacity. For example, Supporting People (SP) is a sizable national fund given to local authorities to provide care and support to help people live independently, much of which is awarded to housing, care and support providers. 'SP' is under serious pressures: the national budget has been reduced from £1.8 to £1.6bn in 2014-15, but more crucially the removal of ring fencing has led to reports of harsh local cuts as high as 60-70% as funds are diverted elsewhere.

The Government also hands out around £220m per year to local authorities in Disabled Facilities Grants (DFG),[28] but this does not go very far. It is now common for local authorities to have to top this up, and demand often outstrips resources, meaning waiting lists are lengthening, and implying that health and social care will pick up the bill for avoidable emergency and unplanned usage. Recent guidance for the Integration Transformation Fund suggests DFGs will in future be tied into health and social care spend. However, this brings considerable uncertainties with it and may impact on low level housing support services, for example Home Improvement Agencies.[28]

Housing, meet public health

Similarly, housing officers may wish to spend time understanding the role and circumstances of public health teams in 2013 and beyond. Teams will be at different stages in moving into local authorities. Whilst most Directors of Public Health (DPHs) were jointly appointed by PCTs and local authorities prior to April 2013, the embedding of public health teams in local authorities was variable. Capacity may have taken a hit in the last 12 months from staff turnover and lower headcounts. Despite this, most public health colleagues were positive and energised by their local authority home. One colleague joked that this was partly due to the fact that few envy those former colleagues left behind in the NHS.

Housing colleagues may find it helpful to seek further information from public health teams as to how a new housing approach might sit in the wider context of what public health does. After all, public health has its own traditional areas of spend and activity, the majority of which is typically made up of sexual health, drug and alcohol abuse services, smoking cessation, and other behavioural change programmes,[29] although this will vary enormously from one area to another. Like their NHS counterparts, DPHs will need to cater to the performance outcomes set to them year-on-year, for example in the Public Health Outcomes Framework, and will vary as to their tolerance for strategic projects that do not show 'on the dashboard'. Unsurprisingly perhaps, a recent analysis by the Local Government Chronicle reveals traditional themes still dominate public health spend and innovative uses of budgets such as falls prevention or debt counselling were shown to constitute only a small proportion of total expenditure.[30] This suggests that it may be a good idea for housing colleagues to start small. Non-traditional investments may also be emotive given widely reported fears of local authorities 'asset stripping' public health to shore up existing services, as claimed by John Ashton, President of the Faculty of Public Health.

In financial terms, it may neither be true that public health feels particularly rich. The recent public health settlement has seen an uplift for many areas, but much of the budget for 2013/14 is likely to already be committed, providing little room for manoeuvre and investment in the short-term.

Public health teams also have a new policy framework to respond to, and strengthened duties on both public health and the NHS to tackle health inequalities could be fertile ground for collaboration with housing. Public Health England has certainly made it clear that DPHs will

be expected to play a leading role at the local health and wellbeing board, supporting the integration of care, preventative and innovative alternatives to hospital-based care, care close to home, and place-based systems generally.[31] In reality though this remains easier to mandate nationally than deliver locally, and the degree to which the public health teams embrace the strategic facilitation of the local health economy as a core role remains to be seen.

6. Working together – some key angles to consider

So wide is the sphere of opportunity between public health and housing that it is impossible to do the issue much justice in this viewpoint. Doubtless, in areas where partnerships are well developed colleagues have plenty of their own plans for building on success.

Nonetheless, several key themes emerged from discussions and these are summarised here for those at an earlier stage of thinking, or for whom next steps are not clear. Overall, it is an obvious point that both housing and public health will wish to improve the lives of local people. The issue is perhaps how to capture this common ground into projects that speak to instincts, experience, existing areas of business, local politics and, not least, the different performance measures under which public health, the NHS and social care will be judged.

Housing condition and existing care and support services

As above, the direct case for investment in physical housing condition should still hold value, and tools like the Housing Health Cost Calculator[32] or data from the Housing Health and Safety Rating System will be helpful discussion starters if they are not already being used in this way.

