Breaking Barriers Innovation Health and Social Care Programme 2018:

HOMES report

On behalf of:

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As Chief Executive of the Royal Society for Public Health I particularly welcome the publication of this report, as it places housing and the environment as a key determinant of health and wellbeing and how prevention must be at the forefront of health and social care. It is a timely and very relevant report as we see increasing concerns about the housing crisis across the country and we await the publication of the NHS ten-year plan that will set out the priorities for health care over the coming decade.

It is of course imperative, as this report shows that we need to consider housing and health as a joint concern, not just from the perspective of the supply of affordable homes, as important as that is, but in terms of the quality and condition of existing housing stock and the impact this has on health. Because a home is so much more than a roof over our heads, it is where individuals and families ought to be able to grow, thrive, and feel safe. But sadly, for far too many people the state of housing and the environments in which people live do not adequately support physical and mental health.
The report demonstrates this very strongly through the local context of the Digmoor estate in Skelmersdale, West Lancashire and I commend the West Lancashire Clinical Commissioning Group for making this the focus of their work with Breaking Barriers Innovations. But there are many Digmoors and we all need to pay much closer attention to the voices of local people as they strive to deal with the impact of poor housing and badly designed estates.

The report also highlights how no single agency or sector can resolve the issues and that there must be a concerted effort to collaborate and establish a coherent and comprehensive integrated approach to housing and health. The BBI HOMES Playbook provides a very practical means by which NHS and local authority leaders, working in partnership with local communities and the full range of providers for health, care and housing, can achieve that approach for their local area.

I especially welcome the focus on workforce development and how this must be undertaken on a cross professional basis recognising that those who work on the front lines in health and housing have a shared interest in ensuring that people can live independently, for as long as possible in their own homes.

The report provides an important message for us all about the impact housing and the environment has on health and wellbeing, and how by acting together we can make a real difference to improving people’s lives and ensuring the long-term sustainability of the health and care system.
1. Introduction

“Long term planning for the NHS in the form of the ten year plan will be welcomed, but it must include the need for action on housing and health as part of a strategic approach to health and social care integration at local levels.”
“If you were going to look at any area and how to address housing, health and community wellbeing and aspiration then this is the area.”

(Local stakeholder, speaking about the Digmoor estate in Skelmersdale, West Lancashire)

There is consensus across the political spectrum that the country is in the grip of a housing crisis and despite continuing investment; the NHS is struggling to meet the rising demand for acute and emergency services. Local authorities have also been seriously challenged by significant cuts in funding and have been under pressure to increase the number of affordable houses, sometimes at the risk of being less able to address problems with existing housing stock. If not for Brexit, housing and health would probably be the two issues that will determine the outcome of the next general election. But these are not issues that can be dealt with separately; they are two sides of the same coin. Housing and the environment is one of the main determinants of health and wellbeing and meeting rising health and social care needs is dependent on the provision of adequate and safe housing. That is the central message of this report. This is fundamentally a report about health and social care integration and how we can apply learning from thinking about this in the context of housing and health to the design and operation of integrated care systems. That is important, not only because of the urgent requirement for greater efficiency and effectiveness in health and social care provision, but because integrated systems are the only way that we can assure the sustainability of health and social care. What we learn about this from housing and health provides invaluable insights into this larger context and challenge. However, that was not so obvious at the beginning of the journey that led to this report.

Breaking Barriers Innovations (BBI) was established following publication by its Chairperson, Professor Lord Patel of Bradford OBE of two reports on integration in health and social care and the criminal justice system:

- Breaking Barriers: Building a sustainable future for health and social care (2015); and

Both these reports focused on some of the main barriers to health and social care integration; for strategy, in leadership management and workforce development, for establishing a collaborative basis for maximising use of shared public authority and community assets and in promoting innovation. Each report was presented at a national summit, attended by a wide range of stakeholders from across health, social care, the NHS, the criminal
justice sector, national and local government, academia and community, voluntary and independent sector providers.

After widespread interest in the reports and ideas generated by discussions at the summits, Breaking Barriers Innovations was set up in 2017 as an independent company in its own right. BBI continued conversations with stakeholders from a range of health, criminal justice and social care organisations as part its planned objectives to develop an ongoing programme of support for place based change and integration.

However, after meeting the Chief Executive of one northern Clinical Commissioning Group (CCG), it was something of a surprise to hear that the priority area for them, and one they would like to investigate further as part of a programme looking at integration of health and social care and place based change was, housing.

It was the Clinical Commissioning Group for West Lancashire, and they didn’t just want BBI to look at housing and the implications for health, they wanted to do it in one of the most deprived areas in the county, the Digmoor estate in Skelmersdale. But as the quote above says if you want to address these issues anywhere, it is in an area like Digmoor.

The reasons for that became quickly apparent at the outset of the programme. For example, housing and health are very clearly part of a wide range of national and local strategy and policy drivers:

- The tragedy of Grenfell Tower and how it has focused minds on the failure of successive governments to provide adequate, safe housing for communities and how local authorities should re think their role as social landlords.
- The Healthy New Towns programme and how housing, health and the environment are being brought together under a common set of design principles.
- The Garden Villages Prospectus and how the Ministry of Housing, Communities and Local Government is changing the way that developers and planners work to provide holistic, high quality solutions to the challenges of modern urban environments.
- Renewed focus on housing by central government as evidenced by the recent Green Paper and the prominence of housing in speeches at the Party Conferences. In particular, the problems caused by decades of lack of investment in house building and what an affordable home means in the current climate of low wages, the Gig economy and increasing use of short term and zero hours contracts.
- The continuing drive towards localism and how public authorities have to manage with less reliance on central grant funding and are needing to explore ways to invest in new community asset and public property vehicles.

For all health and social care organisations, commissioners and providers these are significant challenges. In the absence of system wide commissioning for housing and health there is a void in making plans for health and social care integration a reality. Or, in many cases, there are problems in just agreeing plans in the first place. Health and social care organisations are continually being pulled back from innovation to their traditional business priorities. This report identifies pragmatic ways that local leaders can
avoid this by co-designing and collaborating to deliver an integrated health and housing agenda for the communities they serve.

By working together with the CCG and partners from industry, BBI have developed the BBI HOMES Playbook (The Playbook). The idea of The Playbook is that it is a means of providing a common approach to a range of issues and problems without being overly prescriptive. As the authors of this report, we believe that this is something that needs to be piloted in local areas where there is a shared commitment to addressing the issues for housing and health.

The Playbook is a template that is designed to support and facilitate a learning and adaptation process by which public authorities for health, care and housing can work together, alongside their partners, to increase understanding about housing and health and develop confidence and competencies to address the issues as part of an integrated, whole service solution. In particular, The Playbook will help system leaders to define the process by which an integrated response to housing and health can be developed and worked through at local levels, with a high degree of sensitivity and relevance. It specifically draws on:

- the experience of working with NHS West Lancashire CCG and partners on the Digmoor estate as a case example; and
- insights and learning from a series of interviews with national stakeholders and review of the range of documentary evidence for addressing housing and health as an integrated issue.

The Playbook is a means for addressing both housing and health issues but it does not suggest that housing is always a health issue, or that health is always a housing issue. Rather, The Playbook seeks to define ways by which leaders, professionals, residents and local communities can work collaboratively to address problems that arise when housing and health are only thought about in their respective silos.

The Playbook is based on four building blocks for developing a local action plan:

- Strategic alignment.
- Resident and community engagement and co-design.
- Building professional skills, competence and the right culture.
- Service integration and innovation.

The Playbook is focused on housing and health, but it should be seen as part of a broader agenda for supporting local place based goals and integration of health and social care.

The purpose of this report is to present the findings and evidence that support the concept of The Playbook and to provide the rationale behind its development. Over the coming year BBI will be developing The Playbook through a series of pilots in local areas so that learning can be transferred and disseminated about how to make housing and health work as part of place based change and integration.
The idea that housing has a significant impact on health is not new. It can be traced back to the mid-1800s or even earlier. But it was in 1842 that Sir Edwin Chadwick published his study *Report on The Sanitary Condition of the Labouring Population of Great Britain*. Chadwick undertook this study following the Typhus epidemic in 1838 and he worked with a Manchester doctor, James Kay-Shuttleworth, the first doctor to be employed to consider the health impacts of the environment.

Chadwick and Kay-Shuttleworth’s work resulted in significant reforms to sanitation and public health in England. The report generated widespread public interest and led to the Government of the day setting up the first ever commission on the health of the country’s towns followed by the first ever Public Health Act in 1848.

Octavia Hill, often viewed as the mother of social housing, was working in London in the late 1800s when she started to build up her rented housing stock. She applied a simple homespun remedy to the problems of housing for the poor based on ideas of thrift and good housing management. Today, her legacy is over 4,000 houses that form part of the Octavia Housing Association, one of the first to have been established.

Nearly 200 years later we have come full circle. In the 20th century public health was removed from local authority control only to be returned in the 21st century. The large scale public health scares of the 19th century that were once seen as outside human influence, have largely been removed in the western world, only to be replaced by epidemics and diseases that are largely the result of lifestyle choices and human influences.

The national policy debate on housing has gone from one of the conditions of the labouring poor to one of the conditions of the poor that have no or very little labour.

And our concerns about social housing provision have gone from the aspiration of individual philanthropists who had the vision and commitment to create purpose built environments that sought to create and sustain wellbeing, to a housing crisis that shows no signs of abating and an increasing focus on the need to build healthy new towns and garden cities.

So it is tempting to think that little has changed since Chadwick and Kay-Shuttleworth first started to look at sanitation. But that temptation and the inevitable negativity it invites, should be resisted. That is because a significant shift is taking place, it is a shift in focus from the physical conditions of housing to the personal conditions of inhabitants.

It is a shift from concerns about the public health of populations to one that is about individuals and personal choice. But we can still learn something from the early pioneers of environmental health that will further support these shifts in focus, that is the fact that health and wellbeing is dependent on a complex interplay of factors that must include the social determinants of health, for example, housing, employment, education, and skills — basically the factors that enable people to thrive.

Most recently the social determinants of health were brought to prominence by the work of Sir Michael Marmot, whose work continues to be very influential within the domains of public health and social care. However, there is an ongoing struggle to make the social determinants of health and wellbeing a core part of the way in which we address health service provision. For example, we continue to commission health services for those that are already ill, rather than on the basis...
of prevention or even early intervention and we continue to face restrictive and rigid regulation of what funding streams can and can’t be integrated on the basis of a joined up approach to health care and wellbeing.

These issues are further compounded by the complexity of the current health and social care system, which over recent years has become more fractured and divided.

Regardless of the overarching complexity that the previous sections make plain, it is imperative that we have realistic and achievable models to support local system leaders as they attempt to address critical strategic issues.

Housing and health is one such area and while a great deal of the current political focus on housing is on supply, in particular the need to increase the availability of affordable homes, supply is only part of the picture. We need to put equal emphasis on housing and health and how to address both as part of an integrated, place based approach to improving the health and wellbeing of neighbourhoods, towns and cities.

This becomes very clear when considering the issues faced by an area like the Digmoor estate in Skelmersdale.
1.2 Methods

The review into health and housing on the Digmoor estate in West Lancashire consisted of desktop analysis of local reports, surveys and documentary evidence over several years. Focused interviews (12) took place with local stakeholders from the CCG, the local authority, the community and voluntary sector and health and social care providers.

Analysis from this initial stage was used to inform a series of further interviews (18) with national stakeholders involved with health and housing including government agencies; academia and research institutions; NHS England; Public Health England; the Local Government Association; and Homes England.

The interviews were conducted on a one to one basis either by telephone or face to face. Interview transcripts were subject to a thematic analysis that sought to identify common issues and themes.

All interviews were conducted on a confidential basis and no individuals are personally identified in the report. Quotations are used to highlight common issues that were identified by a number of respondents. If a quotation is used that only represented the view of one or two people this is indicated.

Further desktop analysis was undertaken on the literature base for interventions in health and housing and the national policy context and legislation.

The analysis and findings from all of the above was tested through meetings with the CCG and with partners from industry holding particular expertise and insights into health and housing. Case studies from industry partners are also included in the report that demonstrate some innovative approaches to service transformation.
2. Learning from the local context – the Digmoor estate, Skelmersdale
During one of the first meetings with West Lancashire CCG about the project, the BBI team were taken on a walkabout round the Digmoor estate, Skelmersdale. It was not an unknown area, Digmoor featured in one of the episodes of Grayson Perry’s three-part series exploring masculinity for Channel 4 in 2017. The Digmoor Tapestry that resulted was inspired by Perry’s exploration of gang culture in Lancashire, in particular the murder of one young boy who came from Digmoor, ‘little Kev’. The sections about Digmoor in Perry’s series received mixed reviews, residents of the area found it too negative and bleak and it failed to capture the positive nature of the community and the strength of local community spirit and activism.

Digmoor is situated amidst vibrant green fields and open spaces; it should be an attractive place to live. But, walking round the estate it is hard not to see some of the stark visual cues that suggest an undercurrent of social problems. Graffiti about little Kev still adorns the walls of bordered up houses, the Parade, a short underpass that houses the estate’s only shops appears tired and neglected, the walkways and underpasses can feel intimidating. High metal railings guard the local primary school and high above the Parade sits an industrial scale security camera. We are told this originally came from Northern Ireland during the Troubles. Opposite, across the nearby houses hangs a large banner advertising the local private lettings agency, which proudly boasts that it will buy any house.

