Housing LIN
Connecting people, ideas and resources

Practice Briefing

Closing the health gap – a gap worth closing: How housing can play its part in reducing health inequalities

This briefing equips housing, care and support practitioners, and public health teams, with ideas about practical actions they can take to reduce health inequalities. It draws attention to key measures to remove or reduce the impact of factors that make people ill, such as cold homes and fuel poverty, as well as approaches to increasing the potential for individuals and communities to improve their own health, by taking control of their lives and building confidence and resilience.

For housing organisations - whether seeking to prevent homelessness, tackle poor housing conditions, facilitate better access to care and support services, or improve the life chance of residents - it provides an overview of the nature and causes of health inequalities and explains both traditional and new approaches to reducing them, supported by a selection of useful practice examples. It also highlights the dividends in relation to delivering more cost effective housing management and better allocation of use of resources under the current financial climate.

And finally, the briefing provides links to resources to enable housing providers to better engage with the health sector and to measure changes in health inequalities over time, at the local level.

Written by **Merron Simpson** and **Heather Henry**, New NHS Alliance, for the Housing Learning & Improvement Network

Supported by

Public Health England

July 2016

A rapidly changing world

Health inequality has increased over the last 30 years. The latest ONS statistics show the gap in life expectancy at birth for males widened overall during the period between 1982/86 and 2007/11 from 5.6 years to 6.7 years, and was at its highest (at 7.5 years) between 1997 to 2001. For females, the gap widened from 3.8 years to 5.3 years over the same period, and was widest in 2007 to 2011.[1]

There are different theories for what is driving health inequalities. A longitudinal study tracking the impacts of the Government's welfare reforms, 'Real Life Reform', suggests high levels of anxiety about health and wellbeing, with 44% of study participants saying that their health has got worse over the 18 months of the study (only 6% saying it has got better over that period).[2]

Anecdotally, both housing and health practitioners are feeling under pressure. Housing officers appear to have noticed an increase in anxiety among their clients in recent years, such that many organisations now offer training for officers in how to handle tenants threatening suicide. 'Tenancy sustainment' support, targeted at tenants who are at risk of eviction, has become a routine activity of landlords as homelessness in England has risen.[3] And the NHS appears to be struggling to cope as the number of deaths among mental health patients has risen by 21% over the last 3 years.[4]

Looking forward, a new raft of housing and welfare policies will test the housing sector's long-term viability and ability to provide truly affordable rented housing. A combination of an expanded right to buy with enhanced discount levels, a requirement to charge higher rents (up to market levels) for tenants on higher incomes, forced sales of high value council homes and the channelling of public money into new homes to buy (rather than to rent) are expected to diminish the stock of social and affordable housing for rent going forward.

Furthermore, the introduction of fixed term tenancies may increase levels of anxiety for some tenants. And a 1% year on year reduction in social rents for the next 4 years will further reduce funds available to social landlords to develop programmes to increase health and wellbeing. Perhaps most significantly, the likelihood that Housing Benefit will be capped to Local Housing Allowance levels in future could impact heavily on the business models of smaller housing providers to the point that some decide to exit the sector. All of this is likely to have consequences for some of the most vulnerable people, their housing circumstances and their health and wellbeing (see this range of views[5]).

Recognising that in some localities life expectancy is stubbornly poor, and that this is partly due to entrenched disadvantage and lifestyle factors, some housing organisations and others are starting to adopt behaviour-changing approaches in their day to day work. This has been influenced by work on 'behavioural insight' driven by the Behavioural Insights Team.[6]

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1 https://www.ons.gov.uk/census/2011census

2 www.northern-consortium.org.uk/wp-content/uploads/files/real-life-reform/Report%206.pdf

3 www.crisis.org.uk/data/files/publications/Homelessness%20briefing%202016%20EXTERNAL.pdf

4 www.theguardian.com/society/2016/jan/26/rise-mental-health-patient-deaths-nhs-struggling-to-cope

5 A range of views about the impact of the Housing and Planning Bill:
JRF https://www.jrf.org.uk/report/housing-and-planning-bill-lords-committee-stage-briefing,
Shelter: https://england.shelter.org.uk/__data/assets/pdf_file/0005/1199408/2015_10_Housing_and_Planning_Bill_-_brief_v7.pdf,
National Housing Federation: http://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/Member_briefing_on_the_Housing_and_Planning_Bill.pdf

6 www.behaviouralinsights.co.uk/

The devolution of budgets to several cities and other places has raised the level of debate about the interconnections between the economy, population health and housing. The 'Due North' report says that: *"local strategies for economic growth need to have clear social objectives to promote health and wellbeing and reduce inequalities, backed by locally integrated public services aimed at supporting people into employment"*.[7]

The health sector too is starting to accept that lasting change in people's health can only be brought about by addressing the 'causes of the causes' of poor health, rather than just focusing on the easily discernible causes of illness (such as smoking or obesity). The NHS Five Year Forward View[8] states the need for a "radical upgrade in public health" and there is a new focus on 'prevention', 'place' and 'populations' within the NHS and the New Models of Care programmes.[9]

All of the above has motivated practitioners across housing, health and local government to look for new ways of addressing the nation's health issues, together. Whilst there is a strong desire by many housing practitioners to continue to work with the most vulnerable people in society, in line with their core values, widening health inequalities present specific demands on housing management and housing related care and support services and revenue with operating costs rarely recovered from either acute or primary healthcare.

