ScotPHN report

Scottish Public Health Network

Foundations for well-being: reconnecting public health and housing. A Practical Guide to Improving Health and Reducing Inequalities.

Emily Tweed, lead author on behalf of the ScotPHN Health and Housing Advisory Group with contributions from Alison McCann and Julie Arnot

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Foreword

The Universal Declaration of Human Rights states that everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, *housing* and medical care. This is because the dwelling and its location and immediate environment can have a major impact on social, mental, and physical health. The Marmot Review also argues that tackling health inequalities involves tackling social inequalities: …"the distribution of health and well-being needs to be understood in relation to a range of factors that interact in complex ways. These factors include whether you live in a decent house." With an ageing population we also need homes suitably adapted to allow people to live independently with dignity and in comfort.

This ScotPHN Report is the result of collaboration between a wide range of stakeholders (listed below) to develop a 'best practice resource' to guide the public health and housing sectors in Scotland in their role in improving health and reducing inequalities through the provision of good housing. It addresses how public health colleagues can work within local organizational structures (such as Community Planning Partnerships and Integration Joint Boards) and influence national policy to this end.

Rather than summarising again the already extensive literature on the relationship between housing and health, the Report focuses on opportunities for engagement and ways of working that enable public health colleagues to put that evidence to use. The scope of the Report includes not only the *quality* of housing but also *affordability, availability,* and *security* of tenure. It also considers – in keeping with national policy priorities – the house as a *setting of care* and links to other strands of ScotPHN and NHS Health Scotland work on homelessness, fuel poverty, and adverse childhood experience. In particular, it dovetails with recent NHS Health Scotland briefings on homelessness and health, and housing and inequalities.

We have defined housing as how and where people are accommodated in the broadest sense, encompassing not only the physical dwelling but also household circumstances, neighbourhoods, and communities. Although the term 'homes' is used increasingly to enable a distinction between this concept and that of the housing sector, in this project we have used the phrase 'housing' for both, in keeping with common usage in public health.

It is the hope of the Project Group that the Report will lead to a greater engagement between public health and housing sectors in their shared role in ensuring that housing in Scotland contributes to wellbeing across the lifecourse.

I would like to thank everyone in the stakeholder group who have helped to shape the Report. The leadership provided by ScotPHN colleagues, particularly Emily Tweed, Phil Mackie and Ann Conacher, is gratefully acknowledged.

Challenging times can provide an opportunity for more imaginative thinking and for taking the initiative. It is, however, also a matter of commitment and drive. We owe it to those whose so-called home is a risk to their health, to strive harder to address these problems and to maximise the housing contribution to the health of the people of Scotland. I firmly believe this Report will help us achieve that goal.

Tim Patterson
Interim Joint Director of Public Health
NHS Borders & Scottish Borders Council

ScotPHN Health and Housing Advisory Group

Tim Patterson (Chair & SDsPH Sponsor)	Interim Joint Director of Public Health, NHS Borders & Scottish Borders Council
Emily Tweed (Lead author)	Specialty Registrar in Public Health, NHS Greater Glasgow and Clyde
Moira Bayne	CEO, Housing Options Scotland
Amanda Britain	Housing Lead, iHub and Chair, CIH Scotland
Tony Cain	Policy Manager, Association of Local Authority Chief Housing Officers
Ann Conacher	Manager, ScotPHN
Margaret Douglas	Consultant in Public Health, NHS Lothian
Drew Hall	Service Manager, Community Safety & Wellbeing, Inverclyde Council
Neil Hamlet	Consultant in Public Health, NHS Fife/NHS Health Scotland
Adam Lang	Head of Communications and Policy, Shelter Scotland
Matthew Lowther	Head of Place and Equity, NHS Health Scotland
Phil Mackie	Consultant in Public Health/Lead, ScotPHN
Alison McCann	Researcher, ScotPHN
Chris Morgan	Principal, Locate Architects
Phil Myers	Health & Wellbeing Specialist, NHS Dumfries and Galloway
Angela O'Brien	Head of Housing and Independent Living, Scottish Government
Tim Pogson	Service Co-ordinator, Scotland's Housing Network
Claire Stevens	Chief Officer, Voluntary Health Scotland
Mary Taylor	Chief Executive, Scottish Federation of Housing Associations
Elaine Young	Assistant Director of Public Health, NHS Ayrshire & Arran / Scottish Health Promotion Managers
John Wood	Policy Manager, Communities Team, CoSLA
Kiren Zubairi	Policy Officer, Voluntary Health Scotland

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Executive summary

Good housing is an essential pre-requisite for human wellbeing, and is central to some of the most pressing health challenges in Scotland, including poverty and inequality; climate change; and population ageing. Long-standing interests and new developments – for instance, legislation on health and social care integration, community planning, and community empowerment – have combined to create an ideal window of opportunity for a reconnection between public health and housing. This report aims to act as a practical guide to support joint working to realise the potential contribution of good housing to improving health and reducing inequalities.

As described in Section 2, the relationship between housing and health is multi-faceted. Physical characteristics of the dwelling itself, household experience, and aspects of place and community can all impact directly on health, as well as indirectly on health determinants, such as financial circumstances, education and employment, relationships and social life. Housing also has the potential to create, sustain, or exacerbate inequalities in health between different social groups.

For colleagues working in public health, we provide a basic grounding in concepts such as housing quality; energy efficiency and fuel poverty; tenure; affordability; and the principles of healthy place-making, as well as an overview of relevant policies, organisations, and strategic processes.

For colleagues working in housing, we describe the principles of public health; its workforce and organisation in Scotland; and key concepts such as the social determinants of health, health inequalities, and health across the life course.

A number of useful resources already exist which may help support joint working. These include sources of data on housing and on health; practical tools such as the Place Standard and guidance on Health Impact Assessment of housing developments; resources on costs and cost-effectiveness; and a wealth of case studies from other areas of the UK.

The report concludes by identifying a number of ‘key practice pointers’ for both sectors, which are listed overleaf. These encompass topics such as learning and development; embedding joint working into strategic planning; supporting healthy housing policy; addressing the needs of potentially vulnerable groups; and the importance of a life course approach to public health. Some aim to address known challenges for joint working, including engagement with the private rented sector, and integrating data on housing and health. Though by no means an exhaustive list, these pointers are intended to provide a starting point for engagement, discussion, and, hopefully, inspiration.

In addition to specialist knowledge of the topic area, colleagues from housing and public health have a number of unique strengths, which they can bring to joint work. Though both sectors are increasingly pressured, there are many existing areas of mutual priority on which we can efficiently collaborate.

Greater mutual understanding and closer links between the worlds of housing and public health offer enormous potential to improve health and reduce inequalities across Scotland. The time is right for a reconnection: we offer this report as a starting point.

Summary of key practice points

For local teams from public health and housing

1. Local public health teams should ensure they are aware of how to contact their counterparts in housing, and vice versa, using the channels described in this report.

2. Local public health teams should consider having a named lead for housing, to ensure that they are equipped with the knowledge and capacity to maximise the potential contribution of better homes and places to better population health.

3. Public health teams and housing colleagues should adopt an explicit focus on housing and health across the life course throughout their work in this area.

4. Public health teams and housing colleagues should seek to share intelligence relating to demographics, health and care needs, and housing trends in their local areas, in order to inform strategic planning, identify future trends, and understand gaps in the available data that need to be addressed.

5. Colleagues from public health and housing should be aware of populations or communities in their local area who may be particularly vulnerable to the health effects of poor housing, in order that their needs and views can be addressed as specific priorities in strategic planning and operational delivery.

6. Colleagues from both sectors should seek public health representation in key strategic forums and planning processes relevant to housing, in order to maximise the potential contribution of good housing to improving health and reducing inequalities. Public health teams should also consider the contribution good housing can make to local priority areas identified through Community Planning, and how this contribution can be embedded into Local Outcome Improvement Plans and locality plans.

7. Staff from both sectors should reflect on potential collaborative opportunities to undertake health improvement activity in housing settings.

8. Public health staff should work with housing colleagues to explore the potential for interventions in healthcare settings to identify and support those experiencing housing need.

9. Staff from both sectors should proactively seek opportunities to collaborate on ad-hoc projects and initiatives in areas of mutual priority, including research and evaluation.

10. Staff from both sectors should enhance the value of joint working through the application of existing tools and resources, using their outputs to inform planning and decision-making.

11. At a local level, public health teams should seek to develop an awareness of the private rented market in their area and to identify opportunities for engagement; for instance through local private rented sector forums and partnership working with colleagues in environmental health.

For national bodies and professional organisations

1. The contribution of housing to health should be a key component of training for both sectors at the undergraduate and postgraduate levels, and for continuing professional development.

2. NHS Health Scotland should explore the potential for a series of inter-professional training workshops and/or online network on housing and health, bringing local staff together with their counterparts in other sectors in order to build capacity in this area and enhance relationships.

3. Professional organisations from both sectors should explore opportunities for embedded training, such as shadowing and secondments.

4. Life course considerations – including the relationship between housing and childhood experience; demographic trends; and housing as a setting of care – should be a key focus of inter-professional learning and development opportunities.

5. National and local organisations, and representative forums, from both sectors should reflect on how they might support the development of healthy housing policy in Scotland, and in particular, where there are areas of mutual priority where joined-up advocacy and input may be beneficial.

6. NHS Health Scotland should explore the potential to extend our scoping exercise into a full-scale Health Impact Assessment of the Scottish Government's housebuilding commitment, in order to inform the programme as it develops.