Another no-brainer may be to look at the state of local aids and adaption services, where public health and housing can work to showcase the value of existing care and support. Housing teams may be under huge pressures as central funds prove insufficient for care and support services, or where ring fences have been removed, and the interest is likely to be welcome.

Making prevention and self-management models a reality in chronic disease

As mentioned earlier, chronic disease models offer a major opportunity for collaboration. NICE Guidance is explicit that effective behaviour change approaches to chronic disease prevention require keen local intelligence, close involvement of target populations, and partnership with existing community assets, skills and knowledge.[33] Housing agencies' potential role in leading or supporting such interventions would seem obvious if commissioners are focussed on the challenge of implementing such models in the mainstream. Certainly, 'health literacy' (i.e. the ability and knowledge of an individual to understand a health condition) is known to be a major factor in the success of prevention and self-management approaches, but varies enormously across socio-economic groups.[34] 'One size fits all' interventions will therefore be likely to fail disadvantaged populations, where the greatest burden of ill-health lies.[35]

The business case for wellbeing

Alternative investments will need robust business cases if they are to make the jump from sales pitch to budget allocation. Business cases will come in all shapes and sizes, but all potential providers will wish to consider which of the performance indicators they think they can hit across the 3 Outcomes Frameworks for the NHS, Public Health and Social Care, and build their offer accordingly.

There is no reason why housing providers cannot build cases that speak to existing commissioning streams and clients groups in public health and the NHS. In diabetes, for example, the evidence of effectiveness favours prevention and self-management models provided in the community setting, delivered through a combination of patient education, counselling, practical learning (for example, food preparation or group exercise) and a focus on individual quality of life.[36;37] The NHS in England is not doing hugely well on a range of measures, with early identification and patient education two notable areas of underperformance.[38] Housing providers might attract more regular business in behaviour change and patient education if, for example, they can articulate the improvements to service uptake, compliance and patient outcomes when such interventions are provided or supported through existing community networks - what some housing colleagues called a 'social model' - as opposed to the status quo. In addition, few providers will be able to match the options available to housing to align care models with other relevant support services, such as debt counselling or social activity groups.

Other multiple and high needs groups such as the homeless could get creative juices flowing between NHS, public health, social care and housing teams. As ever, understanding patterns of service use may help clarify the shared interests at stake: one study in London showed rough sleepers have been shown to be seven times more likely to use A&E and use up to ten times more outpatients appointments than the rest of the population,[39] yet effective measures to understand and address underlying causes will need support from all sides.

Strategic planning

A broader relationship could take potential partners away from year-on-year contracting and into a separate debate about mutual support and longer-term collaboration. Most housing, environmental health and public health colleagues will already have considered the potential role of the health and wellbeing board in supporting new partnerships. Ideally, board members can lead commissioners away from the status quo by identifying the overall picture of health and wellbeing through the JSNA and challenging the system as to what it wants to achieve in the joint health and wellbeing strategy. This should create a debate, and hopefully a market, for those who are best placed to provide optimal care, support and ultimately health outcomes. Boards may or may not have allocated seats to housing, but there is no doubting that DPH's can use their position to make sure the sector is well represented. However, as noted above, boards are at varying stages of development and a 'plan B' may be helpful if the local set up does not inspire confidence.

Nonetheless, there are plenty of options for collaboration. Local authority housing and environmental health teams are required to perform a Housing Stock Condition Survey, which could be of significant value to the JSNA and the joint health and wellbeing strategy. Anecdotal evidence and research suggests both processes do not consistently work together as effectively as they might.[40] Data gaps may also reflect housing's own need to broaden strategic collaboration. Local authorities usually collect data on housing condition, statutory homelessness and fuel poverty, but are reported to be less likely to link up with the private housing market, local NHS, schools, or agencies such as Citizen's Advice Bureaus, who could help with providing information on school absence, anti-social behaviour, debt, alcohol misuse, or other factors that could be used to develop more effective housing and health strategies. Assembling such data will be challenging, and it would make sense to do it in partnership with public health.