What is 'health inequality' and what causes it?

Health inequality is often defined and illustrated by two commonly used indicators: (1) life expectancy at birth and (2) healthy (or disability-free) life expectancy.

In relation to each of these, ONS statistics[10] show that in 2012-14:

- men in the most deprived areas had a life expectancy 9.2 years shorter than those in the least deprived areas, while for females the difference was 7 years, and
- women in the most advantaged areas could expect to live 20.1 years longer in 'good' health than those in the least advantaged areas. For males this was 19.3 years.

Furthermore, the influential Marmot Report, 'Fair Society Healthy Lives'[11], showed that both of the above are strongly linked to differences in income deprivation, findings that are echoed in Wilkinson and Pickett's epidemiological data in 'The Spirit Level'.[12] It also found that lifestyle behaviours and the wider determinants of health – the physical, social and economic conditions in which people are born, raised and live – are more important influencers of health than either access to health care or genetics.

From a housing perspective, the home environment is also one such 'wider determinant'. The poorest housing conditions are in the private rented sector where 29% are non-decent.[13]

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7 www.cles.org.uk/wp-content/uploads/2014/09/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final1.pdf

8 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

9 https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

10 www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000049/pat/6/par/E12000004/ati/102/are/E06000015

11 www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

12 The Spirit Level: Why more equal societies almost always do better. Richard G Wilkinson and Kate Pickett 2009, published by Allen Lane.

13 English Housing Survey 2014-15: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/501065/EHS_Headline_report_2014-15.pdf

Evidence set out in NICE Guidance (www.nice.org.uk/guidance/ng6) shows that cold homes negatively affect people's health. And, as recognised in the *2014 Care Act*, having a decent, suitable home is fundamental to good health and wellbeing (see p.4).

Frontier Economics' analysis for the Marmot Review assessed the human cost of health inequalities and found that: *"In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life"*.[14] Furthermore, NHS England estimate that the annual cost to the NHS through the failure to reduce the health inequalities experienced by people in England is £5.5 billion.[15]

It is also worth noting that differences in health outcomes that are due to factors that are not inevitable and contain an element of 'unfairness', are sometimes referred to as 'health inequity'. So, health inequity = avoidable health inequality.[16]

Housing and support providers might find the following regularly updated sources of local authority and clinical commissioning group based information about health inequalities useful to understand trends in health inequalities and public health in their area:

- The Public Health Outcomes Framework currently presents data for available indicators at England and local authority levels, collated by Public Health England[17];
- The Marmot indicators of life expectancy and healthy life expectancy for each local authority[18], and
- NHS England's Health Inequalities 'hub' brings together equality and health inequalities resources and provides useful links and information for the sharing of good practice.[19]

Policies, strategies, guidance and legal requirements to tackle health inequality

Public Health England's mission is:

> *"To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest."*

Recent legislation together with a number of national documents and programmes provide the context for public health and housing and support organisations to work together in new ways to reduce health inequalities. Taken together, they point to a new emphasis on 'place' and populations, systems leadership across professional boundaries, tackling health inequalities as an element of economic regeneration and new models of health care that better serve populations. This is so that care is delivered in a more integrated way that makes sense to, and involves local people: supporting carers and the most vulnerable, seeing communities as a renewable source of energy which include assets as well as needs and the call for a 'radical upgrade in public health'.

14 www.cawt.com/Site/11/Documents/Publications/Population%20Health/Economics%20of%20Health%20Improvement/Estimating%20the%20costs%20of%20health%20inequalities.pdf

15 https://www.england.nhs.uk/wp-content/uploads/2013/09/agm-pres-cm.pdf

16 www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

17 https://www.gov.uk/government/collections/public-health-outcomes-framework

18 https://www.instituteofhealthequity.org/projects/marmot-indicators-2015#163961_20151202030417

19 https://www.england.nhs.uk/about/gov/equality-hub/#163961_20160331034928

For example:

- The *2012 Health and Social Care Act* gave local authorities responsibility for public health and saw the transfer of Directors of Public Health and their teams from NHS to top tier and unitary local authorities. It also established local Health and Wellbeing Boards as the accountable body to improve the health of the local population and reduce health inequalities.
- The *2012 Health and Social Care Act* also says that: *"In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service"*. This duty applies to PHE, NHSE and CCGs. Specifically, NHS England and CCGs both have a legal duty to:
    - have regard to the need to reduce inequalities between patients in *access* to health services and the *outcomes* achieved;
    - exercise their functions with a view to securing that health services are provided in an integrated way, and are *integrated* with health-related and social care services, where it considers that this would reduce inequalities in access to those services or the outcomes achieved … and to subsequently set out commissioning plans and report on those plans.
- The *2014 Care Act* makes explicit the need for integration of housing along with health and care by including a 'duty to cooperate' and stating that "the provision of housing accommodation is a health-related provision". It also sets out how people's care and support needs should be met and introduces the right to an assessment for anyone, including carers and self-funders, in need of support. The act's 'wellbeing principle' spells out a local authority's duty to ensure people's wellbeing is at the centre of all it does, including the suitability of one's accommodation.
- The *2010 Equality Act* includes a public sector equality duty, which means that 'public authorities' must have due regard to the need to:
    - Eliminate unlawful discrimination, harassment and victimisation;
    - Advance equality of opportunity between people who share a protected characteristic and people who do not;
    - Foster good relations between people who share a protected characteristic and those who do not.

    The Act lists nine 'protected characteristics' in relation to discriminatory practice – age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation – and sets out duties and responsibilities in relation to service provision for these groups within populations
- Public Health England produced a series of evidence reviews based on the original Marmot Report that can guide local partners on tackling social determinants of health through early intervention, supporting employment, education, addressing healthy living standards and a healthy environment.[20]

20 https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers

- The *NHS Five Year Forward View* (referenced previously) sets out a new direction to create a health service that is focused on local populations (rather than just individuals), has prevention at its core and is sustainable in the long term, through New Models of Care (see also Vanguards programme).
- The Leadership Centre Systems Leadership Steering Group published, 'The Revolution will be Improvised'[21] which draws on insights from 25 multi-agency programmes around the country to find out how people break or make collaboration and service transformation.
- NHS England, with support from Public Health England, has established the *Healthy New Towns Initiative*.[22] Following a call for expressions of interest, ten sites have been chosen to show how a new approach can help to build new communities that support social cohesion, physical and mental wellbeing, joined up community health and social care services and share land and buildings infrastructure such as NHS clinics, schools, police, fire service and other public services.
- NICE have recently published a guideline, 'Community engagement: improving health and wellbeing and reducing health inequalities'[23], that covers community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations. It includes recommendations on:
    - overarching principles of good practice – what makes engagement more effective?
    - developing collaborations and partnership approaches to encourage and support alliances between community members and statutory, community and voluntary organisations to meet local needs and priorities
    - involving people in peer and lay roles – how to identify and recruit people to represent local needs and priorities
    - making community engagement an integral part of health and wellbeing initiatives
    - making it as easy as possible for people to get involved

Many of these approaches are relevant to housing organisations and are explored in 'What can housing and support organisations do to reduce health inequalities?' later in this briefing.

Why should housing organisations seek to address health inequality?

The shift to a place-based health service brings with it new possibilities in terms of the range of professions that can get involved in improving public health. The Royal Society for Public Health recently published, 'Rethinking the Public Health Workforce'[24], which identified 57 professions and up to 20 million individuals who could, potentially, be part of the wider public health workforce. In addition, a study by Sitra for Public Health England, 'Study into the Impact of the Housing Workforce on Health Outcomes'[25], demonstrates the potential for the housing

21 www.localleadership.gov.uk/docs/Revolution%20will%20be%20improvised%20publication%20v3.pdf

22 https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/

23 https://www.nice.org.uk/guidance/ng44#163961_20160331025721

24 https://www.rsph.org.uk/en/policy-and-projects/areas-of-work/wider-public-health-workforce/index.cfm

25 http://www.sitra.org/documents/public-health-housing-workforce-research/?preview=true

workforce to impact further on public health. More co-operative working between housing and health professionals can offer solutions.[26]

A National Housing Federation report[27] indicates that a relatively high proportion of people who live in social housing have disabilities, ie. those individuals whose 'disability-free life expectancy' is low, due to health inequalities of one type or another. There is a disproportionate number of older people and a relatively high proportion of people living with complex and multiple disadvantage in social housing.

Chaotic lives, characterised by drug and alcohol issues, unemployment, benefit worries, family dysfunction/violence, mental and physical health problems can make the task of maintaining the home, avoiding rent arrears and reducing neighbour nuisance more difficult for housing organisations. Ageing and social isolation in people of all ages are additional problems. Two earlier Housing LIN briefings in this series commissioned by Public Health England as part of this series make the link between older people and alcohol misuse[28], and active ageing and the built environment.[29]

And lastly, a Kings Fund report concluded that health and social care integration is too narrow a focus for health improvement. It said that housing is well positioned to accelerate place-based interventions and be seen as part of new 'health creating' pathways beyond the biomedical model.[30] This is explained below.