7. NHS Health Scotland should consider the expansion of the section of the Scottish Public Health Observatory (ScotPHO) website dedicated to housing, to raise awareness of key policies and available data.

8. NHS Health Scotland, through ScotPHO, should consider undertaking a scoping exercise to investigate potential data sources that may support joint work on health and housing.

9. NHS Health Scotland could explore opportunities for public health to engage with the private rented sector alongside other housing partners, for instance through existing organisations such as the Chartered Institute of Housing and the Scottish Landlords Association.

1 Introduction

Good housing, encompassing not only the physical dwelling itself but also household circumstances, neighbourhood conditions, and the community in which homes are set, is an essential pre-requisite for human wellbeing. Indeed, adequate housing is recognised in the Universal Declaration of Human Rights as a fundamental part of the right to an adequate standard of living[1]. As well as providing protection from physical and psychosocial hazards, housing is central to many other determinants of our health, such as education, employment, social relationships, and environmental sustainability. Our homes are among the places we spent most of our time: they are therefore a ubiquitous influence on health throughout life, and across the population.

The recognition of housing's importance to health has a strong historical tradition. Many of the pioneers of public health and social reform – such as Edwin Chadwick, Friedrich Engels and Octavia Hill – focused their attentions on housing[2-4]. Until 1951, housing policy in the UK was the responsibility of the Ministry of Health[5]. More recently, housing and neighbourhood conditions have been a central theme in key policy reports on health inequalities, from the Black report to Equally Well[6-9].

Despite this precedent, the potential of good housing to contribute to health and wellbeing has not yet been fully realised, and considerable new challenges lie ahead.

Year-on-year increases in housing costs and declines in supply mean that housing affordability remains a key driver of poverty in Scotland[10]. In parallel with this, significant cuts to welfare spending ('welfare reform'), including changes in the rate and criteria of Housing Benefit rates, have affected hundreds of thousands of households across Scotland[11]. At the same time, there has been an increasing trend towards under-employment and insecure jobs, especially among the young[12]. Many people – especially from the younger generation and those on low incomes – are therefore struggling to find affordable, secure housing to meet their needs.

Average life expectancy in Scotland remains significantly lower than in other countries of the UK and the rest of Western Europe, even after taking into account differences in socioeconomic deprivation[13]. Marked inequalities in rates of ill-health and premature death across the socioeconomic spectrum exist, and have been static or widening in recent years. For instance, between the most and least deprived areas of Scotland there is a 25 year gap in healthy life expectancy, the number of years a person might be expected to live in good health.

We have an ageing population with increasingly complex health and care needs[14]. Nationally, there is an aspiration to support people to live at home – or in a homely setting – for as long as possible, as independently as possible[15]. Our homes are therefore central to the two key challenges of our ageing society: how we live well in older age, and how we deliver health and social care in an effective, efficient, and person-centred way.

Our climate is changing: a phenomenon which has been described as the greatest threat – and the greatest opportunity – for global health of the 21st century[16]. Housing can play a key role in mitigating further increases in greenhouse gas emissions, and in adapting to climate change's effects, such as extreme weather events.

In parallel with these challenges exist a number of opportunities, which mean that joint working between housing and public health is more relevant, feasible, and potentially impactful than ever.

Housing is a hot topic in the popular media, and a priority for the public and policymakers alike. Similarly, there is a widespread acknowledgement of the importance of tackling social inequalities, and their downstream effects on health. The overlap between these two priority areas is increasingly being recognised, through dialogue about the potential role of housing in creating a more socially just Scotland[10].

We are increasingly conscious of how the housing decisions of the past have influenced the health of our population, thanks to a large body of evidence showing that our health in adulthood and later life is greatly influenced by our experiences across the life course, and in particular, during childhood and the prenatal period. One specific example can be found in the 'excess mortality' observed in Glasgow and the rest of Scotland, compared to other areas of the UK (Case Study 1). The findings of the Commission on Housing and Wellbeing, and the recent update report, 'One Year On', have provided a welcome focus on housing's central role in wellbeing across the life course[17 18].

We have also come to recognise the complexity of the links between housing and health, and the resultant potential for unintended consequences: for instance, an excessive emphasis on insulation in some areas has increased the risk of harm from poor indoor air quality[19]. There is therefore a need for a holistic and co-ordinated approach, which takes a population perspective on housing and health in the broadest sense.

Finally, new structures (such as Integration Authorities[1] and Community Planning Partnerships); new legislation (such as the Community Empowerment Act); and new policy commitments (such as the Scottish Government's target to deliver at least 50,000 new affordable homes) have created windows of opportunity to strengthen relationships and embed joint working across public health and housing.

The time is therefore right for a reconnection between the worlds of public health and of housing. In this context, this report aims to guide both sectors in their work to improve health and reduce inequalities through the provision of good housing. It is intended not as an exhaustive account of the ways in which housing can influence health, but as a practical resource to support joint working.

In our aspiration to reach as wide a readership as possible, we have attempted to ensure the report is accessible to readers from both housing and public health, though a glossary of specialist terms is included among the appendices.

The report was developed through engagement with key stakeholders in both fields and scoping reviews of the peer-reviewed and grey literature. More details on our methods are provided in Appendix 1.

[1] We recognise that terminology around the structural aspects of Health and Social Care Integration varies across Scotland: for ease and clarity, in this report, we use the term Integration Authority.

Each section may be read as a stand-alone document, or as part of the overall report: some are supplemented by Appendices providing more detailed information on the issues at hand:

- **Section 2** provides a conceptual overview of the links between housing and health, and is supplemented by Appendix 2, which signposts readers to the key sources of evidence in this area;

- **Sections 3 and 4** respectively provide a brief overview of the housing sector for colleagues in public health; and of public health for colleagues in housing. These are supplemented by more detailed guides to each sector, in Appendices 3 and 4;

- **Section 5** collates a number of existing tools and resources intended to support joint working; and, finally

- **Section 6** identifies a number of key practice points to guide work on housing and health at the local and national level.

Throughout the document, we highlight a number of key case studies from across Scotland which exemplify partnership working on housing and health or describe key research findings in this area. More detail on these and on other case studies which could not be included in the final report because of space constraints, can be found in Appendix 5.

There already exist a number of excellent examples of joint working across Scotland, albeit at a relatively small scale. The work of the project advisory group, comprising a broad range of representatives from across housing and health, has also itself already made some contribution to our intended outcomes of greater mutual understanding and new relationships at the local and national level. We are hopeful that, through this report, this initial progress can be replicated and extended across Scotland in order to realise the enormous potential offered by collaboration between housing and public health.

2 Housing and health: a primer

This section aims to provide a general overview of how housing may affect health and inequalities. Rather than describing the evidence in detail, Appendix 2 points the reader towards the most up-to-date existing reviews so they can explore the literature for themselves according to their needs.

Poor housing has long been associated with poor health. This is not surprising: as well as the sheer number and diversity of potential inter-relationships, housing is important to health because of its ubiquity. Not everyone smokes, or drinks alcohol, but we all need somewhere to live, and throughout our lives, we spend a significant proportion of time at home. Furthermore, as described in Section 3, the number of individuals across Scotland who experience poor housing – whether due to aspects of the dwelling, of household experience, or of local places and neighbourhoods – is substantial.

Figure 1 draws on the existing evidence base to provide a conceptual framework for thinking about housing and health.

It illustrates that a number of aspects of housing are relevant to health:

- Physical characteristics of the dwelling itself, such as space, warmth, energy efficiency, and the presence of hazards;
- The experiences of the household within that dwelling, such as affordability, security of tenure, occupancy and overcrowding, and suitability for inhabitants' needs; and
- Features of the place and community in which the dwelling is situated, such as access to amenities and public services, safety, transport and infrastructure, and opportunities for recreation and socialisation.

Whilst some of these aspects of housing may influence health directly (for instance, by affecting the risk of injuries or the progression of long-term health conditions), most are related to health through a number of intermediate determinants, such as:

- Financial circumstances
- Housing satisfaction
- Education and employment
- Access to health and care services
- Health behaviours
- Empowerment and control
- Relationships and social capital
- Environmental sustainability

These household, community, and global factors in turn interact with other social, cultural, and economic, forces to influence our physical, mental, and social health.

Key reviews of the evidence underlying this framework are provided in Appendix 2, organised according to three 'research briefings' on the following topics: how housing influences health and wellbeing; the evidence for improving health through housing interventions; and key studies in the Scottish context.

In parallel with its influence on overall health across the population, housing also has the potential to create, sustain, or exacerbate *inequalities* in health between different social groups.

As described in Section 4, the immediate causes of health inequalities are inequalities in what are known as the social determinants of health; "the conditions in which we are born, grow, live, work, and age"[20]. It could be argued that, in the UK, access to high-quality, affordable housing in neighbourhoods which promote health and wellbeing is one of the most unequally distributed of all the social determinants of health.

The starkest example of the link between housing and health inequality is the enormous gap in life expectancy and other health outcomes between those who are securely housed and those who are homeless as described by a previous ScotPHN report, 'Restoring the Public Health Response to Homelessness in Scotland'[21 22].

However, it is not just evident at those extremes: the influence of housing on health inequality is pervasive across a much broader swathe of the population. Those living in more deprived areas or on lower incomes are more likely to experience housing conditions with the potential to impact adversely on health, such as overcrowding, dampness, and fuel poverty [23]. Housing may, depending on a household's financial situation and tenure, act either as a source of security or of strain: on the one hand, property ownership is the largest single source of household wealth in the UK[24], but on the other, housing costs are a major driver of poverty[10]. The places and communities within which we live are also important mediators of health inequality, through factors such as access to greenspace, exposure to air pollution, and perceptions of safety[25].