There is a strong sense of a community that supports each other and the talents, energy and creativity of local people. At the heart of the estate and the venue for our meeting with the CCG, is the Evermoor Hub, the local community centre and a beacon of hope and inspiration.

The Evermoor Hub, which is managed by a local resident, provides a lifeline and vital community support services for people of all ages and abilities across the estate:

“The community want more aspiration for the area and residents have a strong sense of community, there is a strong local community hub, the Evermoor Hub which is a real focus for local people.” (Local stakeholder interview)

Digmoor, as part of Skelmersdale has also benefited from being one of the Pathfinder areas for Well North¹. This has brought some tangible benefits to Digmoor in terms of the scale of ambition for community engagement in Skelmersdale:

“Well North work with small social enterprises, developing and supporting these, and work with existing community and voluntary services to develop a local community owned vision.” (Local stakeholder interview)

“There is a lot happening in the community sector locally, Well North have been very engaged with residents in supporting involvement.” (Local stakeholder interview)

This is in evidence through the number of social enterprises that are developing locally, for example, the Age of Inspiration, a new project that aims to harness the untapped talent of the older people in the community:

“The ‘Age of Inspiration’ social enterprise looks to improve the health and wellbeing of older people – aiming to ‘ignite’, ‘inspire’ and ‘connect’ them to the things that keep them well.” (Well Skelmersdale Blog, wellskelmersdale.wordpress.com)

The Sewing Rooms is a local social enterprise started by two local residents who describe their mission as being to ‘repair the fabric of society’. The Sewing Rooms does therapeutic creative work with groups and individuals who may be isolated, long-term unemployed and at risk of developing mental health problems. It funds itself by manufacturing soft furnishings, accessories and upholstery for private and corporate clients – including IKEA².
Initiatives such as these clearly demonstrate the potential of community engagement and what can be achieved when the skills, commitment and creativity of local people is harnessed to support health and wellbeing.

However, community engagement doesn’t just happen, it is important to recognise and respect the history and experience of local people. Too often this is forgotten and across the country statutory services in particular can have a limited perspective of local communities. National funding programmes come and go, with too little thought about sustainability and this can have an impact on people’s trust and faith in the ability of statutory agencies to make real changes:

“There have been projects and investments, but ad hoc, not sustainable for the long term – has an impact on trust in the community, lack of faith that anything will change.” (Local stakeholder interview)

Local people need to feel that they have control and that they are listened to, but this is not always their experience:

“The community feel things are ‘done to them’ rather than with them.” (Local stakeholder interview)

This is something the CCG are actively working to change. There is a real commitment to learn the lessons from the past and change the relationship between statutory services and local people. The plans for the new health centre are at the heart of this approach. The CCG, working with Well North are building on the strengths of the local community:

“People in Digmoor have their extended family around and this is a support, there are less problems with single, isolated people.” (Local stakeholder interview)

“There is a lot of support amongst residents, people look after each other.” (Local stakeholder interview)

This includes development of plans for the new health centre as a wellbeing campus that will work in partnership with the Evermoor Hub and local residents with the focus of enabling a more connected community.

The residents of Digmoor continue to thrive despite the hardship and disadvantages of living on an estate that comes near the bottom of every league table on deprivation and poor health. There are undeniable challenges on the estate, some of which can be traced back to faults with the planning system during its creation in the 1960s. Learning the lessons from this legacy and how the strength of local communities can help overcome the challenges is why the focus on housing and health is so important.

2.1 Town planning and promises not fulfilled

The Digmoor estate is situated on the edge of Skelmersdale in West Lancashire. Planned to take the population overspill from Liverpool, Skelmersdale was originally established as a new town in 1961 and was intended to house 85,000 residents, though it has only managed to reach approximately half that number.

The first new towns in England were planned following the New Towns Act of 1946 which provided the framework and guidance for relocating populations after the Second World War to innovative, green places that would provide quality homes, jobs, and were organised around schools and shops.

1 Well North is a strategically collaborative programme operating across the north of England. It aims to improve the health of the poorest fastest, address community resourcefulness and resilience and tackle worklessness. It seeks to tackle the wider determinant complexity of the whole problem, making visible, previously invisible at risk people and attempting to solve, rather than manage, their illnesses and anxieties. Well North has entrepreneurialism as a key catalyst for unlocking the potential in people and places. www.wellnorth.co.uk

2 See the attached link for a short video on the Sewing Rooms: https://www.youtube.com/watch?v=SUhr9WcZzw&feature=youtu.be)
Skelmersdale was a part of the second wave of new towns in the 1960s – (along with Dawley, Shropshire; Redditch, Worcestershire; Runcorn, Cheshire; and Washington, Tyne and Wear) with particular attention paid to house the population that was over spilling from the city of Liverpool.

Lord Reith of Stonehaven, who chaired the New Towns Commission that informed the 1946 Act, recommended that New Towns were constructed through development corporations that were supported by the Government. The Skelmersdale Development Corporation was formed in 1964 and work began immediately to construct estates using the Radburn Principles, heralded as the new style of urban development.

Based on the town of Radburn in the United States and developed by the architect Clarence Stein, the design was intended to meet the needs of an increasing car owning community. The idea was to separate pedestrians from roads through the use of subways and walkways with housing blocks formed through cul-de-sacs. However, what may have worked in the leafy, middle class suburbs of Radburn did not translate well into the largely working class, high density estates in the UK. British designers also changed the concept so that cars were placed in rear parking courts behind high fences and the houses faced onto open pedestrian walkways.

Many residents of these new estates blamed the design on high crime rates and did not feel safe with the convoluted and confusing walkways (Academy of Urbanism, 2015).

West Lancashire Borough Council have undertaken significant housing developments as part of its drive for local regeneration, including the provision of new homes on the Digmoor estate. However, issues arising from the design of the Digmoor estate continue to concern residents and present particular challenges for the council, as they have to balance the national drive for new housing with the need to address problems with existing housing stock. Some of the issues that concern residents include the impact of the estate’s design on anti-social behaviour, crime and safety:

“The design of the estate was on Radburn principles, these have been abandoned elsewhere as a failure, as being a cause of high levels of anti-social behaviour and crime.” (Local stakeholder interview)

“The design was for there to be no pavements, the subways feel unsafe…” (Local stakeholder interview)

If residents struggle to feel safe in their homes, this has an impact on aspirations and health and wellbeing:

“The area is viewed very negatively, people always want to leave, to get out, have no pride in saying this is my home and that impacts on general health and wellbeing.” (Local stakeholder interview)

While the original design of Digmoor is an ongoing issue for local residents, of even greater importance are the failed promises of the new town planning that enticed the first people to move into the estate. National stakeholders, identified this as one of the significant failures of the planning process, which has led communities to feeling stranded and with little opportunity for change:

“New town planning and housing has a lot to answer for, it may have been a good move for people at first, in 1962, coming out of slum accommodation in cities, but the promises have not been kept, employment didn’t materialise, housing design was poor, led to a lot of anti-social behaviour and crime, communities feel they have been stranded.” (National stakeholder interview)

The national housing focus has been very strongly framed in terms of new housing provision; the risk for areas like Digmoor is that they are left behind as regeneration focuses on new areas. This would have consequent impacts of increasing the divide in wealth and health inequalities.
Housing, poverty and unemployment

Some of the indicators showing the links between housing, poverty and unemployment on the Digmoor estate are stark. For example, only a little over half of the households on the state have an employed person (51%):  

The average savings for households on Digmoor are £13 compared to nearly £2,000 for the county as a whole. The lack of financial assets, alongside the high rates of unemployment has a profound impact on residents’ capacity to make use of local amenities:

“Nothing is freely available in Digmoor and people are poor so are not able to take part in things like the Boxing club which costs money.” (Local stakeholder interview)

Analysis of the number of people claiming Job Seekers Allowance (JSA) in 2014 shows that there are significantly higher numbers in Digmoor compared to the county as a whole, 8% for Digmoor compared to 2.6% for West Lancashire.

Almost one out of every four working age residents was claiming some kind of out-of-work benefit (24.1% compared to 10.3% for West Lancashire) (WLBC, 2014).

The levels of poverty can also be seen through a marked increase in numbers of people accessing the local food bank:

“There has been an increase in demand for the food bank, but there are still people too proud to ask for this, perhaps more could be done to encourage people to come forward.” (Local stakeholder interview)

“There are more people using the food bank, it is driven by debt and poverty, people are not managing to cope.” (Local stakeholder interview)

Households with an employed person

“There are very poor transport links, it takes two to three hours to get to the hospital by bus and the services stop after 6.00 pm, people have to get taxis but it takes a lot of their money, they have little capacity for this.” (Local stakeholder interview)
2.2 Changing patterns of housing tenure and ownership

One of the ways that poverty and unemployment can be seen to be having an impact on housing is through the changing patterns of tenure and home ownership. As noted above, when Skelmersdale was established as a new town it was under the management of the Housing Corporation, which later changed to local authority control. At this time the majority of tenures were intended to be social housing, in contrast to today when the majority of the housing stock is either private rented or owned (61%):

There are also significant differences in private equity and income for residents of Digmoor compared to the county:
- 20% of owner occupiers have a mortgage compared to 35% in the county
- the average equity of home owners in Digmoor is nearly half that for the county (£69,000 compared to £135,000);
- average household income in Digmoor is £12,852 compared to £20,398 for the county. (WLBS, 2010).

The relative poverty of the area is perceived as having an impact on the ability of residents, especially those in private rented or home ownership to maintain their properties:

“The housing stock is not adequate, in need of repairs, there are problems with damp.”
(Local stakeholder interview)

Housing tenure Digmoor estate compared to West Lancashire 2009

“The properties are old and out-dated, many have not been brought up to modern standards, the levels of maintenance and repair are low, local residents are poor and it inhibits their capacity to maintain their homes.” (Local stakeholder interview)

Although, compared to West Lancashire as a whole, the percentage of social housing in Digmoor remains higher, (38% compared to 15%) it is the private rented stock that local stakeholders regard as having the biggest impact on declining housing standards and rising health and social care problems:

“There is concerns that the private landlord housing is adding to the health and social needs in the area because it attracts residents with a history of previous evictions from social housing:

“There are a lot of private landlords in Digmoor, taking people that have been excluded from social housing, council evictions – it compounds the problems makes it hard to re-let properties to different kinds of families.” (Local stakeholder interview)

There is also a perception that there are more houses with multiple occupation in the private rented sector, including migrant families and people working in both the day and night time economies:

“There are a lot of people moving through the private rented buildings, a lot of Eastern Europeans and people who have been evicted from the local authority housing stock. There are up to eight or more people living in one house, some working days and some working nights…” (Local stakeholder interview)
2.3 Health and housing – population risks and vulnerabilities

The population of Digmoor have many of the characteristics that are associated with housing and the risk of poor health including:

2.3.1 Age

Concerns about housing and health often focus on the needs of the elderly, in particular the risk of falls and from exposure to damp and cold. These are significant factors, but the resident population of the Digmoor estate are somewhat unusual, in comparison to the rest of the county, in that they are relatively younger. The estate is also characterised by higher numbers of young children and much lower numbers of elderly people over 70.

Out of a population of 4,600 residents in Digmoor, 48% are under the age of 30 compared to 37% for West Lancashire as a whole:

2.3.2 Overcrowding

Living in an overcrowded household is known to have a detrimental impact on health, especially for children and young people who also suffer educationally and developmentally if they lack safe spaces to learn and play. Digmoor has significantly higher proportions of households that are overcrowded compared to the borough:

2.3.3 Households with dependent children and people with support needs

Digmoor also has higher numbers of households with dependent children and adults with support needs compared to the borough:

The highest categories of support needs are medical conditions and learning disabilities:

(Source: WLBS, 2010. West Lancashire Ward Summary: Digmoor)

(Source: Understanding Society. The UK Household Longitudinal study. University of Essex)
2.3.4 Lifestyle factors

The population of Digmoor score highly on some the key measures for lifestyle factors that are having a major influence on health. For example, Digmoor has the second highest obesity rates for children at year six compared to the borough and nationally:

There are also higher rates of hospital admission as a result of alcohol consumption:

Digmoor also has some of the highest rates of teenage regular smokers in the county and significantly higher than the national average:

2.3.5 Mortality and morbidity

All of these factors undoubtedly have an impact on morbidity and premature mortality for the population of Digmoor. For example, Digmoor has the highest rates for premature death from cancer in the borough:
Digmoor has the third highest rate of emergency hospital admissions in Skelmersdale, and significantly higher rates than the average rates for the borough:

Digmoor also has some of the highest hospital admission rates for Chronic Obstructive Pulmonary Disease (COPD):

### 2.3.6 Mental health, self-harm and suicide

Hospital stays for intentional self-harm are also higher in Digmoor compared to other parts of the borough:
2.4 Housing hazards and deficiencies

Many houses in Digmoor contain category 1 hazards (11%) including 5% that are in disrepair and 6% with a category 1 fall hazard (BRE, 2016):

There are a larger percentage of dwellings in the private rented sector with all category 1 hazards and falls, though fewer at risk from excess cold or in disrepair:

2.4.1 Fuel poverty

One of the key factors that links housing and health is fuel poverty, which is directly related to income. The numbers of dwellings in Digmoor in fuel poverty and households with low income is relatively high in Digmoor:

Two measures are used in the above for fuel poverty:

- The first (10%) is the original definition, which states a household is said to be in fuel poverty if it spends more than 10% of its income on fuel to maintain an adequate level of warmth, defined as 21C for the main living area, and 18C for other occupied rooms (2012 Hills Fuel Poverty Review).