<u>A return offer of mutual help</u>

Forward planning may also be useful to both sides, and 'lending out' public health expertise in data collation, gap filling and analysis may prove an attractive return offer. Paul Watson, Managing Director of Guinness Care and Support and long time Housing LIN champion, commented that "*bids for supported or specialist housing cannot just be scratched together. They rely on the physical existing housing stock, access to development opportunities, and strategic information about other services. All of this has a considerable lead in time and the more advance notice we get, the better and more suitable the market will be in meeting health and care needs*". Evaluation may also be a promising area, believe many of those we spoke with. "*By and large housing has put its head down and got on with it. It is rare for the sector to collate data on the services it provides, or to have gone back and evaluated impact*", says Julie Nixon, Head of Housing at Stockton Borough Council. "*An offer from public health to be more scientific in this approach could be very attractive to housing teams*".

Public health and local authority housing should also consider the political incentives for partnering. As mentioned above, public health teams are still relatively new to local authorities and those less well established may be keen to broaden their networks and improve their standing within the organisation. This may also be something that social housing providers can help with, particularly if they represent a large amount of former local authority stock and still retain influence within local councils.

<u>New hooks in national policy and guidance</u>

New policy initiatives may be helpful catalysts for change. Public Health England recently confirmed a new national programme to support alliances across public health, housing and planning, 'Healthy People, Healthy Places', from November 2013, including the Housing LIN. Several participants noted the announcement of a £3.8bn national funding pot to local health and wellbeing boards, and there was considerable speculation as to whether or not housing providers might find themselves involved in new preventative or wellbeing approaches, and the degree to which public health could be an influential champion of housing's offer.

As ever, the National Institute for Clinical Excellence will remain a powerful agent in NHS and public health decision making, and colleagues would be well advised to keep an eye on the new range of NICE guidelines for the NHS, public health and local government. In the meanwhile there are plenty of opportunities within existing guidelines for the entrepreneurial housing provider, for example the NICE public health guideline (PH6) 'Behaviour change: the principles for effective interventions'.[38]

7. Final thoughts

Although colleagues often had quite different views on the state of play and productive next steps, all were determined that housing and public health enjoy close collaboration in years to come. A few key considerations were highlighted as being helpful for those starting new discussions.

If public health and housing do not have a back history of close collaboration then it is an obvious point that neither sides may know much about the other. If so, both sides should be ready to explain what it is that they do from scratch, and how they fit into the bigger picture. Different sectors may also present with their own culture, terminologies and mind sets, meaning colleagues need to be ready to listen and spend time finding common ground.

The language barrier was one such issue, where care should be taken to avoid jargon wherever possible and explain terms clearly. A good example is SAP, which can mean either the 'Single Assessment Process', a form of integrated patient or service user assessment, or the 'Standard Assessment Procedure', an energy rating protocol. Another example is HIAs, which could mean Health Impact Assessment or Housing Improvement Agency.

Realistic expectations will be needed around funding. Neither health nor housing may have much resource to spare, meaning projects will often need to start small and may take time to progress from first discussions to funding. As mentioned above, both sides have existing commitments that take up the great majority of budgets, disinvestment remains highly problematic, and anyone holding partnership hostage to the large injection of funds is likely to be disappointed. In the short term, proposing 'cost neutral' initiatives or new ways of working within existing funding may be necessary to get the ball rolling.

Ultimately there are few short cuts. It is uncertain why some areas report positive, long term partnerships whereas others do not, yet trust and mutual recognition are undoubtedly crucial pre-requisites for successful collaboration, and neither public health nor housing should be ashamed to actively seek out charismatic and senior personalities with which to join forces.

Note

The views expressed in this paper are those of the author and not necessarily those of the Housing Learning and Improvement Network or the named contributors, except where specifically attributed.

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About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing Learning and Improvement Network (LIN) is the leading 'learning lab' for a growing network of housing, health and social care professionals in England involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions, including dementia.

For further information on this and about the Housing LIN's comprehensive list of online resources on health and housing, visit our "healthwatch" pages at:
www.housinglin.org.uk/Topics/browse/HealthandHousing

To participate in our learning and service improvement activities, including 'look and learn' site visits and network meetings across housing, health and social care in your region, login to:
www.housinglin.org.uk

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