This link is explored in more detail in a recent briefing from NHS Health Scotland, 'Housing and health inequalities'[26].

From a policy perspective, housing has the potential to play an important role in achieving the National Outcomes, which reflect the priorities of the Scottish Government, and the National Health and Wellbeing Outcomes, which specifically relate to the delivery of health and social care[27 28]. The contribution that housing can make to these outcomes is described in detail by a forthcoming briefing from the Housing Partners for Health and Wellbeing[29].

This chapter is intended to provide high-level conceptual overview of how housing can affect health. However, it is important to acknowledge some of the complexities inherent in this relationship, which can be:

- **bi-directional:** housing can influence health, but health may also influence housing, through employability and financial status, and constraints on housing design and location;
- **multi-dimensional:** many different aspects of housing have the potential to influence many aspects of health, at the individual, household, and community level;
- **context-dependent**: how housing affects health may vary between different places, eras, and populations. This is particularly important when thinking about the extent to which research findings from other countries are applicable to Scotland; both
- **direct and indirect**: housing may affect health directly, for instance, through exposure to specific hazards such as dampness, cold, noise, or overcrowding, but indirect effects are also important. For example, high housing costs can reduce household's access to other health-promoting factors such as nutritious food or leisure activities; similarly, the availability of affordable

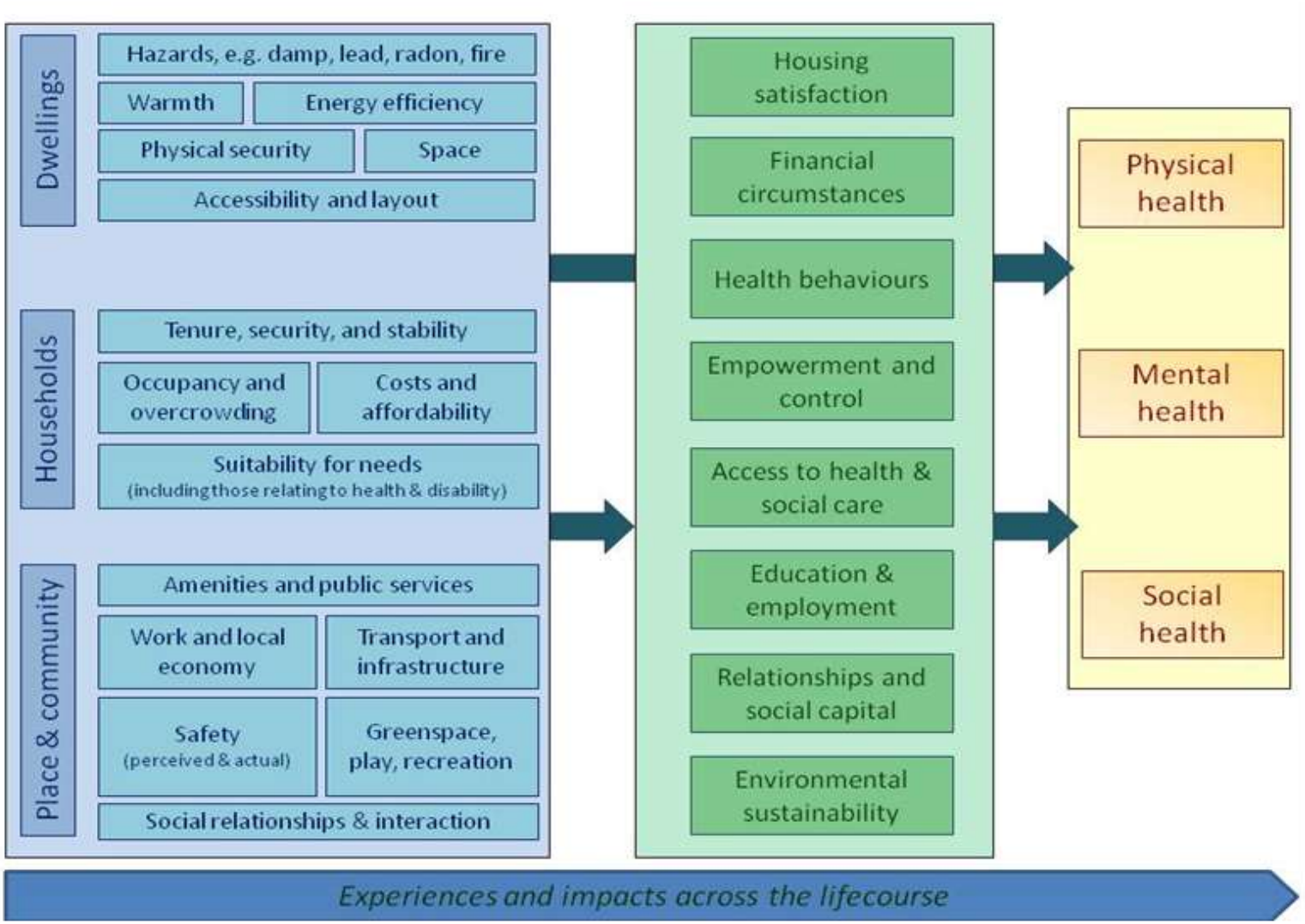
housing in a particular area can constrain or facilitate access to good work; inseparable from other aspects of

- **individual experience, local environment, and societal context**: particularly those relating to socioeconomic circumstances; and especially important for some; and
- **population groups:** for example, children and older people may be more vulnerable to the effects of poor housing, because they tend to spend a greater proportion of their time within the home. Young people may also be vulnerable at the point of transition out of the family home, or out of local authority care. Migrants, asylum seekers, and refugees may be less familiar with their housing rights or be disadvantaged by language barriers, discrimination, or financial precarity.

Acknowledging these complexities helps add nuance to our understanding, but does not undermine the central fact that housing can be a powerful determinant of health and wellbeing, and of inequalities in their distribution across the population.

In the following sections, we explore how joint working between public health and the housing sector can help realise housing's potential contribution to improving health and reducing inequalities.

Figure 1. Conceptual diagram of the links between housing and health



Case study 1. What is the role of housing in the 'excess mortality' seen in Glasgow and the rest of Scotland?

Scotland experiences high levels of 'excess' mortality: that is, significantly higher death rates than would be expected given the country's socioeconomic profile. Compared with England & Wales, and adjusting for differences in poverty and deprivation (the main causes of poor health in any society), 5,000 more people die every year in Scotland than should be the case. This excess plays a major role in explaining why Scotland has both the lowest life expectancy, and the widest mortality inequalities, in Western Europe.

Research led by the Glasgow Centre for Population Health and NHS Health Scotland has led to the development of two 'explanatory models' that describe why Scotland as a whole, and Glasgow in particular, experience this excess mortality phenomenon.

Housing plays a particularly crucial role in the explanatory model for Glasgow, with a number of factors having made the city more vulnerable to socioeconomic – and therefore health – inequalities:

- high historical levels of overcrowding, indicating high levels of socioeconomic deprivation and poorer living conditions than in other comparable cities;
- socially selective New Town programmes, resulting in younger, skilled workers in employment and often with families, being preferentially relocated out of Glasgow to areas of new development; and
- greater and more detrimental urban change in the post-war period, for instance in terms of slum clearances and demolitions; large, poor-quality council house estates on the periphery of the city; more high-rise development; and chronic under-investment in housing repairs and maintenance of public housing stock.

These factors are also influential in the explanations for excess mortality across the country as a whole – partly because Glasgow is responsible for a significant proportion of the national level of excess mortality, but partly because similar processes also affected other parts of Scotland.

The report makes a number of policy recommendations relevant to housing, including:

- a substantial expansion of the social housing building programme;
- an extension of the Scottish Housing Quality Standard beyond the social rented sector;
- targeting cold and damp housing, and fuel poverty; and
- improving neighbourhood quality and maintenance, in particular in relation to greenspace.

Adapted from: 'History, politics, and vulnerability: explaining excess mortality': Walsh D, McCartney G, Collins C, Taulbut M, Batty GD. Glasgow Centre for Population Health, 2016.

3 A brief guide to the housing sector in Scotland

This is a brief guide to the housing sector in Scotland, encompassing data on housing stock and experience, the policy context, and organisational landscape. It is a summary of a more comprehensive guide, available in Appendix 3.

Housing stock

In 2015 there were an estimated 2.56 million dwellings in Scotland, of which 96% were occupied[30]. Overall, these are roughly evenly split between detached; semi-detached; terraced; and tenement properties, with a smaller proportion of other flats: however, there is much regional variation, especially between rural and urban areas[31].

The key source of information on the physical condition of housing in Scotland is the Scottish House Condition Survey. The SHCS suggests that in 2015, 44% (1.1 million) of occupied dwellings across Scotland did not meet the Scottish Housing Quality Standard, which sets a minimum standard for the physical quality of housing across five broad areas[31]. 2% (42,000) of dwellings were deemed to fall below the 'Tolerable Standard' in which it is reasonable to expect people to live.

Poor energy efficiency is one common reason for failing to meet the Scottish Housing Quality Standard: in 2015, 63% of dwellings had an Energy Efficiency Rating of D or below[31].

Housing experience

The key source of information on housing experience in Scotland is the Scottish Household Survey.

In recent years, the number of households in Scotland has grown substantially, due to population growth and a rise in smaller households and solo living[30]. This latter trend has important implications for public health, through potential risks to social capital and mental health; higher living costs; a greater environmental footprint from housing, and reduced access to informal care.