- The second is the more recent Low Income High Costs (LIHC) definition, which uses a formula, based on fuel costs that are above average and where, if households spend that amount, they would be left with a residual income below the official poverty line.
What data does not show are the number of private households in fuel poverty, which is relevant because nationally those living in the private rental sector are nearly three times as likely to be in fuel poverty (19.4 per cent compared to 7.7 per cent in owner occupied properties). Those in the private rented sector also tend to be deeper in fuel poverty, with an average fuel poverty gap of £383, compared to just over £200 for those in local authority and housing association properties (Department for Business, Energy and Industrial Strategy, 2018).

Overcrowding and lone parents with dependent children, which are two of the distinct patterns of tenure in Digmoor, are also two of the highest factors associated with fuel poverty. For example those living in overcrowded houses have an average fuel poverty gap of £413 compared to a single person under 60 (£208) and the highest prevalence of fuel poverty is seen for lone parents with dependent children, 26.4 per cent (ONS, 2017).

The Hills Fuel Poverty Review provides data on the typical households living in fuel poverty; many of these apply to Digmoor:

- 82% of fuel poor households live in houses as opposed to flats or bungalows;
- a third of fuel poor households are found in a fifth of the most deprived households;
- 34% of fuel poor households contain a person with a long term illness or disability;
- 10% of fuel poor households contain a person over the age of 75;
- 20% of fuel poor households contain a person under the age of 5 (Hills, 2012)

2.4.2 Cold and damp housing

Higher rates of circulatory and respiratory diseases, including death is associated with cold and damp housing. For example:

- for each degree Celsius by which the winter is colder than average, there are an excess 8,000 deaths (Wilkinson, 1999);
- over one-third of all excess winter deaths were caused by respiratory diseases in England and Wales in 2016 to 2017 (ONS, 2017).

The population of Digmoor have higher rates than the average in the borough for deaths due to circulatory disease and respiratory disease:

![Graph showing premature mortality from circulatory and respiratory diseases 2008-12](image-url)
2.5 Housing and health – professional culture and practice

Part of the reason that the CCG were keen to explore housing and health is the way in which understanding about the importance of both is understood and interpreted by professionals. For example, the need for different professionals to view housing and health not as single and separate issues, but in terms of how both have an impact on the wellbeing and aspirations of the local community:

“It important to think how health is framed, for example, not just looking at physical or mental health, it needs to be about wellbeing and health in its broadest sense.” (Local stakeholder interview)

“It goes beyond the decent homes standards, it is about how people feel about the environment in which they are living and how that impacts on their wellbeing, security, community cohesion and health.” (Local stakeholder interview)

“You can’t detach housing from health – it is about the impact on people, communities, families, young people, older people and aspirations, self and community esteem.” (Local stakeholder interview)

The culture of some professional groups can be quite insular, with little scope or enthusiasm for crossing professional boundaries or undertaking work that is not strictly part of the professional practice into which people have been trained. Taking on new ways of working, such as social prescribing to address the social determinants of health can also be challenging for GPs who are constrained by rising demands on their time and resources. But there is a clear recognition of the need for a shift in emphasis and practice towards new ways of working with issues like housing and health:

“We need to shift thinking and practice in primary care, people tend to be more comfortable within their professional boundaries but the culture has to change, the workforce needs to embrace things like social prescribing.” (Local stakeholder interview)

It is also important for GPs to be supported in these new ways of working by the Local Medical Council, for example how to address requests for medical support in evidencing health impacts from housing such as those from damp and cold.

Similar professional challenges can exist for the housing workforce, who may not have a full understanding about health and the health care system:

“If you are a housing support worker, you know about housing, you may know about the care system but you don’t think that your role is about health.” (Local stakeholder interview)

“The local authority need to think about their workforce and moving beyond housing development programmes and traditional works – needs a wider approach with other stakeholders including health, education, Community and Voluntary sector, local communities.” (Local stakeholder interview)
There is also a need for a wider group of professionals to be part of a collaborative approach to housing and health:

“There isn’t enough recognition amongst other non-health agencies of the impacts on health, for example worklessness, the job centre doesn’t help. They are increasing a dependency culture, saying that people are not fit for work when in fact some work would help them, it would help with depression.” (Local stakeholder interview)

“GPs see first-hand the impact of housing on health – and other social determinants of health, for example a quarter of patients seen do not actually need to be seen by a GP, but we need to get more agencies directly involved in primary care.” (Local stakeholder interview)

There has been change locally in Digmoor, including the use of more social prescribing:

“The local GPs in Digmoor now have a social prescriber, it is helping the GPs to understand what things are available locally for people.” (Local stakeholder interview)

Close partnership working with a range of community and voluntary sector agencies is seen as important in changing professional culture and practice, but there are capacity issues for the community and voluntary sector to provide feedback:

“There are issues with accountability for third sector agencies, they are less able to give feedback on individuals so clinicians that have referred people to them don’t know if they came or how things progressed, they don’t have the systems and capacity for this so it is not easy to resolve.” (Local stakeholder interview)

For commissioners, these are important issues. CCGs have a statutory duty to address health inequalities and locally in West Lancashire, this is being taken forward through the plans for an Integrated Community Partnership that will have a focus on population health. The plans for a new health centre will be more closely aligned with the local community and voluntary sector services and have a range of health and social care provision. For local stakeholders it is important that the opportunities this affords are focused on close community partnership working and include changes in professional culture and practice, not just a new building:

“The new health centre is an opportunity to do things differently, to create a health campus, but it needs to be done right, with local people involved in the decision making, the trick is to have it close to the community hub so that the two can look like one but keep their own discreet functions.” (Local stakeholder interview)
2.6 Leadership

Having the right leadership and structure alongside a local accountability system for health and housing is something that local stakeholders identified as being essential:

“There needs to be a leadership group focused on Skelmersdale, need all the leaders to come together regularly, it needs to be a specific group to resolve the problems – current meetings are too transactional and they need to be more about banging heads and getting things done.” (Local stakeholder interview)

This is not something that can be led solely from one sector, either health or the local authority, but requires a fully collaborative leadership framework:

“We need to think through how we can get more partners engaged and collaborating, across sectors with health, housing and the community and voluntary sector.” (Local stakeholder interview)

Some of the barriers are thought to relate to the way in which organisations are being increasingly driven by national targets and priorities, rather than the local needs:

“Agencies are working to their own national targets like DWP and job centre plus and this does not help with local solutions that need more flexibility, the target culture acts against health improvement but some of these agencies have better access to people, could have more influence on their health.” (Local stakeholder interview)

2.7 Structures for planning and commissioning

Structural factors that have an impact on local area strategy and planning can complicate the ability of local commissioners and planners to address housing and health as an integrated issue. For example, complications that arise for two-tier authorities:

“There are always more problems with two-tier authorities, creates additional pressures and barriers to collaboration especially with respect joining up housing with other services.” (Local stakeholder interview)

The Integrated Community Partnership and the neighbourhoods that form part of this, will provide a mechanism and strategic focus for addressing health inequalities and population based health needs. While there is broad consensus about the value of these objectives, there is an ongoing need for this to be translated into culture and behaviour change amongst front line staff:

“We are good at creating an integrated strategy, but it needs to mean something on the ground, for staff and for local residents that use the services.” (Local stakeholder interview)

There is not always shared understanding about what it means to have an integrated strategy and a whole system approach:

“There needs to be more thought about what it means to have a whole system approach, it can’t just be about strategy, it’s how people behave, the culture change that is needed.” (Local stakeholder interview)
2.8 Building consensus - a local framework for housing and health

Building consensus locally on the focus for health and housing needs to be embedded within the strategic framework for integration:

“All the evidence supports an approach that brings everyone together, with a strong focus on health and housing as a shared objective.” (Local stakeholder interview)

This should include specific consideration of the impacts and implications for related strategy and planning frameworks in the local authority 'at both borough (Integrated Community Partnership) and county (Integrated Care System) levels:

“It needs to be a whole package, able to address land value deficits, low rental yields and day and night time economy alongside health, leisure and community assets building.” (Local stakeholder interview)

“There needs to be new local accountability frameworks, for example, a landlord forum which would enable communication between the LA, partners and private landlords.” (Local stakeholder interview)

“We need strategic leaders and local politicians to get behind the community and make a single offer for health and housing.” (Local stakeholder interview)

In particular, local stakeholders thought that there needed to be a framework and process by which the local strategy and commitment to improving health and housing can be operationalised in practice:

“We need a clear developmental process that can bring all the strands together, something that can address the system level change required, support the right leadership framework and structural issues but also bring local people, professionals and the community together to create something new. Without this, it will remain separate and the opportunity to make a real difference will be missed.” (Local stakeholder interview)

The risk is that without consensus on housing and health, strategy becomes place blind and doesn’t recognise the centrality of having a system that is rooted in local communities.
3. The national context
It is tempting to think that the issues and challenges faced by residents and commissioners in the Digmoor estate are unique. But in fact, they are very relevant in the national context for housing and health:

- The need to learn from past mistakes, in particular the legacy impact of failed national planning programmes for housing.
- Changing patterns of housing tenure, especially the reductions in social housing tenure and lack of affordable housing.
- The impact of poverty and deprivation factors on housing and health and associated population risks and vulnerabilities.
- Variations in understanding and approaches to housing and health amongst professionals and the influence of professional culture and practice on strategy and planning for housing and health services.

This is also a good time for a renewed focus on housing and health and fresh thinking about how to address the interdependency of these central concerns and how to affectively implement an integrated strategy for housing and health.

### 3.1 Assessment of needs – data and information on housing and health

In its updated report on the health costs of housing, The Building Research Establishment (BRE) estimated that:

> “...if we could find £10 billion now to improve all of the 3.5 million ‘poor’ homes in England, this would save the NHS £1.4 billion in first year treatment costs alone. It is estimated that such an investment would pay for itself in just over seven years and then continue to accrue benefits into the future.”

(Nicols et al, 2015)

There are tools to help local areas identify these cost savings such as the Housing Health Costs Calculator (www.housinghealthcosts.org) developed by BRE but these are not always known or being used to the best effect at local levels:

> “Health services and leaders don’t know about the Housing Health Costs Calculator, if local authorities aren’t using it then no one else will and so they continue to struggle to demonstrate the impact of interventions.” (National stakeholder interview)

An evaluation of the Derbyshire Healthy Housing Hub (HHH) at one year post intervention found proportionally fewer HHH clients were in need of health and care services, other than in the case of outpatient appointments. Also:

- 20% fewer HHH clients were admitted to hospital when compared to those originally admitted as a result of a fall 12 months earlier;
91% of HHH clients were still in their own homes at 12 months, at less cost;

fewer contacts amongst HHH clients with East Midlands Ambulance Service (EMAS) required conveyance to hospital (6% HHH, 19% inpatient, 12% residential); and

there was greater use of 111 and out-of-hours services in the control groups, an average 51% and 74% respectively.

(NHS Southern Derbyshire CCG and Derby City Council, 2016).

There are challenges in making housing and health a priority if the data and evidence on the impact of housing on health is not addressed.

The principle tool by which health and social care needs are identified locally is the Joint Strategic Needs Assessment (JSNA), however, these assessments tend to compartmentalise health and housing data, so that the direct connections between the two for improving health may not be appreciated fully:

"JSNAs are not influencing decisions as much as they could, there needs to be a specific focus with joint data to increase the understanding about the prevention aspects as much as the risks for housing and health." (National stakeholder interview)

"We need to do more to develop the local evidence base, and to promote awareness of the full range of problems and needs." (National stakeholder interview)

"We need to measure the social impacts and sustainability of interventions for housing and health." (National stakeholder interview)

This also requires greater recognition of the different ways in which health and housing data translates into outcomes.