New and traditional approaches to reducing health inequalities

The traditional public health approach is **pathogenic**, which means, "relating to the causes and development of illnesses". This is the predominant public health approach to treating illness and stopping people from becoming ill. The public health framework for thinking about health inequality is in terms of the 3 P's – Prevention, Promotion and Protection. For example:

- Prevention of development of disease states eg., preventing exacerbations of lung disease by avoiding cold damp homes;
- Promotion of health lifestyles eg., smoke free homes and active travel;
- Protection of population against developing diseases eg., by flood prevention and immunisation programmes.

However, there is also an alternative way of thinking, which is about the causes of wellness as opposed to the causes and prevention of illness. This is called **salutogenesis**[31] (the origins of health), first coined by an American sociologist called Aaron Antonovsky. It offers a different way of thinking about how to tackle inequality.[32] Antonovsky's theories are about helping

26 www.cloresocialleadership.org.uk/userfiles/documents/Research%20reports/2014/20150810%20-%20Njoki%20research%20final%20version%20.pdf

27 http://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/In-your-lifetime.pdf

28 www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Practice_briefings/HLIN_PracticeBriefing_PHE_OlderPeopleAlcohol.pdf

29 www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Practice_briefings/HLIN_PracticeBriefing_PHE_ActiveAgeing.pdf

30 www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/inequalities-in-life-expectancy-kings-fund-aug15.pdf

31 https://en.wikipedia.org/wiki/Salutogenesis

32 https://www.youtube.com/watch?v=yEh3JG74C6s

people to manage and reduce chronic stress and find ways of coping, since stress mobilises the production of cortisol in the body, which clogs arteries leading to cardiovascular disease.

In addition, The Young Foundation (2008) studied how neighbourliness strengthens community resilience. This leads us to the idea that in addition to the 3 Ps above (prevention, promotion and protection) there are 3 Cs that can address inequalities and improve wellbeing:

- Control: Providing greater opportunities for residents to influence decisions affecting them and their neighbourhoods leading to the avoidance of stress
- Contact: Facilitating regular contact between neighbours and preventing social isolation
- Confidence: Helping residents gain the confidence to exercise control over local circumstances

In 2012, a team supported by Sir Michael Marmot summarised the evidence for 'What Makes Us Healthy'.[33] This offers an alternative to the predominant public health approach of identifying and meeting needs. In short, the evidence suggests that there is merit in building on what's strong and not just address what's wrong – this is termed an asset or strengths-based approach to public health and has given rise to approaches called asset based community development or ABCD. This is one of a family of community centred approaches which focus on directly working alongside populations to build resilience, mobilise the assets and increase people's control over their own lives, see Public Health England's publication, *'A guide to community-centred approaches for health and wellbeing'*.[34]

More recently, NESTA, Health Foundation and NHS England have opened up the debate about using and measuring the value of empowering people and engaging communities in a programme called, 'Realising the Value'.[35] These approaches have the potential to move housing organisations towards a more place-based approach offering an opportunity to flex between needs-based service delivery to prevent illness and a health-creating approach which involves empowering communities to take control and use their own strengths and skills to solve their own problems.

In the light of the above, housing organisations should be looking to balancing a pathogenic with a salutogenic or 'health-creating' approach. For example, by drawing on the Kings Fund findings of:

- Building social capital – seeing people as the solution, not just as problems (asset based thinking);
- Coproduction – sharing control over key decisions. Moving beyond feedback and into equal partnerships with people such as the development of resident-led community partnerships in disadvantaged communities becoming the norm. Connecting Communities (C2, based at Exeter University), is one programme that supports this approach;[36]
- A catalyst for change – realising that in complex, chaotic and uncertain situations, actions may be unpredictable and communities may self-organise to produce solutions that work for them. Here the role of housing organisations is to act as the catalyst for change rather than directing what happens.

This is explored further in the next section.

33 www.assetbasedconsulting.co.uk/uploads/publications/wmuh.pdf

34 https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

35 http://realisingthevalue.org.uk/

36 www.healthcomplexity.net/content.php?s=c2&c=c2_background

What can housing and support organisations do to reduce health inequalities?

While many of the deep-root causes of health inequity lie beyond the spheres of influence of housing organisations and public health there are, nevertheless, actions they can take to improve health outcomes. Many actions will be much more effective if public health and housing and housing support providers collaborate.

To support collaboration, a pioneering health and housing Memorandum of Understanding[37] has been signed by government departments, its agencies such as NHS England, Public Health England and the Homes and Communities Agency, sector professional and trade bodies and leading learning networks, including the Housing LIN, to work together to place a greater emphasis on the drive for closer cooperation.

Working together, the MoU signatories aim to:

- Establish and support national and local dialogue, information exchange and decision-making across government, health, social care and housing sectors;
- Coordinate health, social care, and housing policy;
- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services;
- Promote the housing sector contribution to: addressing the wider determinants of health; health equity; improvements to patient experience and outcomes; 'making every contact count'; and safeguarding;
- Develop 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.

See more at:
www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/A_Memorandum_of_Understanding_MoU_to_support_joint_action_on_improving_health_through_the_home.pdf

In addition, to better understand the connectivity between health and housing, there are several useful resources to assist housing and health organisations to work together. These are listed at the end of this briefing under 'Useful websites and publications' on pxx.