With regard to tenure, in 2015 61% of households in Scotland were owner-occupiers, 23% were renting from social landlords, and 14% were renting in the private sector (though there is significant regional variation)[31]. The social rented sector is further divided into properties rented directly from local authorities (13% Scottish households) or from Registered Social Landlords (RSLs; 10% of all Scottish households). Social rented properties are allocated on the basis of need: allocation policies vary between different local authorities and RSLs, but are governed by statutory priorities such as unsuitable current accommodation and homelessness or housing insecurity[32].

Tenure mix in Scotland has changed significantly in recent years, with growth in both private renting and owner-occupation: these trends have been driven by economic forces such as the financial crisis at the end of the last decade and by policies such as Right to Buy[33].

Approximately 3% (70,000) of households in Scotland meet a statutory definition of overcrowding[31]; 9% are believed to contain 'concealed households', whereby people who are not able to form separate households are obliged to live with others[34].

Housing affordability is another key dimension of household experience, and is influenced by a complex range of factors. After adjusting for household size, the proportion of median household weekly income spent on direct housing costs (i.e. mortgage or rent payments alone) is estimated to be 25% for owner-occupiers, 24% for those in the private rented sector, and 14% for those in the social rented sector[35]: however, this conceals substantial regional variation. Other costs are also important, with an estimated 31% of Scottish households experiencing fuel poverty (currently defined as having to spend more than 10% of income on maintaining a satisfactory heating regime)[31 36].

Homelessness represents the extreme end of poor housing experience, encompassing those sleeping 'rough' in places not designed for habitation, those staying in temporary accommodation, and those 'sofa surfing' in the homes of friends and family[34]. In 2015, around 54,000 households approached Scottish local authorities seeking homelessness support, with 34,600 making an application under homelessness legislation[37].

Place and neighbourhood

There is no single authoritative data source on place and neighbourhood in Scotland, but data from routine surveys and ad-hoc studies suggest that people's experience of these factors is strongly socially patterned. For instance, those living in more deprived areas are more likely to be exposed to environmental hazards such as traffic pollution and derelict land; they also tend to feel less safe and less connected in their communities, and to have lower levels of neighbourhood satisfaction[38]. Rurality is also a major factor in people's experience of their local area[39].

Organisations involved in housing in Scotland

The organisational landscape for Scottish housing is complex, encompassing both statutory and non-statutory bodies and spanning the public, private, and third sectors. The key players are identified in Table 5 in the paired Appendix 3.

Key activities of the housing sector

These organisations provide a range of functions relevant to housing:

- facilitating, or directly providing housing through the construction of new homes and adaptations and repairs of existing homes;
- strategic planning in relation to housing, planning, and development;
- providing low level, preventative services for tenants, shared-owners, and owner occupiers – such as support for independent living, community alarms & telecare, and handyperson services;
- provision of information and advice on housing options and related issues, such as welfare benefits; and
- supporting tenant participation in housing services and other aspects of community life.

Policy context

Housing policy is a devolved responsibility of the Scottish Parliament, but is also influenced by some powers reserved to the UK Parliament, such as welfare benefits and financial regulation. The Scottish Government's overarching housing strategy is set out in 'Homes Fit for the 21st Century'. The implementation of this and other strategies relevant to housing is overseen by the Joint Housing Policy and Delivery Group, which acts as a key link between work at a national and local level.

Other recent policy developments relevant to housing include the abolition of the Right to Buy in Scotland; the introduction of the Scottish Housing Quality Standard as a statutory requirement for the social rented sector; the implementation of the Housing Options approach to preventing homelessness; and the Community Empowerment Act. More detail on each of these can be found in Appendix 3.

At a local level, key strategic documents and plans relevant to housing include:

- Local Housing Strategies produced by local authorities as a document of their strategic intentions on housing and related services. These are based on data from Housing Need and Demand Assessments, and go on to inform Strategic Housing Investment Plans.
- Housing Contribution Statements produced by Integration Authorities. These describe how each Integration Authority intends to work with housing services to achieve its strategic outcomes.
- Local Outcome Improvement Plans, which describe the priorities of Community Planning Partnerships, and locality plans, also produced by CPPs, which set out intended actions for communities experiencing the poorest outcomes.
- Local development plans, and in some areas, strategic development plans, which describe spatial planning processes and priorities in local authority areas and city regions.

4 A brief guide to public health in Scotland

This is a brief guide to the aims, structure, and functions of public health in Scotland. It is a summary of a more comprehensive guide, available in Appendix 4.

Public health is a multi-disciplinary endeavour which aims to improve health and wellbeing across the population, and reduce inequalities between different social groups. It takes a broad view of the determinants of health, including socioeconomic, cultural, environmental, and commercial factors, and as such, focuses on collective action and shared responsibility.

Public health has three key domains[40], each of which may be relevant to housing:

- health improvement: enabling individuals and communities to improve their health and wellbeing, by addressing the determinants of health;
- health protection: preventing and responding to communicable diseases and environmental hazards; and
- health and care quality: maximising the population benefits of health and care services.

All of these functions are underpinned by the collection, analysis, and interpretation of data and research evidence, known as public health intelligence.

Although the specialist public health function in Scotland is located within NHS boards, and interfaces closely with front-line health and social care services, it differs from the latter in its strategic focus on population health rather than individual patients or service users.

Central to the practice of public health are a number of key concepts:

- the social determinants of health: the conditions in which people are born, grow, live, work, and age, and which therefore shape health and wellbeing;
- health inequalities: the unfair and avoidable differences in people's health across social groups and between different population groups;
- the lifecourse approach: the recognition that our health at any given time depends on the cumulative impact of myriad factors throughout our lives, and in particular during the 'sensitive periods' of gestation, infancy, and childhood; and
- health in all policies: the systematic incorporation of health considerations into decision-making on public policy in diverse areas.

Public health is the responsibility of a core workforce, for whom public health is the mainstay of their professional role, and of a wider workforce, who work in other disciplines or professions but nonetheless have a role in protecting and improving population health and wellbeing[41]. Most of the core public health workforce are based in NHS territorial Health Boards or in Integration Authorities, with a smaller proportion in national health boards which provide specialist functions. Most public health professionals are generalists who cover a range of topic areas in their work: these areas may include, but are rarely limited to, housing.

Local public health teams work in collaboration with a range of statutory and non-statutory partners to provide support, leadership, and advocacy for population health, such as Community Planning Partnerships, local authorities, acute healthcare services, and third sector organisations. They also have responsibility for specific population health programmes, such as screening and immunisation, and, together with the local authority, have a statutory duty to prevent and control environmental hazards and communicable diseases.

5 Tools and resources to support joint working

In this section, we have collated a number of resources, gathered from literature reviews and stakeholder feedback, intended to support joint working between housing and public health.

A great deal has been written on the relationship between housing and health: we have therefore focused on practical tools and resources that we feel would be of most use to colleagues in Scotland.

Some of the tools are accessible to a general audience (such as the Place Standard), whilst others require specialist knowledge and expertise to realise their full potential (such as Health Impact Assessment). We collate them here with the intention that they serve as a starting point, or ongoing reference, for collaborative projects between colleagues in housing and in public health.

This section does include a number of resources from England, where a range of organisations – including Public Health England, the New NHS Alliance, and the Housing Learning & Improving Network – have been particularly active in this area in recent years. Given that the devolution of both health and housing has resulted in substantial policy divergence between the two nations, not all of these materials are likely to be relevant to the Scottish context, but they are highlighted below as a potential source of useful ideas and reflections.

The resources are grouped according to the following headings:

5.1. Data sources on housing and health
5.2. Practical guides and tools
5.3. Resources on costs and cost-effectiveness
5.4. Case studies from other areas of the UK
5.5. Links to further information on specific issues

5.1. Data sources

This section provides links to a number of sources of data and health and housing that may be useful in supporting joint working. For instance, these may inform health needs assessments, health impact assessments, or other joint projects.

Many of these data sources are included in an 'Evidence Finder' produced by the Scottish Government's Centre for Housing Market Analysis (CHMA) to support the specialist provision element of Housing Need and Demand Assessments. CHMA's 'Evidence Finder' is updated on a periodic basis and may be a useful starting point for those wishing to look in detail at specialist housing provision.

Sources of data on housing

Housing and Regeneration Statistics for Scotland – Scottish Government

- Quarterly, annual, and trend data on housing stock, available by local authority areas. Topics include new building, conversions, sales of social sector housing, and special needs housing.

Centre for Housing Market Analysis – Scottish Government

- Quarterly publications with statistics on the housing market, including house prices, cost and availability of finance, and repossessions.

Scottish House Condition Survey - Scottish Government

- Information on the methodology and results of the national survey assessing the physical condition of homes and the experiences of householders.
- Provides information on housing quality and disrepair, overcrowding, energy efficiency rates, and fuel poverty rates.
- Results published on an annual basis, and available at the national and local authority level.

Scottish Household Survey - Scottish Government

- Information on the methodology and results of the national survey of on the characteristics, attitudes, and behaviour of the Scottish population on a range of issues.
- Provides detailed information on demographic characteristics and household composition; housing experience; neighbourhood and communities; and other factors relevant to housing, such as self-reported economic situation and attitudes to local services.
- Results published on an annual basis and available at the national and local authority level.