For example, local authorities assess the number of local houses with category 1 hazards, but they do not readily make the link between these and the anticipated health outcomes if the hazards are reduced:

"Health commissioners need measurable health outcomes, but the data on housing doesn’t always provide this, that is where the disconnect lies between housing authorities and health commissioners." (National stakeholder interview)

"Data is key but some CCGs and local authorities don’t collect and save data in a way that is accessible, so it is harder to show how improvements save money, how you can demonstrate what can be done." (National stakeholder interview)

The JSNA is one part of the evidence base that is needed at local levels, there is also a need for greater recognition of the full range of health needs associated with housing and the long term sustainability of interventions to address these:
3.2 Collaboration and partnership working

There is a growing gap between national strategy and policy on housing and health and the ability and capacity for system leaders to implement changes at the ground. This is not just a matter of austerity and increasing financial constraints, though that is undoubtedly part of the picture:

“People are so bogged down with day to day running despite real efforts to bring thinking around to the wider determinants of health. The reality is that people are interested in saving money in the short term rather than thinking about prevention for the long term. We know the importance of prevention but the reality of making it happen on the ground when facing debts is slim.” (National stakeholder interview)

“There are real challenges to collaboration, stretched budgets for social care, it is hard to look at wider determinants of health for those teams when they are putting out fires daily and delivery has suffered.” (National stakeholder interview)

It is also fundamentally about collaboration and partnerships, for example, housing authorities are not routinely involved in development of strategies for reducing health inequalities:

“There is a general lack of involvement of housing authorities in strategy for addressing health inequalities, even though housing is key to this.” (National stakeholder interview)

This is not helped by the fragmentation of the NHS since the introduction of the Health and Social Care Act in 2012:

“The fragmentation of the NHS since 2012 has affected all aspects of health and social care. Housing is just one issue that it is much harder to get traction on under the current system.” (National stakeholder interview)

Lack of local collaboration on housing and health is also a feature of the siloed nature of central government departments:

“National agencies are all siloed, locally integration is very difficult;” (National stakeholder interview)

“We need counter gravitational forces to get collaboration across departmental boundaries for health and housing.” (National stakeholder interview)

There is a need for leaders from across the relevant sectors to come together, including health, local authorities and housing associations:

“Need a triangle of leadership between housing associations, health and Local Authorities. More can be done together rather than separately.” (National stakeholder interview)

This is thought to be easier when the issues are focused on problems that are recognised as priorities, for example reducing unnecessary hospital admissions:

“Give leaders a solution to the problems that they see as priorities, for example, how to make a difference on hospital admissions, not just as a housing issue or a health issue but as something tangible that will relieve current pressures, makes sense to leaders as a priority area of concern.” (National stakeholder interview)

But it is also necessary to have the right people round the table, the people who can actually make decisions:

“You can’t dumb it down, need the right people at the top, the decision makers, if it moves too far down the ladder then it just becomes a talking shop.” (National stakeholder interview)

(See Appendix A for an example of a programme using collaboration and partnership working to manage patient flow).
There is a need for an explicit local accountability framework for an integrated approach to improvements in health and housing. This could take the form of adoption of the national Memorandum of Understanding (MoU) to support joint action on improving health through the home (PHE, 2018). Public Health England (PHE) report that in excess of 50 CCGs have adopted the MoU to date and the specific benefits that arise from the MoU include:

- enabling local partnerships to collaborate more effectively across health, care and housing when planning, commissioning and delivering homes and services;
- ensuring the public and service users are heard and involved in collaborative work across health, care and housing;
- greater joint action on housing’s contribution to different care pathways including prevention and transfer of care or discharge planning;
- more effective use of resources to improve health through the home, prevent illness, manage demand and deliver service improvements across local housing, health and social care sectors;
- promoting the housing sector contribution to: addressing the wider determinants of health; health equity; improving people’s experience and outcomes; preventing ill health and safeguarding;
- promoting the adaptation of existing homes and the building of new accessible housing with support which is environmentally sustainable and resilient to future climate change and changing needs and aspirations;
- developing the workforce across sectors so that they are confident and skilled in understanding the relationship between where people live and their health and wellbeing, and are able to identify suitable solutions to improve outcomes.

Nottingham has established a Health and Housing Partnership Group, which is chaired by the Director of Public Health. The Partnership Group have used the national MoU as a framework to embed housing and health in the local Health and Wellbeing Strategy (Harding, 2017).
3.4 Financial and budgetary alignment

One of the significant barriers to improved collaboration and partnership on housing and health is the lack of financial and budgetary alignment. The regulatory frameworks by which finances and budgets are determined for health and housing are difficult to integrate:

“The budgets are not aligned, they don’t work in tandem.” (National stakeholder interview)

Problems can also arise because expenditure in one area can result in the shift of costs to another, which reduces the incentives for local system leaders to collaborate on housing and health:

“Investment on one side leads to lack of investment in another, it is hard to get these issues joined up in budgets that encompass both health and housing.” (National stakeholder interview)

This is not helped by the strict nature of regulation on budgetary alignment and integration, which can act as a barrier to innovation in using pooled resources and finances collaboratively:

“Strict rules on health budgets mean they can’t be spent on housing.” (National stakeholder interview)

“There is always talk of pooled resources and budgets but we have yet to see this on the ground.” (National stakeholder interview)

The impact of austerity and the focus on managing critical financial issues and constraints is also thought to be limiting the capacity for partnership working on housing and health:

“It is counter intuitive to retrench in times of austerity, people draw the wagons round instead of thinking more imaginatively and creatively about collaboration and integration.” (National stakeholder interview)

“Health and social care has been significantly affected by cuts and austerity, and as a result innovation and collaboration has fallen by the wayside.” (National stakeholder interview)

Increasingly tight financial constraints also mean that there is little scope for investment to support new initiatives on a joint basis:

“No additional money to allocate to housing or health, so even harder to address health and housing programmes as a joint endeavour.” (National stakeholder interview)

“We need additional resources to fund activities for health outcomes within housing and for better housing outcomes within health, but the system doesn’t support this kind of integrated budgetary approach.” (National stakeholder interview)
3.5 The Better Care Fund

The Better Care Fund (BCF) provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from CCG allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services. However, while the DFG has been instrumental in developments for the disabled, there is less evidence for use of the BCF to support specific housing and health programmes:

“The Better Care Fund should have been used to support local housing and health initiatives but this has only happened in a few areas.” (National stakeholder interview)

“More could be done with mechanisms such as the Better Care Fund on health and housing.” (National stakeholder interview)

Funding from the Better Care Fund has enabled Nottingham City Homes, which manages the Council’s social housing stock to support three Housing and Health Coordinators (HHCs) to integrate housing support within the local healthcare system. An evaluation of year two of the project, known as Housing 2 Health (H2H) estimated that it had created savings of over £2.1m (Nottingham City Homes & Nottingham City Clinical Commissioning, 2017).

In their final report on evaluation of the Better Care Fund, Forder et al., note that the BCF has in some ways been subsumed under Sustainability and Transformation Partnerships and related programmes on integration such as vanguards and the shift towards integrated care systems (Forder et al., 2018). However, this does not address some of the accountability and responsibility issues for the delivery of outcomes. For example the DFG is allocated to county authorities but local authorities still have the duties regarding home adaptations.

The combination of two-tier authorities and the overlay of STPs can result in additional challenges for local authorities and CCGs trying to establish collaboration on housing and health.

3.6 Two-tier authorities and Sustainability and Transformation Partnerships

The majority of Sustainability and Transformation Partnerships contain references to housing as a factor that influences health. But amongst the plans that do mention housing, one quarter lack any advanced planning guidance or strategy about how to address housing and health (Care & Repair 2017). Stakeholders, who thought that STPs lacked sufficient focus on the broader determinants of health, echoed this view:

“Transformation plans often have tunnel vision.” (National stakeholder interview)

“The Transformation Partnerships are focused on immediate health priorities, it is too much to expect them to take on housing.” (National stakeholder interview)
The lack of focus on housing within Sustainability and Transformation Partnerships can constrain local commissioners from making it a priority:

“Local commissioners need to lead on this, they have the energy and insight into the problems, but is hard for them when it is not a priority for the STP.” (National stakeholder interview)

“STPs don’t have statutory leverage to make things more integrated, to make local partnerships work effectively.” (National stakeholder interview)

In their exploration of the opportunities for health and housing, the Kings Fund concluded that greater involvement of housing within Sustainability and Transformation Partnerships could relieve pressures in social care:

“While there is a need to invest time in understanding the potential opportunities, the housing sector can help with the pressures facing health and social care services and can help them deliver their short-term goals, while building on this for longer-term transformation.” (Buck and Gregory, 2018)

Amongst their recommendations the Kings Fund include:

• exploring the value in establishing housing and health alliances to strengthen policy and practice links;
• establishing lead roles in Sustainability and Transformation Partnerships for housing across work streams;
• assessing progress through the criteria in the national memorandum on improving health and care through the home;
• greater use of NHS estates capital funds release for social value including meeting housing need;
• closer alignment of capitated budgets for housing and health (Ibid).

The division of responsibilities for housing, care and public health across two-tier authorities adds to the complexity of establishing integrated provision for housing and health in local areas:

“The problems are greater in two-tier authority areas, it is harder to get local collaboration.” (National stakeholder interview)

“CCGs and local authorities need to work together on housing and health but key responsibilities and resources sit at the county level, it doesn’t easily come together.” (National stakeholder interview)

Working across complex layers of local government and NHS structures can also be challenging for Directors of Public Health, who in two-tier authorities sit at the county level:

“Public health sits at the county level but this doesn’t mean there is a good relationship or understanding with the local borough councils.” (National stakeholder interview)
3.7 Health and wellbeing boards

The main local structural mechanism for health and social care integration, including housing and health, is the Health and Wellbeing Board. These boards sit at the level of each local authority area and have a statutory responsibility to produce the Joint Strategic Needs Assessment (JSNA) for the area and a joint health and wellbeing strategy.

Health and Wellbeing Boards may have someone on the board with a passion about or commitment to housing but there is no requirement for housing or environmental health to be part of the structure.

The absence of environmental health from health and wellbeing boards has been linked with their relative lack of engagement in health policy making in local areas and likewise, lack of understanding about environmental health and housing amongst public health policy makers (Dhesi, 2018).

A report on Health and Wellbeing Boards for the Local Government Association in 2017 concludes that the Boards are growing in competence and that they are increasingly becoming the ‘anchor for place in a sea of STPs’.

Structural imbalances are highlighted between the different systems with the view that some STPs completely bypass the Health and Wellbeing Boards (Shared Intelligence, 2017).

The Housing Federation, which represents Housing Associations in England, has suggested that engagement with Health and Wellbeing Boards may be better achieved through sub-groups rather than through seeking membership of the Board (National Housing Federation, 2013).

Stakeholders also thought that there needed to be local groups with a specific remit to address housing and health:

“To get new integrated initiatives off the group we will need multi-agency project boards to come together across organisations and systems.”

(National stakeholder interview)

3.8 Integrated Care Systems

Some STPs are becoming Integrated Care Systems (ICS), which have no statutory basis but are increasingly taking over responsibilities for improvements and transformation in local care systems. They provide local commissioners in the ICS with delegated decision rights for determining commissioning of both primary and specialist care. Initially ten ICS pilot areas were established:

• South Yorkshire and Bassetlaw
• Frimley Health and Care
• Dorset
• Bedfordshire, Luton and Milton Keynes
• Nottinghamshire
• Lancashire and South Cumbria
• Berkshire West
• Buckinghamshire
• Greater Manchester (devolution deal)
• Surrey Heartlands (devolution deal)

Guidance issued in February 2018 stated that more areas would be encouraged to become an ICS if
they can demonstrate the right leadership and quality of planning and financial management. To date these include Gloucestershire, West Yorkshire and Harrogate, Suffolk and North East Essex and North Cumbria.

NHS England and NHS Improvement expects ICSs to lead sustainable improvements in health care by:
• creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
• supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
• delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
• allowing systems to take collective responsibility for financial and operational performance and health outcomes.
(NHS England and NHS Improvement, 2018)

The guidance makes no mention of housing or environmental health though it does clearly intend greater collaboration and partnership working.

All of these structural differences and changes, STPs, two-tier authorities, Health and Wellbeing Boards and Integrated Care Systems add to the complexity and challenges for local commissioners to make housing and health a priority in their own plans and strategies:

“Hospitals can the hardest organisations to engage on housing, hard to get them to collaborate, they use the complexity of current systems as a blanket barrier to greater collaboration and integration.” (National stakeholder interview)

“All even when the local authority is willing to look at new developments, it can be hard to get all the relevant stakeholders engaged, health, police, education, social care, public health, community and voluntary sector...it takes a lot of time and resources to get the proper building blocks in place and ensure local commitment.” (National stakeholder interview)
3.9 A new approach to investment for housing and health

There is a need for fresh thinking about investment opportunities for housing and health. Traditionally, this has been split between development planning and public health, but the time may have come for the various funding streams on housing and health to be focused on the same outcomes.

3.9.1 The role of Housing Associations

Housing Associations have resources that could be leveraged for health outcomes and not just as a means to improve housing conditions or increasing supply:

“Housing Associations have seen an increase in their incomes, they have been less affected by austerity and have residual funds that can be leveraged for local investment.” (National stakeholder interview)

“There are untapped resources in Housing Associations, many have benefited from housing price increases and have capital funds that can be leveraged to support innovative new developments.” (National stakeholder interview)

The inclusion of Housing Associations in local partnership arrangements for housing and health would help to bring the additional resources they command into play:

“Housing associations have considerable resources and partnerships are needed to exploit these.” (National stakeholder interview)

3.92 Social impact investment

Financing for social impact is a good way to being in additional investment for housing and health:

“Bond financing offers an innovative way to create a joined up approach and can add considerable value to local investment.” (National stakeholder interview)

Homes England are also thought to be prioritising projects and programmes that can offer additional social and health impacts:

“Homes England is keen to invest in initiatives that have far reaching social impact.” (National stakeholder interview)

However, it is not always clear to health commissioners know how to access these funds and local authorities and health commissioners need to work more collaboratively on establishing the social impact gains from housing programmes. Guiding principles for use of Social Impact Bonds includes:

• the desired outcome is clear and measurable (for example reducing unplanned hospital admissions resulting from poor housing conditions);

• there is clear scope to improve outcomes;

• there is a need to identify and strengthen the local evidence base for interventions;

• public authorities are looking to share the financial risks of investment and to stimulate the market for innovative financing;

• there are clear cost improvement benefits to be gained from system improvements and these can redirected locally for additional social impacts.
3.9.3 NHS and local authority estates

The One Public Estate programme and recommendations for the Naylor review into NHS estates and efficiency provides a useful template for using the capital receipts from sale of public authority and NHS land and buildings to support the shift to health and social care integration.

The One Public Estate (OPE) programme is jointly delivered by the Cabinet Office Government Property Unit (GPU) and the Local Government Association (LGA).

It supports cross-public sector working to deliver ambitious property-led projects that create local economic growth, integrate public services and drive efficiency savings.

At its heart, it’s about local and central government working together with other public bodies to transform communities and local public services and deliver value for money for the taxpayer.