However, many housing and support organisations are already taking actions to reduce health inequalities. For example, they see the dividend in relation to:

- keeping housing management costs down eg. staff time on anti-social behaviour, costs of possession proceedings, undertaking emergency repairs etc.;
- improving their income streams eg. reducing arrears, fewer relets, less voids etc.;
- helping residents to better self care, establish social networks or access community support eg. reduce demand on housing management, make better use of care and support services, develop greater resilience etc.

37 www.housinglin.org.uk/Topics/browse/HealthandHousing/HealthPolicy/Policy/?parent=8683&child=9425

Those that want to go further and align their business to work with the grain of reducing health inequalities and creating healthy populations might want to consider the following 3 steps:

Step 1 - Develop a more relational approach to the housing management service

'Relationship' is important for organisations that work directly with residents because:

- A standard, bureaucratic or transactional response to families experiencing multiple disadvantages can compound their issues because they are not meeting the actual needs or difficulties. Residents say that having to tell their story over and over again to different professionals makes them feel bad and depressed about their situation and frustrated that services are only dealing with one aspect at a time.
- When services are provided in a transactional way, without seeking to understand the individual, family or community, the balance of power is stacked in the favour of the organisation. Sometimes people begin to see an 'us and them' relationship which may settle into learned helplessness, passivity or sometimes active hostility.
- The most unequal people in society often feel judged by the services that support them and this can result in hostility and avoidance and in some cases criminality, mental illness and substance misuse.

Example: The Bromford 'deal' – wholesale change to a relationship-based service

Bromford Group in the Midlands is in the process of rejecting the dominant 'transactional' model of housing management and adopting a 'relational' approach to how they do business.

They have adopted a 'coaching model' to customer relations and are helping people to build up 'protective factors' in their lives – such as friendship, knowledge, aspirations – things that help to protect people against poor health. Importantly, they are accepting and responding to where people are 'at' and providing routes to personal development.

There is an expectation that residents will want to address problems in their lives, and they find that the large majority do want the chance to do that (and sometimes need help to believe it's possible). They then work with the individuals to enable them to 'be the best they can be' – reflecting Bromford's goal.

See more at: www.bromford.co.uk/find-a-home/the-bromford-deal

Step 2 - Adopt new 'health creating' practices

In addition to the alternative approaches suggested above, there are a range of other practices that housing organisations can consciously adopt.

- ***Become a 'listening organisation'***

Train staff to actively listen to residents and hold 'appreciative conversations' to gain a better understanding through asking questions. Hold regular 'listening events' with residents and other service providers, making sure these are led by residents. Regular 'walkabouts', guided by local people, are good ways of listening informally and experiencing the reality of people's

lives; informality allows people to say what they really think and being on residents' turf helps them feel comfortable. When planning larger developments such as capital schemes, door knocking with personal invitations to a public listening event held in a place of the resident's choosing allows greater control and contact which will increase confidence.

If you hold a listening event, make sure you follow up quickly (a week is good) with a simple written action plan explaining what you are going to do, and what is outside scope and why.

Example: Love Limehurst - Listening in Oldham

Regenda is taking a long-term view to regeneration and reducing health inequalities in Oldham. At the centre of their approach in Limehurst, Oldham is a commitment to 'listening to people' – both the people who live in the place and others such as local employers, GPs, bus drivers. The project steering group reflects the community being made of community representatives and groups as well as representatives from local businesses, doctor's surgeries, police etc. It acts as a shaper and moderator of opinions. Residents also lead several strands of activity. 'Listening' drives decision-making, giving local people a strong influence over the plans for a locality.

See more at: www.regenda.org.uk/love-limehurst

- ***Make your organisation a Psychologically Informed Environment***

The concept of the Psychologically Informed Environment (PIE) stemmed from work carried out for the Royal College of Psychiatrists. It recognises the high levels of emotional trauma that accompany, and in many cases precede an individual becoming homeless, and aims to address their complex needs. For this reason, the adoption of practices to create Psychologically Informed Environments has been led, in the housing sector, by homelessness organisations.

The reason for adopting PIE practice is to avoid compounding people's experience of rejection and isolation. Developing a PIE involves aligning staff practice within a consistent psychological/ thematic approach and requires continuous reflective learning. Organisations that want to become a PIE will need specialist advice and guidance.

Example: The power of PIE

Research by Homeless Link shows that putting relationships at the heart of service provision can make the real difference between success and failure in attempts to support people out of homelessness.

See more at:
www.homeless.org.uk/connect/blogs/2014/oct/23/power-of-pie#sthash.1IAltf1d.dpuf

- ***Coaching and healthy conversations***

The aforementioned Sitra study identified ways in which housing organisations are adopting 'healthy conversations' with young people living in their Foyers. It found that person-to-person transactions that take place through everyday encounters offer great potential for both customers and staff to build their motivation to improve their health outcomes.