Homelessness statistics – Scottish Government

- Information on the number and characteristics of:
    - households applying for, and granted, local authority statutory homelessness support (HL1 data);

    - those receiving local authority support to maintain their current residence, through Housing Options approaches (PREVENT1 data); and
    - those in temporary accommodation (HL2/3 data).
- Results published on a bi-annual and annual basis, at a national and local authority level.
- These data form the basis for the Scottish Government's national project to link data on homelessness from local authorities to data on health outcomes and deaths. More information on this data linkage exercise can be found here.

Housing Need and Demand Assessment tool – Scottish Government

- An Excel-based model, produced by the Scottish Government Centre for Housing Market Analysis and used by local authorities to estimate current and future housing need across different tenures.

- Based on projections of the number, size, and income of future households, and housing affordability across different tenures. Allows users to vary certain assumptions (such as rates of migration or changes in income inequality).

Statistical Information – Scottish Housing Regulator

- Annual statistics submitted by Registered Social Landlords to show performance against key indicators from the Scottish Social Housing Charter, such as tenant satisfaction; average waits for repairs; completion of medical adaptations; tenancy sustainment; and financial details.

- Data are available in raw format: either broken down by individual landlords or presented in aggregate.

Homelessness Monitor – Crisis

- A series of independent annual reports, produced for each devolved nation as well as Great Britain as a whole, which combine a range of data sources relevant to homelessness and the wider housing market with an analysis of the broader policy context.

Homelessness Statistics – Shelter

- A summary analysis of key Scottish housing and homelessness statistics, presented in an accessible format and updated on a six-monthly basis.

Sources of data on health

Scottish Public Health Observatory

- Provides information and analysis on the health of the Scottish population, through routinely-updated topic-specific data and policy briefings, and one-off reports.
- Topic-specific information is available on:
    - population groups and dynamics;
    - life circumstances (such as education, employment, and rurality)

    - clinical and behavioural risk factors (such as obesity, alcohol, and nutrition); and
    - specific health conditions (such as asthma, injuries, and disability)
    - health inequalities.
- The website also provides an Online Profiles Tool, which collates a number of public health indicators into an easy-to-use format allowing selection of geographical areas and inter-area comparisons using spine charts.

Information Services Division Scotland

- Provides data and analyses of activity within health care and social care in Scotland.
- Topic-specific information is available for a range of areas, including:
    - emergency care;
    - child health;
    - prescribing and medicines; and
    - health and social care, including the SOURCE project which aims to provide an integrated dataset to support integration.
- ISD have recently produced two briefing documents on data sources that may support population health needs assessments and joint strategic commissioning by Integration Authorities; these are also likely to be of interest and use to colleagues working on health and housing in other contexts:
    - ISD – Population Needs Assessment for Health and Social Care Partnerships: guidance on the use of data sources
    - ISD – A Guide to Data to Support Health and Social Care Partnerships in Joint Strategic Commissioning and Joint Strategic Needs Assessment

5.2 Practical guides

Undertaking Health Impact Assessment of proposed housing projects and policies

Health Impact Assessment is an established methodology for identifying the potential health and equity impacts of different policies, plans, and projects and making recommendations as to how benefits can be maximised, and risks or negative impacts minimised.

The Scottish Health and Inequalities Impact Assessment Network (SHIIAN) has produced a detailed guide to assessing the health impacts of proposed housing improvements. As well as providing background information on the housing sector, and a review of evidence linking housing and health, it details how that evidence can be used in health impact assessment, using a set of key questions to guide the process. It also highlights examples of how HIA has previously been used to inform housing-related proposals in Scotland, including in the development of Local Housing Strategies. An additional case study, which draws on this guide to examine the potential health impacts of the Scottish Government's commitment to 50,000 new affordable homes, is described on page 45.

- Health Impact Assessment of Housing Improvements: A Guide (2013)

Other SHIIAN documents which may be relevant to colleagues working in housing and health include:

- Health Impact Assessment of Rural Development: A Guide (2015)
- Health Impact Assessment of Greenspace: A Guide (2013)

Using the Place Standard to support the delivery of high quality places

The Place Standard is a practical tool developed in partnership between Scottish Government Architecture & Place, NHS Health Scotland, and Architecture and Design Scotland. It aims to provide a framework for assessing a particular place, whether well-established, in transition, or planned, against key aspects of the physical and social environment that support health and wellbeing. The tool can highlight the assets of a place as well as the areas where it could be improved, using an easily-understandable output diagram.

It is freely accessible for all, including communities, the third sector, the private sector, and the public sector. It can be used to support conversations about places, planning, and regeneration; undertake assessments; and identify priority actions.

Some case studies of its use are described in the box below; Figure 2 shows an example output diagram.

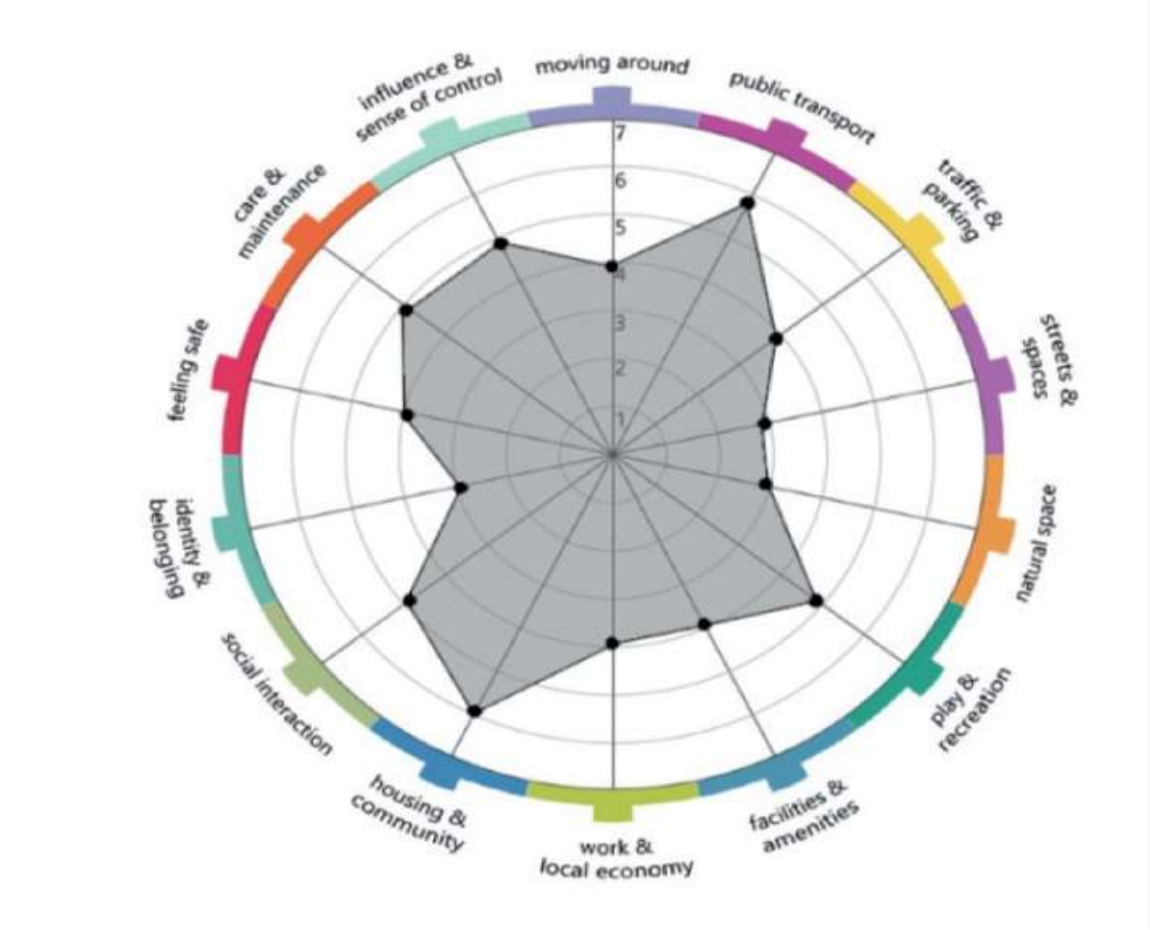
Case study 2. Using the Place Standard to support co-production of healthy places

Since its launch in December 2015, the Place Standard has been used across a number of different settings and by a number of different user groups.

Examples of areas using the Place Standard include:

- In Fife and the Shetland Islands, it has been used as part of online consultations on strategic planning, with each area receiving more than 900 responses.
- East Dunbartonshire Council are using the Place Standard as part of their Locality Planning process to develop their Local Outcome Improvement Plans (LOIPs).
- In the Broomhill area of Greenock, the Place Standard has been used by Inverclyde Council and Riverclyde Homes as part of a regeneration programme. Focus groups with local residents were undertaken using the Standard in order to gather baseline data, identify priorities, and monitor improvements over time.
- In other areas, the Place Standard has been useful in planning and development processes. For instance, in Lerwick, its use informed the spatial planning of a large new affordable housing site.

Figure 2. Example output diagram from Place Standard tool.



Joint Improvement Team

Making the Connection: guide to assessing the housing-related needs of older and disabled households (2015).

This guide was commissioned by the Joint Improvement Team, a partnership between Scottish Government, NHS Scotland, COSLA, and the third, independent, and housing sectors.

It aims to support the processes of Housing Need and Demand Assessment and Joint Strategic Needs Assessment by providing practical guidance on assessing the housing needs of older and disabled households.

It includes background information on the nature of specialist housing provision and relevant planning processes in Scotland; data sources and a series of reflective questions that can be used in the assessment process; and links to other useful resources.

World Health Organisation

Environmental burden of disease associated with inadequate housing: methods for quantifying health impacts of selected housing risks in the WHO European Region.