The programme has expanded rapidly since its inception in 2013 across 12 pilot areas to over 300 in 2018. By 2020, the OPE projects are expected to deliver £615 million in capital receipts and £158 million in running cost savings, create 44,000 jobs and release land for 25,000 homes (LGA, 2018):

“NHS strategic estates advisers will connect the country’s 44 sustainability and transformation partnerships ever more closely with OPE to maximise the potential of collective assets.” (LGA, 2018)

There is an opportunity for local commissioners and planners to consider how to better use these assets in furthering health and social care impacts for housing and health:

“We could add considerable value through using profits from land sales to make greater social impacts for housing and health in communities.” (National stakeholder interview)

(See Appendix B for an example of a programme for strategic hospital estates transformation).

3.9.4 Infrastructure led development

One of the lessons from large scale housing developments in the past, is that infrastructure needs to be addressed at the start, not as an afterthought. This is especially important from consideration of housing and health, for example, the need to address facilities and access to local amenities and transport within housing developments:

“The drive now needs to be for infrastructure led developments, how to get funding and investment for school, sports and leisure into housing developments.” (National stakeholder interview)

Achieving this will require a shift in the national focus on housing supply, towards one that takes greater account of quality of housing and community needs:

“It’s hard to get the issue taken up locally, the national debate is all about supply.” (National stakeholder interview)

“The problem, nationally, is how to get real traction in the system for this issue, to move it beyond the supply and demand side to more tangible health and social outcomes.” (National stakeholder interview)

### 3.9.5 A place for prevention

The Secretary of State for Health and Social Care has made prevention one his top priorities; in particular the need for integrated approaches to health and the wider determinants of health such as housing:

“Prevention cannot be solved purely by the health and care system alone. Everyone has a part to play. To make serious progress on prevention we need to understand that. From the education we receive, to the home we live in to the job we do and so much more - all of this shapes our physical and mental health.” (The Rt Hon Matt Hancock, MP, Secretary of State for Health and Social Care, July 2018)

Housing is an area where there are significant gains that can be made in preventing health problems and sustaining health and wellbeing. However, for this to be realised there needs to fresh thinking about the way in which health care and the approach to public health and prevention is focused:

“Directing resources toward a single disease or condition rather than working to improve the overall housing environment is inefficient and does not holistically address residents’ health and safety risks.” (Fukuzawa and Morley, 2010)

The NHS Five Year Forward View called for a radical upgrade in prevention and public health:

“If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.” (NHS England, 2014)

NHS England also called for elected mayors and local authorities to be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health (Ibid Page 10).

In its recent publication on prevention, the Department for Health and Social Care states public health needs to be tailored to local needs including housing and that it will publish a Green Paper on prevention in 2019 (Department for Health and Social Care, 2018a).

### 3.9.6 Place making for housing and health

Local authorities already have many powers that they can use to further the prevention agenda for health. These should be brought together with leaders in health and public health to frame a local housing and health prevention programme. It is essential that this involves robust arrangements for managing incidents and presentations of health problems that are associated with housing and the environment. But it is equally important to consider prevention and how place making in particular can contribute to keeping people healthy and independent.

‘Place making’ is a term that means different things to different people, depending on their particular role or interest. Place making is more than spatial planning; it encompasses a range of factors that go into making environments a place that people feel comfortable and safe to live in, including:

- How local people perceive their surroundings and the value they put on where they live as a home.
- The social benefits of the environment including open spaces, parks and places to meet, socialise and play.
• The economic benefits including local amenities, shops and facilities and the opportunity to work.

• Facilities that support the growth and potential of children and young people including play schools, nurseries, schools and opportunities for further and higher education.

• The infrastructure including transport links, car parking, walkways and street lighting.

• The health and wellbeing benefits including access to local services, affordable food, exercise and leisure.

All of these factors can have an impact on health outcomes and more importantly, preventing poor health. Prevention is a necessary requirement of any health system, but unfortunately it is not an essential one. The health service continues to be dominated by the treatment of ill health and local health economies are weighted to hospital provision at the expense of primary and community care. Turning principles into action for putting prevention in place means making prevention an essential criterion of the housing and health systems. This has implications for community leadership and engagement and professional training and development.

3.9.7 Community leadership and engagement

Communities need to be at the heart of partnerships for housing and health, with local residents able to take on leadership roles to support public authorities in ensuring that community engagement is meaningful:

“Community ownership of housing projects is very important.” (National stakeholder interview)

In the aftermath from the tragedy of the Grenfell Tower fire, the government has attempted to go some way towards the need for this new relationship between residents and social landlords. For example, the recent Green Paper on housing sets out five principles that will underpin a new, fairer deal for social housing residents:

• a safe and decent home which is fundamental to a sense of security and our ability to get on in life;

• improving and speeding up how complaints are resolved;

• empowering residents and ensuring their voices are heard so that landlords are held to account;

• tackling stigma and celebrating thriving communities, challenging the stereotypes that exist about residents and their communities; and,

• building the social homes that we need and ensuring that those homes can act as a springboard to home ownership.

(Ministry of Housing, Communities and Local Government, 2018)

However, the risk is that if once again the lure of home ownership comes to dominant government policy, it will undermine the gains being made in redressing the housing shortfall and further exacerbate the divide between those who own their own home and those who need social housing. If residents and communities are actively leading and engaging with planned housing developments, they will be more likely to take ownership of the intended health and social benefits:

“We need to encourage people to take ownership as they know their own issues and what form solutions could take.” (National stakeholder interview)

“Local authority housing stock surveys are done ‘to’ rather than ‘for’ people, it is purely about structure and investment, not based on resident feedback.” (National stakeholder interview)
Partnership working with the community and voluntary sector can support the development of local community leaders:

“Get local leadership on board, by getting the communities on board, work with the community and voluntary sector to do this.” (National stakeholder interview)

This could be further supported by housing authorities and social landlords moving away from contractual relationships with tenants that are focused on regulation, to one where health and wellbeing is at the forefront:

“We need to re think the landlord and tenant relationships, move away from a contractual relationships that is focused on control to one that puts wellbeing and health at the forefront.” (National stakeholder interview)

Community engagement needs to also be inclusive, so that the needs of the full range of residents and different community groups and populations are recognised and addressed:

“There are a range of barriers to community engagement, need to think about who is involved in consultation and engagement, the race disparity audit has highlighted some key issues for BAME communities, there is discrimination in home ownership and crowding amongst some communities.” (National stakeholder interview)

3.10 Digital innovation

Digitally enhanced homes are developing organically with more households making use of technological innovations such as Alexa, Hive and digital lighting and alarm systems. These technologies can bring significant health benefits and there is a need for digital technologies to be part of all new housing developments.

However, some NHS and local authority planners and commissioners are nervous of what may appear to be a high cost, high risk strategy of bringing more digital innovations into people’s homes:

“There are some excellent developments for technology support in people’s homes, but these are not being developed yet at scale, commissioners are nervous of investment in digital innovation.” (National stakeholder interview)

In fact, if done right digital innovation can save money and reduce cost inefficiencies.

The Housing Learning and Improvement Network (LIN) argues that there are two elements to consider:

1. **Plumbing (capital)** – The fabric/infrastructure of the building – this is not likely to change rapidly and makes it a good value for money investment. For example Cat 6 cabling seems to have a fairly long timespan.

2. **Personalised technology (revenue)** – equipment and services personalised to the individual, for example, easy to use apps on tablets provided. This may be a device residents already own, so connectivity to an existing infrastructure is key.

(Housing LIN, 2018)

In its paper on digital housing and the preparedness of the UK housing sector to go digital, HACT set out some of the actions that need to take place to increase the movement to digitally enhanced housing:
• Digital literacy and leadership.
• Attitudes to technology-led expenditure.
• Approaches to innovation.
• Awareness of and understanding of the latest technology trends and opportunities.
• The use of data to drive business decisions and inform new and more relevant customer focused strategies.

(HACT, 2016)

Feedback from stakeholders and national evidence supports shifting resources towards more digitally enhanced homes including:

• Reframing health and housing technology as a core driver of transformation.
• Increasing understanding about the challenges involved, for example, not just improving existing systems, but taking more radical approaches to the potential of digital to transform how housing and health is structured and delivered.
• Identifying a lead technology/digital officer as part of the overarching management structure for the housing and health strategy.
• Recruiting champions from technology-savvy businesses with experience of health and housing digital applications to take lead development roles across the housing and health programme.

(See Appendix C for an example of how significant savings were made from a radical refresh of digital systems to support service transformation).

3.11 Workforce development

Stakeholders called for a much stronger focus in workforce development on the social determinants of health:

“Across clinical practice we need to focus more on public health and prevention. We can’t continue how we are, given the volume of problems with long term conditions and greater need for prevention, which means working with social determinants of health and housing is key to this.” (National stakeholder interview)

There are specific standards and guidance notes, for example the National Institute for Health and Care Excellence (NICE) have been including housing in their clinical guidance notes for some time:

“NICE have produced a number of guidance notes on working with health and housing issues, for example dementia, mental health and substance misuse. They recommend joint working and including housing in assessments and care planning to prevent relapse.” (National stakeholder interview)

NHS England have provided funding to up-skill the housing workforce on related health issues such as mental health and this kind of joint approach is valued by stakeholders:

“NHS England have training money to up skill the housing workforce on mental health issues, 60% of the young people we see have mental health problems so this is really important. If we up-skill housing workers to address the issues, identify them earlier and work with the young people it will help reduce barriers and improve health and housing outcomes.” (National stakeholder interview)

Stakeholders also identified blended learning methods, such as using case studies to highlight the issues involved in health and housing as a useful method of attracting a wider range of professions to address the issues:
“We need more shared learning examples, actively collect case studies to show local government as they appreciate this approach and it helps improve working effectively with them.” (National stakeholder interview)

3.11.1 The social determinants of health

However, there is a perception that public health and the social determinants of health are not addressed well in medical and nursing professional development and training:

“Are people talking about housing? Not from a nursing perspective. But in my role, I’ve heard a lot of discussion around wider determinations of health.” (National stakeholder interview)

“Public health is a gap within nursing curriculum. Quality of public health education is poor particularly as lecturers often don’t have interest around this.” (National stakeholder interview)

“There is a major training gap in public health and the wider determinants of health like housing.” (National stakeholder interview)

3.11.2 The primary care workforce

A qualitative study undertaken by Shelter in 2017 with 20 GPs found that:

- GPs spontaneously identified housing issues when discussing factors involved in their patients’ mental health presentations.
- Where housing was seen as the sole cause of mental health conditions, the most commonly cited conditions were anxiety and depression.
- Where patients presented with a mental health condition that was linked to problems with housing, the GPs felt they had a knowledge and support gap.

There is growing awareness of the need to engage medical staff on housing and health, but at the level of training and development this is seen as a gap and something that needs to be addressed by the accreditation bodies, including through greater variations in training placements:

“We need to have medical students engaging with the new integrated system models so that they can be part of this in their professional lives, housing and health is a good example of this new approach and what this means for medical practice in the future.” (National stakeholder interview)

“Medical students need placements that are viable and lead to improved health and social care outcomes while providing a good learning environment for the students.” (National stakeholder interview)

Accreditation bodies will need to ensure that housing and health is addressed in curricula and standards for professional training and development:

“We need to see more from the accreditation bodies for teaching and learning in health, to take more account of things like housing and how these impact on health.” (National stakeholder interview)

This needs to do more than raise awareness of the issues; it needs to address the practice and decision making of professionals at the ground:

“No point in just raising awareness of the issues, we need to equip the workforce to make changes at the ground.” (National stakeholder interview)
There is also a need to ensure that the local CCG is able to engage the primary health workforce, especially GPs in the process of developing an approach to housing and health:

“Commissioners are miles away from the front line in service delivery, they need to understand the capacity and pressures better and how to engage the medical workforce in new ways of working.” (National stakeholder interview)

This should include work with professionals, especially those GPs who are more resistant to change, to overcome the professional culture and barriers to working on housing and health as an integrated issue:

“We need strong leadership at the CCG level, but many are struggling with behaviour change amongst traditional, often older GPs and primary care teams.” (National stakeholder interview)
4. The BBI HOMES Playbook
The following sets out the building blocks for the BBI HOMES (Healthier Outcomes Making Environments Safer) Playbook (The Playbook). The Playbook draws on the learning from the local context for housing and health on the Digmaor estate, West Lancashire and evidence from national stakeholder feedback. The design is based on four building blocks, which are flexible enough to ensure they can be applied to suit local dynamics and priorities:

- Strategic alignment.
- Resident and community engagement and co-design.
- Building professional skills, competence and the right culture.
- Service integration and innovation.

The Playbook is focused on housing and health, but it should be seen as part of a broader agenda for supporting local place-based goals and integration of health and social care.

4.1 Why a Playbook?

The Playbook has become the principle product from the housing and health programme for the following reasons:

- A growing consensus that the major challenges facing public services are complex and interdependent and therefore cannot be resolved through single organisational or sectoral approaches.
- Additional resources alone cannot resolve the problems and the likelihood is that financial constraints will remain the norm and will require increasingly strong, place based coordination on a cross sector basis.
- As place based strategy becomes mainstream, there is a need to address growing tensions between the requirements of partnership working and the traditional model of public services that prioritises organisational objectives above the needs of the system.
- Further top down reform of public services is undesirable and unlikely and The Playbook represents a bridge between traditional professional and organisational delivery of public services and approaches to place based change and transformation.

A playbook is essentially a means for identifying how different stakeholders can have a range of strategies for achieving particular goals and that these are not always commensurate with each other. A playbook provides a means for achieving consensus about the dominant strategy or ‘play’ that is most likely to bring the highest level of benefits for all the relevant stakeholders. This includes eliminating or providing mitigation against those strategies and action plans that run counter to the desired objective.