Example: Three Square Project, Bath

Curo is a not-for-profit housing and support organisation based in Bath. In conversations with residents at the Bath Foyer, young people identified a common problem of how to cook and eat healthily with little or no income. Together the staff and residents came up with creative ways to address this. During the three-month period of this project, several different activities were provided to promote healthy eating at five different supported housing sites, including the foyer. Activities included cooking lessons, learning how to make healthy food from scratch, a 'free food Tuesday' (delivery from a local store) a 'ready steady cook' competition and a 'breakfast bombing' campaign. The project has had lasting impact and healthy eating continues to be a key theme within CURO's services.

See more at: www.sitra.org/documents/public-health-housing-workforce-is-the-key-case-studies/?preview=true

- ***Undertake pre-tenancy work with prospective residents***

This will enable your organisation to build a relationship with an individual or family before they become a resident. You can get a good understanding of where they're 'at'– in terms of their Control, Contact and Confidence – and therefore what sort of programme and protective factors might help them to move in a 'healthy space', including successfully securing and holding down a job they like, where necessary. This is important in the light of changes to welfare benefits, as employment is becoming the route through which people will become sufficiently financially secure to pay their rent/mortgage and other bills.

Step 3 - Undertake special projects and programmes

Many housing organisations are now taking forward projects and programmes, over and above their core business, designed to improve health outcomes of their customers and the wider population. These include many that are geared to vulnerable people and reducing health inequalities. Some are outlined below.

- ***Assisting community groups to set up and run social enterprises***

Social enterprises are one vehicle through which local residents can have control over what and how services are delivered, as well as an income and development opportunities. They help to build long-term sustainability into community life. Roles housing and public health (with other local partners) can play in supporting social enterprises include:

- Supporting the establishment of the enterprise
- Providing start-up investment (providing long-term, low costs loans, premises etc.)
- Appointing social enterprises as contractors
- Being customers of the enterprise
- Mentoring those residents who are leading
- Providing back-office functions

Example: Furniture recycling in North Manchester

Northwards Housing, together with local charity the Mustard Tree, has supported the development of Stand Firm, a social enterprise in the business of furniture recycling. Stand Firm is sub-contracted by Northwards Repairs and Maintenance contractor to clear every void property of furniture, belongings & rubbish. Anything re-usable goes into Mustard Tree's furniture scheme to be sold through their outlets. Items not capable of being re-used go into general recycling and anything left over goes to the tip. The scheme provides work and training opportunities by re-using abandoned items and minimising landfill.

The social enterprise provides skills training, work placements and employment opportunities for those facing significant barriers to employment in the Manchester area.

See more at: www.mustardtree.org.uk/what-we-offer/standfirm-social-enterprise/

- ***Social prescribing and community navigation***

Several housing organisations are working directly with GP practices to establish social prescribing schemes. This enables GPs to 'prescribe' their patients non-medical solutions to their problems. Ideally, the GP will first refer the patient to a trained 'community navigator, who is able to spend more time with the individual and work with them to identify how best to address the issues they have presented. Social prescriptions can be wide-ranging and might include: exercise, social contact, energy efficiency improvements to their home, gardening club, lunch club or vouchers and much more.

Examples of housing organisations involved in social prescribing include:

- Doncaster Social Prescribing, led by South Yorkshire Housing Association: www.housingforhealth.net/doncaster-social-prescribing-service
- Riverside Housing: (scroll down to final section on 'Supporting Primary Care') www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Healthcare_brochure__-_Riverside.pdf
- Hertfordshire, involving Watford Community Housing: www.housingforhealth.net/community-navigator-hertfordshire

- ***Warm homes and reducing fuel poverty:***

This Catalogue of Health Related Fuel Poverty Schemes lists 75 different schemes across England and Wales: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/451025/DECC_FINAL.pdf

The previously mentioned Sitra study identified several examples of housing organisations addressing a range of issues focused on people who typically (and statistically) have poorer health outcomes, including:

- ***Temporary respite accommodation for homeless people being discharged from hospital:***
    - Horton Housing Association runs a 14-bed scheme for people who are homeless, inadequately housed and need support around health issues on discharge from hospital (Sitra study, example 5).

- ***Healthy eating and lifestyles programmes:***
    - Oldham Partnership that facilitates sports activities, 'grow your own' and healthy eating activities for schools and local community groups (Sitra study, example 12)
    - Walsall Partnership offered free health and fitness, and healthy lifestyles programme to men over the age of 40 (Sitra study, example 13)

This briefing from the National Federation of ALMOs (NFA) also contains several relevant case studies and ideas being taken forward by ALMOs at:
www.almos.org.uk/guidance_docs.php?subtypeid=123462

- ***Support for local social enterprises*** – Generation Community, Berneslai Homes, Barnsley: http://ignitesocialenterprise.com/casestudy/generation-community/