This detailed report from WHO attempts to quantify the health impacts of a number of housing-related hazards to health, such as dampness and mould; lead; radon; and indoor cold.

It provides practical methods for attempting to calculate locally the disease burden caused by inadequate housing conditions, and therefore may be useful to colleagues wishing to obtain quantitative estimates of existing burden and potential impact to support joint work between housing and health.

Public Health England and the Chartered Institute for Environmental Health

Developing a Housing and Health Profile for your local area.

This practical guide aims to support the development of local housing and health profiles that can contribute to local decision making; the targeting of resources; and evaluating the impact of initiatives on health and equity outcomes. It was developed on behalf of the Chartered Institute of Environmental Health and commissioned by Public Health England. It therefore has an English focus in terms of the planning and policy context, and relevant data sources, but may provide useful background on the content and production of such documents.

Chartered Institute for Environmental Health/BRE

Good Housing Leads to Good Health. A toolkit for environmental health practitioners.

This toolkit aims to support links between public health and private sector housing at a local level. It uses a health impact assessment framework, but relies heavily on quantitative tools which unfortunately are not available in Scotland.

What may be of most benefit are case studies of joint working between public health and housing, including on topics such as warm homes and overcrowding. Other case studies from CIEH can be found at: CIEH Housing and Health Resource. Case studies focusing in particular on the role of environmental health officers in the private rented sector are also available from CIEH.

Shelter (England)

Good practice guide: Working with housed Gypsies and Travellers

This good practice guide from Shelter describes how staff from a range of services can support housed Gypsies and Travellers. It includes sections on history and culture, community cohesion, health and housing, and sources of advice and information.

Though aimed at an English audience, many of the principles may be applicable to the Scottish context. It is important to note, however, that some aspects of legislation (for instance, in relation to housing, or equality rights) may differ in Scotland, and that it

does not make specific reference to some Gypsy/Traveller communities resident in Scotland, such as Scottish Gypsies or Scottish Showpeople.

Resources on co-production

Co-production can be defined as "*delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.*" Recent policy developments e.g. the Public Bodies (Joint Working) Act 2014 and the Community Empowerment (Scotland) Act 2015, have put co-production at the heart of public services, including public health and housing.

Many of the tools described above, including the HIA guide and Place Standard, are explicitly designed to support community involvement in planning and delivery processes.

However, colleagues from housing and public health looking for more information on the theory and practice of co-production may also find the following resources from the Scottish Co-production Network useful:

- Co-production in Scotland: a policy overview
- Co-production of Health and Wellbeing in Scotland
- 'People Powered Health and Wellbeing' – how people with lived experience and people who work in services can have good conversations and build connections to co-produce wellbeing.

Resources on evaluation

Those wishing to evaluate local projects on housing and health may find the following resources useful:

What Works Scotland **(WWS)**

WWS is a partnership initiative which aims improve the use of evidence in decisions about public service development and reform. Though WWS is currently directly supporting thirteen local areas throughout Scotland, their website is accessible to all and has a number of resources on the translation of evidence into practice at the local level, which may be of use to those working in housing and health.

Housing Associations' Charitable Trust (HACT)

Standards of evidence in housing: producing evidence of the effectiveness of interventions.

This resource offers a practical guide to the process of producing evidence of the effectiveness of interventions, with particular reference to the fields of housing and health. It may be useful for supporting projects to evaluate the health impacts of housing interventions. Though produced by HACT, an England-focused housing solutions agency, and Public Health England, its guidance and recommendations are not specific to the English context.

Centre for Sustainable Energy/Department for Energy and Climate Change

Affordable warmth and health impact evaluation toolkit.

This toolkit provides more specific guidance on evaluating the health impacts of affordable warmth schemes. It is intended for a predominantly English audience, but the practical aspects of the guidance are likely to also be of use to Scottish colleagues.

5.3. Resources on costs and cost-effectiveness

Few resources from Scotland on this topic were identified, so we also highlight a number of reports from England and Wales which may provide useful practical guidance to those seeking to build a business case for joint working or to evaluate the potential financial benefit of a particular initiative.

The economic impact of investment in affordable housing – Shelter Scotland

This narrative report describes the potential economic impacts of investing in affordable housing in Scotland, including in relation to health, wellbeing, and inequalities.

Social Return on Investment of Stage 3 Adaptations in Sheltered and Very Sheltered Housing – Bield, Hanover and Trust Housing Associations

This report attempts to quantify the value for money of home adaptations for people living in sheltered and very sheltered housing, with a particular focus on health and social care.

The case for investing in prevention: housing. – Public Health Wales

This report from Wales summarises the evidence on the cost-effectiveness of housing interventions for improving health, including specific data on costs and benefits where available.

The economics of health and housing, - The King's Fund
and
Prescription for success - National Housing Federation

These two reports from the King's Fund and National Housing Federation describe a number of ways in which housing associations can make an economic case for their contribution to health, including some practical examples relating to falls and mental health.

Briefing paper: the cost of poor housing to the NHS. – Building Research Establishment (BRE)

This briefing paper describes a project to estimate the costs to the NHS and wider society of a range of hazards associated with poor housing, such as cold, falls, overcrowding, noise, and fire. Though the report is primarily focused on England, it does provide an extrapolated total estimate of potential savings for NHS Scotland of £58 million.

Financial benefits of investment in specialist housing for vulnerable and older people

Assessing the social and economic impact of affordable housing investment - Frontier Economics

These two reports from England assess the economic implications of investing in specialist and affordable housing respectively, including potential savings for health and social care.

Better outcomes, lower costs. Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence. - School for Policy Studies, University of Bristol

This report, commissioned by the Office for Disability Issues and the Department for Work and Pensions, collates evidence on potential savings from investment in housing adaptations and equipment.

5.4. Case studies from other areas of the UK

As well as the case studies from Scotland collated in this report, a large number of case studies of joint working between housing and health elsewhere in the UK are available from the following sources:

- Chartered Institute for Housing
- Housing LIN
- National Housing Federation
- Local Government Association

5.5 Links to further information on specific issues

In this section, we highlight some sources of further information on a number of specific issues related to housing, health, and wellbeing. The resources gathered here are generally horizon-scanning reports, strategic guides, or scoping reviews of the evidence, rather than detailed systematic reviews or practical guides, which are included elsewhere in the report.

Fuel poverty

- Literature review: Defining, Measuring and Analysing Fuel Poverty in Scotland (Scottish Government)
- Literature review: Fuel poverty and health(NHS Health Scotland)
- Report: Addressing fuel poverty: guidance for Directors of Public Health (ScotPHN and NHS Health Scotland)

Homelessness

- Report: Restoring the Public Health Response to Homelessness(ScotPHN)
- Inequality briefing: Homelessness and health (NHS Health Scotland)

Place and community

- Literature review: The relationship between neighbourhoods, housing and crime, (Scottish Government)
- Literature reviews: Good Places, Better Health Evidence Assessments, including obesity, asthma, unintentional injury, and mental health and wellbeing among children (Scottish Government)
- Report: Lifetime Neighbourhoods(UK Government Department for Communities and Local Government)

Housing in later life

- Report: The impact of population ageing on housing in Scotland (Scottish Government)
- Review: Housing with care for later life: a literature review (Joseph Rowntree Foundation)
- Report: Housing our Ageing Population: Panel for Innovation (HAPPI): final report (UK Government Department for Communities and Local Government; Department of Health, and Homes and Communities Agency)
- Report: Future of ageing: adapting homes and neighbourhoods(UK Government's Foresight unit)
- Report: Living well in old age: the value of UK housing interventions in supporting mental health and wellbeing in later life(King's College London)

Specific communities or vulnerable groups

- Report: Gypsies/Travellers in Scotland: summary of the evidence base(Scottish Government)
- Report: Impact of insecure accommodation and the living environment on the health of Gypsies and Travellers (Inclusion Health)
- Report: Mind the step: an estimation of housing need among wheelchair users in Scotland (Horizon Housing Association/Chartered Institute of Housing)
- Report: No Place Like an Accessible Home: quality of life and opportunity for disabled people with accessible housing needs (Centre for Analysis of Social Exclusion)
- Report: Prison Leavers and Homelessness (Iriss/Shelter Scotland)
- Report: Transition in Scotland [from the Armed Forces] (Scottish Veterans Commissioner)

6 Opportunities for joint working

This section aims to identify the key opportunities for joint working between public health and housing, with reference to existing activity and capacities; mutual priorities; and the challenges ahead, as well as case studies of best practice.

Boxes like this highlight our 'key practice points' to guide joint working between public health and housing at the local and national levels.

As described in our introduction, we believe that the opportunities for joint working are manifold, and that the case for strengthening of the relationship between public health and housing in Scotland is more timely than ever.

With this great potential in mind, we look first at existing relationships between housing and public health.

6.1 What's already happening?

Local and regional activity

Engagement with local public health teams, our project advisory group, and key informants identified great diversity across Scotland in terms of existing relationships between housing and public health.

Encouragingly, many respondents felt there was an increasing awareness of – and enthusiasm for – the role of housing in improving population health across a range of agencies. In particular, several boards highlighted how health and social care integration and community planning arrangements have enabled them to strengthen their strategic input to health and housing. However, some areas reported that relationships between health and housing were better developed within Health and Social Care Integration at present than within Community Planning. There was a recognition that public health teams in different areas are at very different stages in the process of engaging with CPPs, depending on staff capacity, local context, and other factors.