Playbooks can be especially useful when the goal in question requires close co-operation between a range of individuals or separate organisations.

The Playbook recognises that the starting points, motives, incentives and disincentives will vary between stakeholders and that these need to be explicitly addressed as part of the process.

The idea of The Playbook is not to produce a blueprint or to be prescriptive. The Playbook guides system leaders by helping them to define a vision or dominant strategy for all stakeholders no matter what the wider external or internal organisational factors may be. Within the health arena there are examples of some playbooks, for example:

- the World Health Organisation (WHO) has a playbook for Tobacco control (WHO, 2018);
• NHS England has developed a system-wide Data and Cyber Security Operations Playbook to manage incidents (Department of Health and Social care, 2018b); and

• the American Public Health Association have developed a playbook for environmental health that includes issues related to health and housing (American Association for Public Health, 2017).

However, there is not a specific playbook for system leaders and practitioners that can be used within local contexts for housing and health. The BBI HOMES Playbook seeks to fill that gap.

4.1 Aims

The aims of The Playbook are:

• To achieve consensus across system leaders for a dominant strategy on housing and health, based on evidence for how investment into a place-based approach for housing and health improves service user outcomes and provides better long-term value.

• To engage residents and the community and voluntary sector in co-design of the health, housing and care pathways that will deliver the strategy.

• To build professional skills, competence and the right culture to deliver the strategy for housing and health by identifying the critical expertise and learning models that are required and how these can best be deployed in the local context.

• To develop an integrated service response for housing and health that provides assurance that resources are being directed at the right priorities and that growth can be accelerated through new facilities and programmes that get running quickly and effectively.

4.2 The building blocks for local action

The Playbook uses four building blocks for local action:

1. Strategic alignment.
2. Resident and community engagement and co-design.
3. Building professional skills, competence and the right culture.
4. Service integration and innovation.

4.2.1 Strategic alignment

The primary function of the first building block is to increase understanding about the local evidence base for housing and health, which can be used to gain consensus amongst system leaders for alignment of a dominant strategy to address the issues. The consensus must meet the objectives of system leaders in a mutually beneficial way whilst being applicable and relevant for delivery in their respective organisations. The Playbook is not about creating new strategy, but finding the optimum means by which existing strategies and resource allocations can be aligned and harnessed in furthering an integrated and collaborative approach to housing and health. In order to do this it is first necessary to map the local evidence base.

Shared strategy is most effective when it is evidenced based as opposed to ideological. However, in the context of housing and health the evidence base can appear problematic, as it is spread across a variety of siloed data and intelligence systems that have little interoperability.

There are also challenges to the causal nature of evidence on housing and health, for example whether people with pre-existing conditions and poorer health tend to live in areas that are already characterised by poor housing. These challenges
need to be confronted at the outset by bringing together the full range of evidence on housing and health, including:

- Health activity and outcomes data from Hospital Episode Statistics (HES), Quality Outcomes Framework (QOF) data etc.
- Local authority housing statistics and condition reports on hazards Housing Health and Safety Rating System (HHSRS) etc.
- Joint Strategic Needs Assessment (JSNA)
- ONS data on population demographics
- BRE housing health cost calculator
- Health and Wellbeing surveys and local studies

The evidence mapping should take the form of a rapid appraisal; it is not about new research to establish causal links. The purpose is to provide a rich picture or dashboard of how current resources for housing and health are distributed and managed and what specific outcomes can be attributed to this. Some actions that will support this include:

- Establish a data sharing protocol across the relevant data and intelligence systems owners.
- Agree the data and intelligence parameters, for example, timeframes, demographic cohorts, geographical distribution etc.
- Consider the scope and application of digital innovation to support greater interoperability across the relevant data systems (this may be significant at a later stage in terms of monitoring and evaluation).
- Use of narrative methods to gather case studies can strengthen the service user voice and provide a strong means of describing outcomes from the experience of the user.

There are various ways by which the data and intelligence can be reported. As the primary intention is for this to form the bedrock of consensus development, it should be presented in the form of an accessible report that draws out the main impacts. It will also be useful for system leaders to understand the limitations in the data and intelligence and what gaps exist.

**The dominant strategy**

While some significant steps have been taken across the country to develop integrated care systems, these have not tended to encompass housing and health. It therefore remains the case that for many areas the local strategic context for housing and health remains disparate and in some instances conflicting.

It is a complex task to achieve strategic alignment for housing and health, and the objective may itself act as a deterrent to system leaders who are already facing multiple, complex challenges. Inclusion of specific objectives for housing and health within Integrated Care Systems (ICS) and Integrated Care Partnerships (ICP) and/or Health and Wellbeing Boards will help overcome this resistance.

Housing and health encompass a complex range of circumstances, health conditions, demographic groups and consequently an equally complex variety of strategies to address these across commissioning, planning and development, standards and regulations and services and professional practices.

Some of these strategies may be ‘go it alone’ for example a local authority may have a strategy to address housing deficiencies and repairs in private sector rented housing. Some may be joint between different agencies; for example, as part of a hospital strategy to address delayed transfers of care there may be a joint strategy between the hospital Trust and the adult care directorate of the local authority.
There may also be strategies at higher levels for example through the Health and Wellbeing Boards and/or the Sustainability and Transformation Partnership and/or the Integrated Care Partnership to address the social determinants of health, which may include housing. Related strategies to further health and social care integration for CCGs and the establishment of Accountable Care Organisations may also be relevant, even if they do not directly address housing.

A strategic review needs to be undertaken to address all of the possible strategies that are in scope and the degree to which these are supportive or possibly running counter to an integrated approach to housing and health. The objective of the review is to identify the dominant strategy and how this can be better leveraged to encompass housing and health. This should include an assessment of whether or not related strategies need to be mitigated or adapted so that they do not run counter to the primary strategic goals.

Identifying and agreeing the dominant strategy has the advantage of providing a formal mechanism by which local system leaders sign up to a shared commitment for action, while also providing a means by which the range of related strategies that influence housing and health can be brought within a clear framework.

It is important to achieve consensus amongst the prime system leaders on the dominant strategy at the outset, because there is little chance of it being formally adopted if it does not meet their business imperatives and governance priorities. The strategy should also take full account of the evidence mapping that has been undertaken and ensure that there is a clear and direct link between strategic objectives and the local evidence base.

As the review produces a clear picture of the full strategic context and identifies the dominant strategy it is possible to use this as the basis for engagement.

### 4.2.2 Resident and community engagement and co-design

If the first building block is about local evidence and getting system leaders to agree a dominant strategy and framework for collaboration, then the resident and community engagement is about ensuring the way forward reflects residents’ needs and aspirations.

Local residents are the intended beneficiaries of the integrated approach to housing and health and their voices and experiences need to shape the programmes and services that become the centre piece of development. There is a strong policy and legislative context to this approach:


- **Community engagement: improving health and wellbeing and reducing health inequalities** (NICE, 2016) – ensures local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives.

- **National Planning Policy Framework 2018** (Ministry of Housing, Communities and Local Government, 2018b) – states that local plans should have proportionate and effective engagement between plan-makers and communities.

- **Tenant Involvement and Empowerment Standard** (Homes and Communities Agency, now Homes England, 2017) - registered providers shall support their tenants to develop and implement opportunities for involvement and empowerment.
• Public Services (Social Value Act) 2012 (HM Government, 2012) - requires a plan of community engagement activities and social value contribution of engaging with communities.

• Localism Act 2011 (HM Government, 2011) - contains a wide range of measures to devolve more powers to councils and neighbourhoods and give local communities greater control over local decisions like housing and planning.

• Equality Act 2010 (HM Government, 2010b) - Places a Public Sector Equality Duty on public authorities that means they have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services.

The local evidence mapping and subsequent strategic alignment with the dominant strategy will have highlighted ways in which these duties are being fulfilled, or not, with respect to housing and health. This will inform the approach to engagement and enable existing structures and processes to be adapted. It will also be important to have a means by which gaps in engagement with different community groups and residents are identified and addressed.

**Principles for co-design**

Residents and the community and voluntary sector need to be brought into the process of co-design of the types of service responses and outcomes that they would like to see delivered under the strategy for housing and health. This should be undertaken on the basis of neighbourhood localities for different care groups.

There are a host of models for different forms of co-design and no single one holds all the answers to how to do this in the most effective way. The following sets out some common principles that should guide the approach to co-design for housing and health:

• **Inclusion** – residents are not homogenous groups and there is a need to actively take steps to ensure inclusion of those individuals and groups who are least seldom heard and who may face particular barriers to inclusion. For example, disabled people and other groups with protected characteristics\(^2\) and other vulnerable groups such as those at risk of being homeless.

• **Resourcing and facilitation** – co-design is not a cheap option and it is not something that can be done on an ad hoc cost free basis, as this risks it being tokenistic and less effective. System leaders need to ensure that there are adequate resources for co-design and that the process is facilitated effectively. Involvement of local community and voluntary sector agencies in facilitation can greatly strengthen the process.

• **Assets and capacity building** – co-design should be an active process and not simply about consultation. This is best achieved when there is an explicit aim to use the process of co-design as a means to build residents’ and community assets. In this way the capacity of local people to be meaningfully engaged in co-design is greatly increased.

• **Empowerment** – residents should not be passive participants in the process. Their contribution to developing the approach to housing and health is essential and by ensuring the voices and experiences of residents are a central part of the process, the overall strategy and development of services will be stronger and more effective.

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\(^2\) Protected characteristics are the nine groups protected under the Equality Act 2010. They are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.
• **Sustainability** – co-design should not be undertaken as a one-off exercise, but needs to be planned on a sustainable basis. People’s needs and experiences change over time and co-design needs to be part of an ongoing process to capture these changes and enable an organic process of intelligence and feedback over the longer term.

The diagram below shows how the principles can be used, alongside various actions to create a robust engagement programme for housing and health:
Building trust and awareness between system leaders and residents and communities is important for housing and health, given the common legacy of poor engagement and involvement in housing developments and planning.

The process of engagement not only raises awareness amongst residents about the evidence base and strategy for housing and health, it informs system leaders about the needs and aspirations of local people.

The process is also designed to build on community strengths and assets, which can be harnessed throughout the programme of development as a valuable resource.

4.2.3 Professional skills, competence and culture

Equally important to engaging with residents and communities is the need to engage with professionals and practitioners from across the housing and health fields. However, professionals and practitioners in housing and health come from a variety of professional backgrounds, each with its own skill sets, competencies and culture and these differences are not always well understood. Professional cultures can also act against integration when these are too restrictive or narrowly defined. For example, health professionals may not feel skilled or competent in determining the role of housing and the environment in health conditions and equally, housing practitioners may not feel it is their role to advise on health and care options.

This is often most apparent in conflicts between the medical and social models for health and wellbeing. The reality, despite increasing moves towards integrated health and social care systems, is that the health service is still largely configured on the basis of illness and conditions. The professional culture behind this is one that is focused on treating symptoms rather than the underlying causes, which are very often related to social factors like housing. Creating the right culture for housing and health requires a new approach to core competencies and skills that puts cross professional collaboration and development at the centre of learning and training pathways.

Place-based professional practice

There is a need for workforce development that is based on place and the social determinants of health. This is challenging as most workforce development is based on professional lines and can be quite siloed. Therefore, there is a need for various strands to this that can start to generate momentum and create the right culture for change.

Some professional bodies have started to recognise the importance of place, including the social determinants of health, in curricula and standards. For example the Royal College of Nursing (RCN) stated in 2012:

“Nurses are able to view individuals’ needs and circumstances holistically, to understand the full package of support and care required, often by working closely with other agencies outside of the NHS to help address the underlying causes of illness.” (RCN, 2012).

However, in its survey on nursing involvement in public health in 2016, the RCN found that nursing involvement in housing and homelessness was the least common, less than 25% (RCN, 2016).

In May 2015 the Royal College of General Practitioners (RCGP) published a policy paper on health inequalities detailing the College’s position on the role of the GP in addressing health inequalities. Amongst several actions recommended in the paper, the RCGP call for the creation of:
“...a supportive environment for GPs and their teams to take a more proactive population based approach to preventing ill health in their communities, working with other professionals to tackle the underlying causes of health inequalities.” (RCGP, 2015)

However, in addition to calling for additional resources and capacity to support this, the RCGP also states that GPs and other professionals must lead it from the bottom-up rather than through imposing top-down interventions.

Professional bodies and training providers need to work with local areas on developing professional practice for housing and health. Health Education England (HEE) are seeking to support this approach through a national pilot programme for place based professional development and practice. The pilot programme has five objectives:

• to understand how a place-based model can address supporting areas of greatest need and use tariff as a way to mitigate against impact of market;
• to understand how placement budgets can be ‘flexed’ to respond to levels of placement activity, market behaviour and student flows;
• to identify the barriers, risks and issues to implementing place-based placement funding model and how these maybe overcome;
• to understand what type of collaboration and joint working approaches are required to inform place-based placement commissioning decisions locally;
• to define the ‘unit’ for place and the criteria that should be used to inform HEE’s definition of ‘place-based’ (HEE, 2018).

Learning from the HEE programme can be used to support local areas as they develop professional practice models for housing and health. In particular, it will be important to think through the implications of this for workforce development and training placements.

However, there is also a need to think through the parallel implications for the social care and housing workforce and how an integrated approach to training and development can be developed as part of the overall programme for housing and health.