- ***Community hubs through sheltered schemes*** – Kirklees Neighbourhood Housing – see also Community Hubs in Gloucestershire: www.housinglin.org.uk/_library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy_106_CommunityHubs.pdf

- ***Small group homes and support for young people leaving care*** – Nottingham City Homes (see NFA paper)

- ***One-stop shop of support and wellbeing services to all residents*** – Solihull Community Homes (see NFA paper)

- ***Identifying and addressing a range of issues*** including: home injury prevention, physical activity, mental health 'first aiders', addressing alcohol dependency, reducing risk of tenancy loss, affordable pantry scheme – Stockport Homes (see NFA paper)

Other examples include:

- ***Addressing domestic violence and other 'hidden' problems through pregnancy massage*** – Bolton at Home: www.housingforhealth.net/building-a-relationship-of-trust-through-pregnancy-massage-bolton

- ***Addressing domestic violence through interventions in A&E*** – Staffordshire Housing Group: www.housingforhealth.net/domestic-violence-ae-intervention-project

- ***Advocacy to enable people with mental health problems to access forms of support that are available to them*** – Home Group, Devon: www.housingforhealth.net/devon-enhanced-community-recovery-service-decrs

- ***Transforming Care and Support*** – South Yorkshire Housing Association, LiveWell: www.housinglin.org.uk/_library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy_108_SYHA_LiveWell.pdf

- ***Providing support to homeless people leaving hospital:*** Bristol Churches Housing Association and Shelter: www.housinglin.org.uk/HousingRegions/SouthWest/?&msg=0&parent=1025&child=9332

- ***Provide managing agency services for private landlords***

Many homes that present a risk to health are in the private sector. If they wish, housing and support providers can take action in partnership with local councils. They can operate alongside councils' enforcement teams, providing a managing agent service for landlords who choose to respond positively to legal orders to improve their homes.

Example: Managing agent for private landlords renting poor condition homes – Barnsley

Barnsley Council approaches landlords renting poor condition properties and, using its legal powers, undertakes a housing assessment. They sometimes serve a relevant order on the home (such as an improvement notice or prohibition order) and at the same time they also invite the landlord to lease their home to Berneslai Homes to improve the property and manage it, for a fee. As well as improving the living conditions of the tenant, this also helps to protect them by reducing the likelihood of eviction. The approach has been very effective in focussing landlords' minds on doing something about their run-down homes.

See LGA briefing: www.local.gov.uk/c/document_library/get_file?uuid=0d9686a2-4431-4adb-9fc6-7155f99ec36b&groupId=10180

Evidence of impact

It is becoming increasingly important to generate credible evidence that demonstrates the impact, or the lack of impact, of what you are doing. This is partly because money is in short supply, making it important to direct limited resources to impactful activity, and partly because the health sector as a whole looks for credible evidence within a wider business case, upon which to make decisions.

There is no single 'right' way to generate evidence, and no perfect evaluation study. Precisely what you measure will depend on the nature of the activity and how you collect and 'package' that evidence will depend on who it is you are trying to satisfy. In order to help you think through what sort of evidence you might collect and how, you might want to ask yourselves the following questions, set out below:

Question	Types of evidence and/or method to consider
Are you seeking to enable the individuals you work with (your customers) to see the difference for themselves and increase their motivation as a result?	Use self-reported health and wellbeing measures including outcomes stars, encouraging people to take photographs and videos of the changes they experience, storytelling, art and drama.
Are you seeking to measure improvements in people's mental wellbeing?	Use the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) www.nhs.uk/Tools/Documents/Wellbeing%20self-assessment.htm
Do you want to measure increases in levels of the 3Cs (Control, Contact, Confidence)	Consider using Social Return on Investment http://socialvalueuk.org/what-is-sroi/the-sroi-guide
Is the evidence to satisfy your own organisation that you are spending money on the right things?	Measure the reduction in costs eg. reduction in repairs, evictions, antisocial behaviour using before and after measurements, or compare the costs to a control group
Is it to persuade an external audience (eg. Public Health, a GP Federation or a Commissioner) to cooperate with you or commission you?	You will need to tailor both what you collect, and how you make your business case, to the audience you are hoping to persuade since public health, commissioners, GP Federations, acute trusts, mental health trusts all have different attitudes towards evidence. As a minimum, you will need to demonstrate reductions in costs for NHS services and you may need to go further. www.nhsalliance.org/wp-content/uploads/2015/10/sitra-what-the-doctor-ordered-brochure-print-1.pdf
Are you looking to measure changes in health inequalities, together with partners working together in a particular locality, over time?	Locally updated measures of inequality – the Marmot indicators and healthy life expectancy measures – provide a means for local partners to assess the impact of their collective actions over time: https://www.instituteofhealthequity.org/projects/marmot-indicators-2015#163961_20151202030417

Another consideration is the time period over which you measure the outcomes. While short-term pilots are often necessary to test out an intervention, they are often too short to identify the improvements in health that take place over the medium to long term. Commitment to longitudinal studies, measuring outcomes over 3, 5 or even 10 years, will provide a much stronger evidence-base than a 6 month study.