Strategic links between health and housing had also been developed in some areas through proactive engagement with Local Housing Partnerships and Local Development Plans. As described in case study 6, in Fife, a public health consultant is now a member of the Local Housing Partnership and chairs its homelessness prevention subgroup. In Lothian, the public health team have been involved in scoping the health impacts of draft Local Housing Strategies and plans for new developments.

A number of boards described joint working also taking place through ad-hoc projects, such as health needs assessments and service re-design. Several pointed to research collaborations e.g. the GoWell programme in Glasgow and a project on energy efficiency in the Western Isles, which have helped build and strengthen relationships between public health and housing.

While there was clear evidence of enthusiasm for joint working on housing and health, a number of barriers were cited. First and foremost among these were constraints on resources (both human and financial) within each sector, suggesting a need to identify areas where joint working can address mutual priorities. Other NHS Boards highlighted a lack of access to housing data to inform decision-making; different organisational cultures; and ever-greater expectations of the role of housing officers. Some respondents expressed a wish for a greater leadership and strategic direction for joint working, and for shared training able to build capacity and relationships across both sectors. The complexity of the housing sector was also recognised as a challenge for public health colleagues.

Finally, feedback from some areas identified that joint working to date may have been constrained by narrow constructions of the links between housing and health, for example, a focus specifically on homelessness, or on meeting the housing needs of people with existing health conditions. Instead, there was a recognition that work should be directed by a broad understanding of how good housing can contribute to good health across the population.

National activity

At present, representatives from NHS Health Scotland sit on a number of national strategic groups, including the Joint Housing Policy and Delivery Group and its two thematic sub-groups; the national Homelessness Prevention and Strategy Group; and the independent forum, Housing Partners for Health and Wellbeing. Links have also been established with Shelter Scotland, the Scottish Federation of Housing Associations, Scotland's Housing Network, and the Chartered Institute of Housing.

6.2 What are the opportunities to enhance joint working?

These existing links indicate that there is a great deal of positive activity already underway. However, there remains considerable untapped potential. Despite resource constraints and other potential barriers, there are a number of ways in which the mutual interests of both sectors, and new windows of opportunity created by policy changes, can be leveraged to realise improvements in health and reductions in inequalities.

In this section, we highlight some key opportunities to strengthen joint working between housing and public health. This will not be an exhaustive list, but is intended to provide a starting point for engagement, discussion, and – hopefully – inspiration.

Sharing our strengths: what can each sector bring?

In addition to specialist knowledge of the topic area, those working in housing or in public health have specific skills or experience that characterise their profession or sector. These can be extremely powerful in helping to initiate, support, or sustain joint work.

Staff working in the housing sector are often closely rooted within their communities, with strong local connections and local knowledge. This can be helpful in informing the planning and delivery of public health initiatives, particularly those with a community development focus. Indeed, the housing sector has a long tradition of community and service user involvement and leadership. For example, housing associations have the potential to act as key 'community anchors': multi-purpose, locally-led organisations with a focus on community development[17 42]. Housing colleagues' experience in this role may offer important lessons for public health, particularly in the context of shifts towards greater community involvement in the planning and delivery of healthcare and other public services. Furthermore, organisations and networks within the housing sector, especially those working at a national level, often have active advocacy roles and well-established policy connections: these may provide a strong foundation for cross-sectoral coalitions for advocacy on housing and health.

Staff working within public health have a characteristic toolkit of skills that includes the gathering and interpretation of data; the collation and synthesis of published research evidence; and the evaluation of health impacts of specific initiatives or policies. These skills are brought together in several of the specialist methods of public health, such as health needs assessment, and health impact assessment. The application of these methods can an offer an ideal basis for ad-hoc projects that bring together staff from housing, staff from public health, and communities, to identify and address local needs, or inform national policy and strategy. Case study 7 (page 45) illustrates how health impact assessment methodology can be used to structure thinking around housing-related initiatives, in this case the Scottish Government's commitment to build 50,000 new affordable homes. Finally, arguments made on the basis of health benefits can carry a great deal of weight in other areas of policy or practice either through financial savings, equity concerns, or as a valued outcome in its own right.

Mutual priorities

Good housing has the potential to contribute to many of the National Outcomes, which guide the work of all public services in Scotland, as well as the National Health and Wellbeing Outcomes, which specifically apply to the planning and delivery of health and social care and provide the framework by which the performance of each Integration Authority is evaluated by the Scottish Government[27 28].

These outcomes therefore provide a number of mutual priorities towards which public health teams, local authorities, and registered social landlords can work together.

Housing can also play an important role in action on local priorities. Of particular relevance here are the priorities set out by Community Planning Partnerships in their Local Outcome Improvement Plans and locality plans, and by Integration Authorities in their Strategic Plans. Though these must be clearly aligned with National Outcomes described above, they may help partners focus on specific areas of need in the local context.

There are also many other potential areas of mutual benefit from joint working on health and its upstream determinants, outwith these formal frameworks. Improvements in the health and social circumstances of individuals and communities are likely to:

- increase tenant satisfaction with their homes and neighbourhoods, and with the services provided;
- reduce the need for additional support services provided by social landlords;
- help people remain in their homes for as long as they wish, especially where they have complex health needs or are at risk of homelessness; and
- yield cost savings (as described in Section 5).

Case study 3. Improving the Cancer Journey in Glasgow, through action in the home

In Glasgow, a partnership project has been attempting to improve quality of life and person-centred care for people recently diagnosed with cancer. It is a collaboration between Glasgow City Council and Health and Social Care Partnership, NHS Greater Glasgow and Clyde, Macmillan Cancer Support, and the Wheatley Group Housing Association.

Anyone newly diagnosed with cancer and resident in Glasgow City is offered a holistic needs assessment with a dedicated links worker, focusing on practical and personal support needs. Housing has been identified as a key issue for many service users, resulting in the addition of the Wheatley Group as a key partner. For instance, links workers have liaised with Home Energy Scotland to address problems with boilers and obtain grants for home insulation; have helped expedite home adaptations following occupational therapy assessments; and have helped individuals access more suitable accommodation.

The project is currently being evaluated by academic partners, and a similar approach is being piloted with people who have recently undergone lower limb amputations.

As well as direct links between housing and public health, the latter can also play an important 'bridging' role, helping build connections to other areas of the health service relevant to housing, such as maternity and children's services; mental health; and addictions care.

A key first step is knowing who to contact. Through this project, we have been able to establish the following initial points of contact for staff wishing to identify their local counterparts across the two sectors. While roles and responsibilities, and the most suitable contact, may vary between different areas, the suggestions below offer a first port of call:

- Public health teams can contact Scotland's Housing Network to obtain the contact details for housing staff in their area with responsibility for: local authority housing; strategic aspects of housing supply across tenures; and the oversight of private rented sector.
  Email tim.pogson@scotlandshousingnetwork or visit
  http://www.scotlandshousingnetwork.org/

- Staff from housing can find out the contact details for their local public health teams from the Scottish Public Health Network. When getting in touch, it may be helpful to consider the domains of public health practice illustrated in

Appendix 4, Figure 8, in order to identify which is most relevant to your enquiry or area of interest.
Email nhs.HealthScotland-ScotPHN@nhs.net or visit http://www.scotphn.net/.

1. Local public health teams should ensure they are aware of how to contact their counterparts in housing, and vice versa, using the channels described above in the first instance.

Learning and development

As previous sections have highlighted, housing and health is a complicated area: both in terms of the evidence base and the organisational and strategic context. This complexity, and the resulting challenges for staff, were highlighted by a number of those participating in our engagement exercises.

It is important that staff from both sectors have the necessary knowledge and skills to put this evidence into practice and realise the benefits of good housing for health and equity. This understanding should encompass not only housing, but related issues such as homelessness, fuel poverty, and place-making.

Some good examples already exist: for instance, NHS Health Scotland are leading the development of training on health and wellbeing for local authority housing teams via the regional Housing Options Hubs, and are considering the potential for material on housing and homelessness to be incorporated into core health inequalities training for NHS staff.

Building on these existing efforts, there may be particular value in shared learning events that bring together local staff from both health and housing. This principle of 'inter-professional learning', recognising the importance of staff from different professions and sectors coming together "to learn with, from, and about each other", is now widely used in the training of health and social care staff[43 44]. For those needing to gain more in-depth understanding and experience, embedded training opportunities such as shadowing and secondments, may be of benefit.

Indeed, the Housing Options Hubs, which bring together all 32 local authorities into 5 regional groups to share best practice in relation to housing support and the prevention of homelessness, may be a particularly valuable route through which to co-ordinate training opportunities, share best practice and scale up effective programmes.

In light of the complexity of the housing sector, and the breadth and strength of its potential contributions to health, we feel there is a strong case for each public health team to have a named lead for housing and place. This role might include leading the public health contribution to Local Housing Strategies, Housing Contribution Statements, and other key strategic documents (see Appendix 3, Table 6); identifying opportunities for collaboration towards mutual priorities; and acting as the key point of contact for staff from housing and planning departments. While it should not preclude capacity-building across teams on this topic, the existence of a named lead in each

area would facilitate the development of specialist expertise and ensure better co-ordination of public health activity in this important area.

2. The links between housing and health should be a key component of training for both sectors at the undergraduate and postgraduate levels, and for continuing professional development.

3. NHS Health Scotland should explore the potential for a series of inter-professional training workshops and/or online network on housing and health, bringing local staff together with their counterparts in other sectors in order to build capacity in this area and enhance relationships.

4. Professional organisations from both sectors should explore opportunities for embedded training, such as shadowing and secondments.