This will need to be done for the specific local area context but will require existing joint workforce forums and planning mechanisms for health and social care. This should include additional practitioners from within the housing sector.

Skills ladders, competency based training and the Apprenticeship Levy

There is a need to support the local care and housing workforce through the development of skills ladders and competency based training. Competency based learning (CBL) is an approach to life-long learning that focuses on specific competencies rather than time spent in class rooms or on pre-defined courses. It uses a range of learning techniques and assessments that enable students to build up credits as they progress through a skills ladder that recognises when students have achieved a particular competency (Patel et al., 2015).

This will require work with local Further and Higher Education providers to increase the entry points at which people come into the care and housing workforce and then how they are supported to develop their skills and competences as part of their career development. In this way the programme of work for housing and health can contribute to wider local area skills shortages and capacity.

One of the ways to address this could be use of the Apprenticeship Levy to develop a cohort of workers across the care and housing systems that can work on the basis of an integrated approach to housing and health. By combining components of the Levy across NHS providers, the local authority and industry these funds can be used to support workforce development for the housing and health programme. When combined with competency based learning this will have the advantages of:
- addressing shortfalls in the care workforce by creating incentives and longer term career prospects;
- attracting people back into the care market who may have left due to the lack of opportunities;
- providing recognition of prior accredited and non-accredited learning;
- improving confidence amongst employers that people have an appropriate skill set and competence to work across housing and care;
- being more attractive to a wider range of adult learners and increasing the diversity of the local workforce including women, disabled people and Black and Minority Ethnic workers.

Local training providers will need to be engaged in developing core competencies for housing and health, but this could be undertaken as part of a broader programme of skills and competency development for addressing health inequalities, public health and the social determinants of health. Learning from the Royal Society for Public Health (RSPH) Champions programme could help with this. For example, the programme is designed to build capacity of community health champions, helping them to encourage others to adopt healthier lifestyles via peer led behaviour change. RSPH Website: https://www.rsph.org.uk/event/community-health-champions.html

### 4.2.4 Service Integration and Innovation

The final building block, which is dependent on the previous three building blocks, is to create service integration and innovation. There are various elements that go towards creating service integration for housing and health and these will differ according to the local area priorities and strategy.

There may also be different approaches and structures depending on the target care group, for example elderly people, children and young families, disabled people and for those with poor mental health. It is beyond the scope of The Playbook to set out the criteria for each of these as this will be developed locally, but the following components will be common to each.

**Streamlined referral and care pathways**

Health incidents arising from conditions in housing and the environment often lead to multiple referrals across a range of care pathways. This can involve duplication and waste in terms of repeat assessments and also delays in access as some referral pathways involve long waiting times that can have subsequent impacts for increasing risk and exacerbating problems. One of the biggest causes of delays and repeat procedures is where a combination of health, care and housing support interventions are required.

Streamlining the referral and care pathways leads to speedier responses and interventions with less waste and improved service user access, experience and outcomes. Ways in which this can be achieved include:
- Establishing a common assessment framework for health, care and housing.
- Shared protocols for triage at key entry points including primary care, accident and emergency and non-elective admissions to hospital.
- Care pathway mapping – this can help identify where repeat processes and procedures exist and establishing joint access criteria across different care and health professionals.

**Multifactorial assessments**

Multifactorial assessments are commonly recommended as part of best practice for the assessment of falls (NICE, 2015). The aim of these
assessments is to think beyond the immediate presentation of the health condition and to identify the full range of factors, health, social and environmental that may be significant for treating the problem and in preventing recurrence. For example, a multifactorial assessment for a fall would include:

- strength and balance training;
- home hazard assessment and intervention;
- vision assessment and referral;
- medication review with modification or withdrawal.

Care pathway mapping may be required to determine the optimum points of entry for a variety of conditions that are likely to be impacted by both housing and health, for example:

- respiratory diseases;
- depression;
- frequent cold and flu like symptoms, especially in children and the elderly;
- falls in the home;
- poisoning and exposure to gas or chemicals.

**Single points of contact**

Alongside streamlined referral pathways and to support the use of common assessments it is helpful to establish single points of contact for key conditions related to housing and health. An example of this includes having social workers and/or housing support workers based in Accident and Emergency departments. Similar approaches have been undertaken within urgent care teams to prevent delayed transfer of care from hospital.

Single points of contact can be particularly useful for complex cases, for example, poor mental health, where the person may be having many contacts with a multi-disciplinary team and there are a variety of related factors influencing recovery such as the state and condition of the person’s housing.

A single point of contact is not a catchall service; it is about ensuring that there are clear lines of communication between the service user and the multi-disciplinary team and that risk assessments are coordinated. The advantages of creating single points of access include:

- Rationalisation of resources so that these are targeted at the identified priorities (based on both the evidence and resident, service user and community needs).
- Increased ability and capacity to scale up interventions and move from individually focused care pathways to a population based model.
- Enhanced functioning of the multi-disciplinary team and co-ordination of care and interventions.
- Improved service user access, experience and outcomes.

**Supportive digital technologies**

Integrated service provision can be greatly enhanced through the development and use of supportive digital technologies. These are being increasingly used in the care of elderly people, for example home alarms and movement trackers.

Advances in technologies for telemedicine are also increasingly being used to support the multi-disciplinary team process and enabling a range of professionals to have input to urgent case reviews.
Digital health and care applications are being developed that can be very helpful for the elderly and people with poor mental health who may be isolated in their homes. There is scope to combine these applications with local neighbourhood support networks.

Housing providers are increasingly using Customer Relationship Management (CRM) systems to provide detailed information about tenants, including rent transactions, complaints and repairs information. As these systems develop they will be able to help identify tenants at risk of health problems using key indicators such as rental arrears, housing hazards and complaints about antisocial behaviours. NHS commissioners and local authorities working closely with housing providers can develop early warning systems and improve the ability and capacity to intervene earlier when problems are identified.

Recent announcements by the Secretary of State for Health on digital transformation in the NHS provide an opportunity to develop the approach to housing and health. For example, the NHS Test Beds programme could provide a useful framework for development of specific digital innovations for housing and health.

**Public estates transformation**

Estates transformation is one of the levers by which system leaders can generate capital receipts to support housing development. This has primarily been thought of in terms of making key worker accommodation available for the health care workforce. The release of hospital estates for the provision of key worker housing would benefit the increased availability of affordable housing but could also help address shortages in the care workforce.

However, the broader rationalisation and efficiency drivers behind estates transformation, such as those highlighted by the Naylor Review can support a wider programme approach to housing and health. This could include the hospital of the future programme and development of step-up or step-down accommodation to alleviate pressures and demand on actuate care beds that are linked to poor housing conditions.
4.3 Developing the process – milestones and timeframes

The developmental process for The Playbook may differ from area to area according to local circumstances and contexts. The following is intended to provide a guide and to indicate the kinds of milestones and timeframes that might be involved. This is described through three stages over an indicative timeline of 6 to 12 months, though service transformations may require a longer timeframe to deliver impacts and outcomes at scale and could also require formal evaluation.
## Stage one

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<tr>
<th>Actions</th>
<th>Milestones</th>
<th>Timeframe</th>
<th>Building block</th>
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</thead>
<tbody>
<tr>
<td>Identify the main system leaders for housing and health, for example CCG and local authority leaders and agree sign up to The Playbook.</td>
<td>Sign-up to Playbook agreed, resources confirmed.</td>
<td>Pre project initiation (1-3 weeks)</td>
<td>Strategic alignment.</td>
</tr>
<tr>
<td>Map the local evidence base for health conditions and outcomes related to housing and the environment, including the allocation and distribution of resources:</td>
<td>Rich picture and dashboard for local evidence base including gap assessment and appraisal of interoperability of data systems.</td>
<td>Months 1-3</td>
<td>Strategic alignment.</td>
</tr>
<tr>
<td>• Identify gaps and limitations in the available data.</td>
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<tr>
<td>• Use the BRE Health and Housing cost calculator to assess the local costs for housing and health.</td>
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<tr>
<td>• Use narrative methods and case studies to describe the service user journey.</td>
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<tr>
<td>Review the range of related strategies that are relevant to housing and health and assess the degree to which these support or may act against the dominant strategic commitment:</td>
<td>Evidenced based commitment to health and housing within the dominant strategy for health and social care integration, for example this may sit with the Health and Wellbeing Board or as part of the ICS/ICP/STP process.</td>
<td>Months 1-3</td>
<td>Strategic alignment.</td>
</tr>
<tr>
<td>• Determine the strategic fit across the different strategies for health and social care and what mitigation may be required to support the commitment for housing and health in the dominant strategy.</td>
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### Milestones

- Sign-up to Playbook agreed, resources confirmed.
- Rich picture and dashboard for local evidence base including gap assessment and appraisal of interoperability of data systems.
- Evidenced based commitment to health and housing within the dominant strategy for health and social care integration, for example this may sit with the Health and Wellbeing Board or as part of the ICS/ICP/STP process.

### Timeframe

- Pre project initiation (1-3 weeks)
- Months 1-3
### Stage two

<table>
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| Review the current duties and obligations for resident and community engagement and where existing projects and programmes can be used for housing and health. Where existing groups and forums exist that fit the purpose these may be the best starting point, but this should meet the principle of inclusion:  
  • Determine the resource commitment that will be made for co-design. This may include both financial commitments and personnel to lead and facilitate the process.  
  • Identify community and voluntary sector partners to co-facilitate and lead the process. | Performance dashboard on duties to engage and involve – resources identified for tailored approach to housing and health. | Month 4   | Resident and community engagement and co-design.    |
| Define the localities and care groups that will be the focus for co-design work with residents. This may be undertaken on a rolling basis, for example starting with one locality and then developing this out to other areas as the housing and health programme matures. | Engagement is in line with priorities and goals in strategy. | Month 4   | Resident and community engagement and co-design.    |
| Recruit participants from a range of care groups from the resident cohorts in the chosen locality. | Engagement is inclusive or all relevant groups. | Months 4-6 | Resident and community engagement and co-design.    |
| Ensure that the system leaders are personally involved in the process of engagement. | Parameters within which the resident and community and voluntary sector participants can operate clearly defined. | Month 4   | Resident and community engagement and co-design.    |
Stage two continued

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<tr>
<td>Establish a workforce review team for housing and health that encompasses medical, nursing, social care and housing workforce.</td>
<td>All relevant stakeholders signed up to programme.</td>
<td>Month 1</td>
<td>Building professional skills, competence and the right culture.</td>
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<tr>
<td>Review learning pathways for the care and housing workforce: Review how competency based training models can support recruitment and retention.</td>
<td>Learning pathways identified including appraisal of competency based models.</td>
<td>Months 4-5</td>
<td>Building professional skills, competence and the right culture.</td>
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<tr>
<td>Review the local workforce training placement options.</td>
<td>Learning placement options enhanced for housing and health.</td>
<td>Months 4-5</td>
<td>Building professional skills, competence and the right culture.</td>
</tr>
<tr>
<td>Working with FE and HE partners and professional bodies and other training providers identify the core competencies and skills for housing and health.</td>
<td>Core competencies developed.</td>
<td>Months 4-6</td>
<td>Building professional skills, competence and the right culture.</td>
</tr>
<tr>
<td>Work with HEE on developing learning from the place based pilot programme and how this can inform the local programme for housing and health.</td>
<td>Place based learning pathways applied to housing and health.</td>
<td>Months 4-6</td>
<td>Building professional skills, competence and the right culture.</td>
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<tr>
<td>Establish cross professional learning and development networks for housing and health.</td>
<td>Workforce collaboration strengthened.</td>
<td>Months 4-6</td>
<td>Building professional skills, competence and the right culture.</td>
</tr>
<tr>
<td>Resident and community engagement workshops.</td>
<td>Co-design of options for service development.</td>
<td>Months 4-6</td>
<td>Building professional skills, competence and the right culture.</td>
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### Stage three

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| Review current referral and care pathways for housing and health with a view to streamlining these so that waste and duplication is eliminated and the service user access, experience and outcomes are enhanced:  
  • Use the co-design work with residents, service users and communities to shape the service response for housing and health.  
  • Ensure multifactorial assessments are being used across all of the conditions related to housing and health.  
  • Establish single points of contact and care-coordination.                                                                                                                                          | Pathways for housing and health care and support are integrated.                            | Months 6-12       | Service integration and innovation.                  |
| Work with a digital innovation partner to develop digital technologies for the home. Consider digital applications in all new social housing developments.                                                  | Plans for technologically enhanced homes developed.                                          | Months 6-12       | Service integration and innovation.                  |
| Leverage public estates transformation plans to provide additional capital funds for housing and health developments. Use of key worker homes to support recruitment and retention of the care and housing workforce. | Additional capital receipts for housing and health realised.                                 | Months 6-12       | Service integration and innovation.                  |
| Programme outputs used to inform local area spatial planning and implications for housing and health.                                                                                                  | Fully integrated approach relevant planning systems.                                        | Months 6-12       | Service integration and innovation.                  |
5. Conclusion and recommendations
There is increasing awareness amongst health commissioners, government and in local authorities that housing and the environments in which people live have profound impacts on health and wellbeing. This is not a new insight by any means; however, many areas have struggled to make housing and health part of the shift towards an integrated health and social care system.