Published sources of information, including ideas for how to go about undertaking evaluations, include:

- Family Mosaic, Health Begins at Home: www.familymosaic.co.uk/userfiles/Documents/Research_Reports/Health_final_report_2016.pdf
- HACT Standards of Evidence: www.hact.org.uk/sites/default/files/Summary%20guide%20to%20StEv2-1_0.pdf
- DECC Affordable Warmth Health Impact Evaluation Toolkit: https://www.gov.uk/government/publications/affordable-warmth-and-health-impact-evaluation-toolkit
- National Housing Federation evaluation of housing association health interventions, undertaken by New NHS Alliance and Kings Fund: forthcoming.

Summary of key messages

The focus of health and social care is increasingly on places and populations as a means to pay more attention to prevention. Public health professionals in local authorities are in a good position to connect these sectors with those focussed on improving quality of life for populations in the community including housing.

Housing and support providers are increasingly involved in a wide range of activities to improve community health and wellbeing and thereby support reductions in health inequalities experienced by their customers. While the current direction of travel regarding housing policy and funding makes some of these activities more difficult, as we have highlighted earlier in this briefing, there are many actions they can take that won't necessarily cost a great deal but that could have a big impact.

Housing organisations can take actions that help to prevent illness, such as installing measures to improve energy efficiency and aids and adaptations to reduce the likelihood of an accident in the home. They can also adopt ways of working that help to promote good health which can be more successful when faced with people with multiple disadvantage and complex dependencies. Small but significant changes in how organisations relate with residents day-to-day can help to cultivate meaningful relationships through which residents feel they matter and can get things done, and this fosters positive behaviours. Local people are both assets and the experts in their own communities. Local agencies should recognise this and work with them to develop successful solutions to their particular circumstances.

Useful websites and publications

Other useful resources to assist housing and health organisations to understand each other and work together better include:

- The 'Health Intel' pages on the Housing LIN website: www.housinglin.org.uk/Topics/browse/HealthandHousing/
- New NHS Alliance Housing for Health website for strategic health leads: www.housingforhealth.net
- New NHS Alliance and Sitra guide: 'Housing, just what the doctor ordered': www.nhsalliance.org/wp-content/uploads/2015/10/sitra-what-the-doctor-ordered-brochure-print-1.pdf
- NHF interactive map of case studies : www.housing.org.uk/topics/health-care-and-housing/what-do-good-partnerships-look-like/

Note

The views expressed in this paper are those of the authors and not necessarily those of the Housing Learning and Improvement Network.

About the Authors

Merron Simpson is Chief Executive of New NHS Alliance and Heather Henry is Co-Chair of New NHS Alliance.

Acknowledgements

We are grateful to Public Health England (PHE) for commissioning this briefing. In particular, our thanks go to Gill Leng, Claire Laurent and Carl Petrokofsky for guidance and for their expert input on the topic, and Jeremy Porteus at the Housing LIN for his additional comments and insight.

About New NHS Alliance

New NHS Alliance is a values-led movement of people and organisations who are committed to building a sustainable, community-based health service. We are making transformational improvements to population health and the whole patient journey, embracing community health and wellbeing, out-of-hospital care, hospital at home and transfers of care. With a current reach of over 10,000 passionate individuals and organisations across primary care and beyond, we actively welcome members who are dedicated professionals from all sectors working to improve community health.

Website: www.nhsalliance.org

Twitter: @nhsalliance

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. Public Health England is an operationally autonomous executive agency of the Department of Health.

About the Housing LIN

The Housing LIN is a sophisticated network bringing together over 40,000 housing, health and social care professionals in England and Wales to exemplify innovative housing solutions for an ageing population.

Recognised by government and industry as a leading 'knowledge hub' on specialist housing, our online and regional networked activities:

- connect people, ideas and resources to inform and improve the range of housing choices that enable older and disabled people to live independently
- provide intelligence on latest funding, research, policy and practice developments, and
- raise the profile of specialist housing with developers, commissioners and providers to plan, design and deliver aspirational housing for an ageing population

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing LIN is called upon by a wide range of statutory and other organisations to provide expert advice and support regarding the implementation of policy and good practice in the field of housing, care and support services. Along with Public Health England, the Housing LIN is a signatory of the Health & Housing Memorandum of Understanding:
www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/A_Memorandum_of_Understanding_MoU_to_support_joint_action_on_improving_health_through_the_home.pdf

Further information about the Housing LIN's comprehensive list of online health and housing resources can be found on the 'Health Intel' at:
www.housinglin.org.uk/Topics/browse/HealthandHousing/

Published by

Housing Learning & Improvement Network
c/o EAC, 3rd Floor,
89 Albert Embankment
London SE1 7TP

Tel: 020 7820 8077
Email: info@housinglin.org.uk
Web: www.housinglin.org.uk
Twitter: @HousingLIN & @HousingLINews