The report demonstrates the imperatives for an integrated approach through the learning from exploration of housing and health in the Digmoor estate in West Lancashire and from national stakeholder feedback. In particular there is a need for:

• development of the local evidence base that can be used to achieve consensus amongst health commissioners and local authorities that they need to collaborate on aligning the strategy for housing on health;
• rationalisation and pooling of resources for housing and health that makes maximum use of existing resources and ensures these are directed at the right priorities;
• meaningful engagement with residents and communities including co-design of options for service changes to better meet needs;
• support for the community and voluntary sector to strengthen local community assets building and ensure that resident voices inform developments;
• workforce development on a cross professional basis that helps to create the right culture for collaborative practice and makes place and addressing the social determinants of health such as housing part of core skills and competencies;
• integrated service responses for housing and health that streamline care and support pathways, reduce waste and duplication and improve service user access, experience and outcomes.

The BBI HOMES Playbook seeks to address the above by providing a flexible template for programme development based on the four building blocks:

• Strategic alignment.
• Resident and community engagement and co-design.
• Building professional skills, competence and the right culture.
• Service integration and innovation.

Over the coming year BBI will be working with a range of local partners and national agencies to develop The Playbook further through a series of pilot programmes. Learning from these pilots will be used to support other areas that are seeking to make housing and health part of their move towards an integrated health and social care system.
5.1 Recommendations

The recommendations are designed to address some of the system barriers that prevent greater collaboration and integration on housing and health. These are based on the evidence in the report and seek to influence some of the current and pending policy and legislative landscape at national levels and to support local area plans for Integrated Care Partnerships.

NHS England are currently designing a ten year plan for the NHS and the Department for Health and Social Care is due to publish the Green Paper on Adult Social Care this year and a further Green Paper on Prevention in 2019. These national developments provide a concrete opportunity to make integration of health and social care a reality, in particular ensuring that housing and health are central to the policy and planning frameworks for health and wellbeing of the population.

The shortfall in housing supply will continue to occupy a prominent place in government strategy, but this must be matched with an equal commitment to bring existing housing stock up to standards. The growth of Healthy New Towns and Garden Cities is to be welcomed, but learning from these developments needs to be applied in spatial planning and place making strategies at local levels. Action is needed to prevent a growing divide between those who can benefit from new housing developments and those who have to continue to live in areas that are marked by inadequate and poor quality housing.

1. National planning guidance should make clear that Integrated Care Partnerships have a clear remit for housing and health, as part of a collaborative approach with local authorities for addressing the social determinants of health.

2. Local authorities and CCGs should have a duty to publish data on the costs of housing and health for local areas alongside a joint action plan to address poor health and social care outcomes that are associated with housing.

3. Programmes to support digital innovation in the NHS should include projects to develop technologically enabled housing that promote independence and support people to stay longer in their own homes.

4. Residents and local communities should have a statutory right to live in a safe environment that promotes health and wellbeing.

5. Steps should be taken to ensure that NHS commissioners and local authorities could work collaboratively to access the full benefit of the Apprenticeship Levy for integration of health and social care.
Overcoming the constraints to transformational change is not something that can be done by any single organisation acting on its own. It requires collaboration between the NHS, local authorities and the private sector, including care home providers, the construction industry and support service companies. This collaborative approach must also be clearly focused on rehabilitation, as part of a systemic solution to addressing patient flow that is able to encompass all of the potential and actual blocks in the care pathway. This should include:

- Shared management and Administration – based on collaboration across systems and organisational boundaries.
- Joined up health and social care delivery – including shared care protocols for admission and discharge planning.
- Home Installation Services – able to quickly assess and address practical equipment and installation issues that may prevent a home discharge.
- The establishment of permanent and temporary step-down facilities with appropriate support services – combining estate and facilities management to ensure a flexible mixed provision that can be scaled up or down as required.
- Funding Management – a single funding mechanism that is able address the dis-incentives to provision of appropriate services.
- Maximising the potential use of digital technology – greater innovation and use of digital technologies to support earlier discharge and remote home-based patient monitoring.

Sodexo Health UK have developed a model for a rehabilitation support pathway that can meet the above criteria (Holley et al, 2017).

Appendix A:
A collaborative care solution to managing patient flow

The Sodexo Rehabilitation Solution Model
The core attributes of the Sodexo model include:

- A fully maintained turnkey solution.
- All facilities management.
- A complete clinical care solution including a modular ward model with registration and qualified staff.
- Rapid response/development – can be mobilised and operational within months of order.
- Choice of modular wards units in multiples of 30/28 beds
- HTM compliant.
- Costed on a bed day price with additional flexibility for temporary hire charges.

The model allows for a managed patient flow solution for discharge from acute and emergency care.

Patient Flow for Discharge from Acute
Sodexo would maintain registration of the units through its clinical arm – Nursing Prestige + Care. During the mobilisation period Sodexo would link with Trust clinical divisions to agree local operating procedures (LOP’s) and governance requirements. Operational and clinical governance of patients will have to be clearly defined and agreed between parties prior to operational commencement. This will include:

- Applying the management and administration capability of Sodexo to enable a unified patient pathway from discharge to the establishment of care and support services outside of the acute environment, either through residence at home or in a care home.
- Provision of care services by either the Local Authority or by Sodexo with appropriate funding.
- Liaison, records management, and funding from the Acute Trust (discharge), through to the Local Authority.

Appendix A: A collaborative care solution to managing patient flow
Authority for social care, home installation and related services including as appropriate, the involvement of the voluntary sector.

- Home Installation Services provided directly by Sodexo as part of its Hard Services operation and funded accordingly.

Once installed at Trust locations, Sodexo would service, operate and maintain the modular wards, including the clinical management of the Rehabilitation inpatient beds, providing Occupational Therapists and support to discharge. Although these units will be on Trust land, they will be managed and operate as a non-acute zone into which patients are discharged.

Furthermore this turnkey solution could be used by Trusts for operational decant of wards to carry out backlog maintenance or other operational requirements.
The STRIDE joint venture has been established to deliver strategic estates services, with the aim of achieving maximum efficiency in the way the Trust operates and in how it uses its sizeable physical estate, in line with the Trust’s clinical priorities for patient care, and reflecting its strategic plan for the future.

STRIDE, through its Property Development Partner, Community Solutions (a subsidiary of Morgan Sindall Investments) proposed alternative uses for the Trust surplus land (Outwoods) and developed the concept of a Health Village. This would complement the services provided on the Queens Hospital site as an alternative to the site being disposed of in the open market. Community Solutions also proposed an innovative property development structure to minimize the risk to the Trust whilst enabling them to equally share in any profit after the development reaches practical completion. In addition the Trust receives market value for the land. The Trust consider the development will also support the delivery of the following benefits:

- Help to prevent unnecessary permanent admission to residential care.
- Help to prevent unnecessary admission to hospital.
- Facilitate alternative discharge from hospital and contribute to managing delays in discharge from the acute or community hospitals.
- Support the safe and full reDintegration into the Service Users home and local community.
- Assist Service Users’ in setting and achieving their planned goals, placing the emphasis on the Service User’s needs.
- Support Service Users to regain and maintain daily living skills.
- Support for carers.
- Help with system wide support plans.
- Providing continued support into a person’s own home.
- Providing alternative housing provision where necessary.
- Provide the opportunity of integrating Primary and Community Care at scale.

Outline Planning was submitted by STRIDE in January 2018. The development is scheduled to provide GP and community services for about 20,000 patients as well as:

- 80 extra care residences;
- 40 Care Home Beds
- a step-down facility to mitigate delayed discharges;
- 88 bed doctors and nurses accommodation; and
- a 100 plus place nursery
The Health Village will also benefit from the inclusion of a community hub that will support greater integration between the different users and the local community.

“We have long recognised the need to ensure services in the community, including GP services, are better integrated into the services we provide at Queens. The Outwoods development proposed, in lieu of a standard housing development, enables a greater focus for the community in providing more seamless care. We are also conscious, as outlined in the Naylor Review published earlier in the year, that the NHS has to make better use of its surplus land and we are delighted that our partners in STRIDE have put forward this exciting development.” (Helen Scott-South Chief Executive Officer, Burton Hospitals NHS Foundation Trust)

The proposed Health Village will consist of:

- **88** Doctors and nurses residences
- **55** Stepdown beds
- **80** Extra care residencies
- **40** Care home beds
- **20,000** Community Primary Care Pts
- **100+** Children’s nursery places
Appendix C: Helping residents help themselves: Agilisys enables Community Solutions for the London Borough of Barking and Dagenham

Agilisys brought to life the London Borough of Barking and Dagenham’s bold vision for faster and more effective community services, while driving multimillion-pound savings.

The Challenge: A new vision for community services
Facing significant social and financial hurdles, the London Borough of Barking and Dagenham (LBBD) knew that a radical rethink was needed to improve its services. The challenge was to look after the well-being of residents more effectively, while also helping to achieve a tough savings target.

To meet these goals, LBBD needed to overturn its existing ‘siloed’ culture, where individual services were provided in isolation and opportunities to address wider challenges in residents’ lives could be missed. By identifying and addressing the root causes of issues earlier, the council could better prevent future problems, diminishing the need for later costly intervention and reducing pressure on acute services like housing and social care.

LBBD also wanted to transform service delivery models to respond more strategically to challenges across the borough, such as improving job skills, employment and well-being. With services provided at more than 30 locations, the use of council property needed to be rationalised to give residents faster and more effective access to information, advice and support.

To enable a coordinated approach to residents’ challenges, a significant technology refresh was required. LBBD’s existing services relied on outdated IT and inefficient manual processes that could not support a more strategic approach to service delivery. Staff needed a single, combined view of resident information to work more effectively and make better use of council assets.

To conquer these challenges, LBBD committed to a bold five-year transformation programme. At the heart of this strategy, a new Community Solutions service was envisioned to identify and resolve the root cause of individual or family problems earlier and forge a new deal for residents.

The Solution: Collaboration from conception to completion
Agilisys supported LBBD to make Community Solutions a reality.

Exploration
We worked closely with LBBD and partners to understand the requirements for change and undertook in-depth research and evaluation of the options available. A clear business case was created for LBBD’s approval, outlining the service rationale, as well as the implementation plan.
Design and service creation
We then developed a target operating model and service design that would enable LBBD to achieve its objectives. Crucial to this process was understanding the council’s current position - for instance, mapping LBBD’s existing IT systems, processes and established ways of working.

We then worked with the council to look ahead: facilitating and supporting them to outline the best working processes for the future, the ideal technology stack and organisational structure, as well as how to handle the transition seamlessly.

Delivery
The new Community Solutions service was ultimately delivered in two phases: a provisional trial in April 2017, followed by a full launch in October 2017 and the completion of service-wide restructuring in April 2018. We provided robust collaboration and support throughout this process - advising senior management, developing guidance and training materials, transforming LBBD’s internal culture, testing new ways of working, and capitalising on any and all opportunities for improvement as they arose. Notably, this included developing and securing approval for both new business procedures and the rules governing new ways of working.

We also provided the expertise to support cultural change - enabling the successful transition to a radically new set of job roles, behaviours and values, as well as developing a forward-looking roadmap.

Critically, we ensured that LBBD faced no ‘knowledge gap’ after the service handover in March 2018 – providing council staff with all the methods, tools and learnings needed to oversee the Community Solutions service effectively.

The Impact: A new deal for residents
Today, the Community Solutions service is already on course to create savings of £4.6m by 2020/21. LBBD staff now have the systems and information they need to make early and effective decisions. Data and insight is leading to an increasingly evidence-led service. LBBD is better targeting the borough’s resources through capabilities like the predictive modelling of housing demand, the creation of a single view of debt and greater visibility into the most high-risk households. With easier access to high-quality advice, guidance and information now established via a new online portal, residents are able to be more self-sufficient, resilient and independent. Mediated support - provided by volunteers in community locations as well as frontline council staff - is also available for those who most need additional assistance.

Community Solutions is already providing early evidence of reducing pressure on the most expensive council services by reducing placements into temporary accommodation, helping more people into jobs and reducing the need for complex, late- stage interventions by limiting referrals into social care. LBBD’s ‘silied’ working culture is also being transformed.
Staff are embracing new working practices based on a holistic understanding of residents and much closer collaboration with the community and voluntary sector, further strengthening the council’s options for early intervention and preventative support.

“Agilisys partnered with LBBD to bring to life our vision for Community Solutions. Agilisys provided expertise, advice and capacity across all phases of the work in a blended approach. The strong sense of collaborative working has helped us successfully move the new service from conception to reality and secure a realistic five-year journey to realize significant service and financial benefits, focused strongly on a new relationship with the residents in Barking and Dagenham”.

Mark Fowler, Director - Community Solutions, London Borough of Barking and Dagenham

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<th><strong>Solution</strong></th>
<th><strong>Impact</strong></th>
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<tr>
<td>• Deliver more effective services.</td>
<td>• Researched options and established business case.</td>
<td>• Improved services to enable early intervention.</td>
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<tr>
<td>• Drive culture change.</td>
<td>• Developed ideal target operating model and tested new working processes.</td>
<td>• Reduced pressure on most costly acute services.</td>
</tr>
<tr>
<td>• Optimise use of council assets.</td>
<td>• Created a single service through redesign of 15 services, across £15m in spending, involving more than 300 staff.</td>
<td>• On track to deliver savings of £4.6m by 2020/21.</td>
</tr>
<tr>
<td>• Help contribute to the council’s overall savings target of £63m by 2020/21.</td>
<td>• Rationalised building footprint.</td>
<td>• Enabled people to become more self-sufficient and resilient.</td>
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<td></td>
<td>• Roadmap for replacing inefficient IT &amp; manual processes.</td>
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<td></td>
<td>• Established a robust collaboration and support structure.</td>
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