5. Local public health teams should consider having a named lead for housing and place, to ensure that they are equipped with the knowledge and capacity to maximise the potential contribution of better homes and places to better population health.

Case study 4. Learning and development through Community Planning in the Scottish Borders

The Scottish Borders Community Planning Partnership has identified housing and neighbourhood as one of the five key themes of its Reducing Inequalities Strategy. The delivery group for this strategy brings together staff from housing and public health, as well as from other areas such as education and community safety.

One of this group's priority actions is to develop shared learning opportunities for frontline staff to raise awareness of health inequalities and provide the necessary skills and knowledge to address issues that arise through core service delivery – for instance, by referral to sources of support on housing, homelessness and financial issues.

A series of workshop-style learning sessions are being planned collaboratively by service managers from health improvement, homelessness services, employability, welfare benefits, and customer support.

A lifecourse approach to housing and health

One of the most significant developments in public health over the past few decades has been the accumulation of overwhelming evidence that our health at any given point is greatly influenced by our experiences earlier in life, particularly in the antenatal period and early years: known as a 'lifecourse' understanding of health. Increasingly, this concept is being used to understanding how housing may affect our health and wellbeing throughout life [17 45].

The importance of a safe, secure, suitable home to health and wellbeing is a constant across the lifecourse, though the nature of that relationship is likely to vary between different stages, as our needs evolve. Families with children require secure tenures in spacious homes which are safe from physical hazards and which facilitate play, learning, and the development of secure interpersonal attachments. Young adults may value residential mobility and flexibility, but may be vulnerable to the risks of housing insecurity, disrepair and overcrowding, and to difficulties in accessing home ownership[46]. In later life, when long-term health conditions and activity limitations are more common, people tend to prioritise accessibility of homes and local amenities, and often express a preference for 'down-sizing'[47 48]. Accessible and adaptable homes can play a crucial role in maintaining independence, health, and wellbeing in later life and for those with disabilities.

A lifecourse understanding of housing's contribution to health is more important than ever, given the trends we highlighted in the introduction: an ageing population, with increasingly complex health and care needs; the rise of the 'precariat' and 'Generation Rent', population groups characterised by insecure employment and housing; and persistent socioeconomic inequalities in health outcomes across multiple generations. Furthermore, there is a strong policy emphasis in Scotland on shifting the balance of care towards community settings, in order to enable older people and those with long-term conditions to live independently at home, or in a homely setting, for as long as possible[15].

In this context, we believe that applying a lifecourse perspective to housing and health will help both sectors to:

- respond flexibly to demographic trends, sectoral change, and the particular needs of local populations;
- integrate key considerations such as reducing inequalities, shifting the balance of care, and preventing adverse childhood experiences into strategic and operational activity on housing; and
- understand where gaps exist in the knowledge and data required to support joint working, and how they may be addressed (see Section 6.3 for more on this topic).

6. Public health teams and housing colleagues should adopt an explicit focus on housing and health across the lifecourse throughout their work in this area.

7. Public health teams and housing colleagues should share intelligence relating to demographics, health and care needs, and housing trends in their local areas, in order to inform strategic planning, identify future trends, and understand gaps in the available data that need to be addressed.

8. Lifecourse considerations – including the relationship between housing and childhood experience; demographic trends; and housing as a setting of care – should be a key focus of the inter-professional learning and development opportunities described above.

Potentially vulnerable groups

As identified in Section 5, there are a number of population groups who may be particularly vulnerable to the adverse health impacts of poor housing. This may be because they:

- spend longer periods of time within the home, and therefore have greater exposure to its potential benefits or hazards e.g. children and older people;
- are more likely to experience housing insecurity or poor housing conditions e.g. migrants, asylum seekers, and refugees; Gypsy/Travellers; veterans; care leavers; or those in contact with the criminal justice system; or
- have specific health and care needs which may affect their access to suitable housing or ability to maintain a tenure e.g. long-term physical or mental health conditions; age-related frailty; or drug or alcohol dependency.

The principle of 'proportionate universalism', that is, universal action but at a scale and intensity proportionate to the level of need[9],suggests that these individuals and communities may require additional attention and support to meet their housing needs and to ensure that housing can positively contribute to their health and wellbeing.

However, the nature of this need, and appropriate responses, will vary according to the local context. For instance, rural areas may be more likely to be home to Gypsy/Traveller communities, whilst some urban centres may have a particularly high prevalence of people with complex needs, such as combined drug/alcohol dependency and mental ill-health. We therefore suggest that the needs and views of potentially vulnerable groups in the local context should be a central consideration in action on housing and health.

9. Colleagues from public health and housing should be aware of populations or communities in their local area who may be particularly vulnerable to the health effects of poor housing, in order that their needs and views can be addressed as specific priorities in strategic planning and operational delivery.

Case study 5. HOSmates: peer support to navigate the disability housing world

Housing Options Scotland runs a peer support project known as HOSMates, in which trained volunteers, who are themselves disabled or who care for someone who is disabled, help people navigate the maze of the disability housing world. This project is the first disability housing-specific peer support project in Scotland, and now has eight volunteers across the country.

By sharing their lived experience, volunteers not only help other disabled people access services but also have the opportunity to develop their skills and shape the future work of Housing Options Scotland.

Case study 6. Partnership working in NHS Fife

In NHS Fife, a consultant in public health now represents the health board on the Local Housing Partnership, including chairing the priority theme group on homelessness prevention. This role has enabled public health input to local work on housing and homelessness in a number of areas, both strategic and operational:

- close involvement of public health staff in the development of the Housing Contribution Statement, to ensure it focuses on the health-promoting value of housing across the lifecourse;
- creation of a contribution statement describing housing's role in poverty alleviation;
- broadening the membership of the prevention group to include education, criminal justice, the Scottish Prison Service, and the Health and Social Care Partnership;
- arranging for Home Energy Scotland to visit GP practices during flu vaccination weeks, to help patients access home energy checks and support for fuel poverty; and
- investigating how data from the primary care tool SPARRA can be used to provide individual support about fuel poverty to individuals at the greatest risk of hospital admissions.

Embedding joint working into strategic planning

Key vehicles through which to realise the potential health benefits of good housing at a local level include the following strategic planning processes (described in detail in Appendix 3):

- Local Outcome Improvement Plans and locality plans, produced by Community Planning Partnerships.
- Local Housing Strategies, Housing Need and Demand Assessments, and Strategic Housing Investment Plans, produced by local authorities.
- Local Development Plans, produced by local authorities, and Strategic Development Plans covering Scotland's four city regions, produced by Strategic Development Planning Authorities.
- Strategic Plans and Housing Contribution Statements, produced by Integration Authorities.

There will also be opportunities to pursue the housing and health agenda beyond these specialist housing forums, through strategic planning in related areas, such as Community Justice[49]; alcohol and drugs[50]; and community resilience[51].

NHS representation on the groups responsible for these strategic plans is often already a statutory requirement or routine practice. However, we would suggest that public health involvement can offer particular value, given the discipline's unique focus on health and wellbeing at the level of the population; the social determinants of health; and preventing and mitigating health inequalities. An example from Fife is provided in case study 6.

For instance, public health staff may be able to:

- support the collection, analysis, and interpretation of data on the demographic characteristics, health, wellbeing, and care needs of the local population e.g. through health needs assessments on the topic of housing and/or homelessness;
- highlight how housing can contribute to a broad range of strategic priorities, such as supporting independent living, reducing inequalities, and preventing or mitigating the impacts of environmental change;
- interpret how existing research evidence on the relationship between housing and health can be applied in the local context, and identify evidence-based interventions for achieving strategic goals; and
- facilitate health impact assessment of draft strategies and investment plans (see HIA guide, page 24, and case study 7).

We therefore recommend that colleagues from both housing and public health actively seek public health involvement in the development and revision of these key documents. Even where direct representation may not be feasible, public health colleagues can guide and support those colleagues who are more closely involved.

Though this has been realised in some areas, public health participation across Scotland in the processes described below is patchy, and often dependent on individual interest or pre-existing relationships. There is therefore a case for greater consistency, to ensure that all areas are able to benefit from this resource.

10. Colleagues from both sectors should seek public health representation in key strategic forums and planning processes relevant to housing, in order to maximise the potential contribution of good housing to improving health and reducing inequalities. Public health teams should also consider the contribution good housing can make to local priority areas identified through Community Planning, and how this contribution can be embedded into Local Outcome Improvement Plans and locality plans.

In many ways, the policy context in Scotland in this area is very favourable, particularly in comparison to other areas of the UK. This is exemplified by existing legislation on homelessness, security of tenure in the private rented sector, and ending the Right to Buy, and by commitments to increase the supply of affordable housing and mitigate the impact of housing benefit reform and the 'bedroom tax'. The recognition of housing as an important consideration in other policy areas, such as the new model for Community Justice in Scotland, is also welcome[49].

However, there remain a number of policy areas where the potential for good housing to improve health remains unrealised, as highlighted by the Commission on Health and Wellbeing's 'One Year On' report[18]. Of particular relevance are the proposals for:

- a cross-tenure Common Housing Quality Standard, whose introduction is supported not only by the Commission but also in recent reports from the Glasgow Centre for Population Health on excess mortality in Glasgow, and from NHS Health Scotland[17 18 26 52] ;
- universal minimum standards for temporary accommodation; and
- a Warm Homes Bill to address fuel poverty and reduce the use of fossil fuels in heat supply

As well as these specific areas, there are opportunities to maximise the health benefits of existing housing policies, and a pressing need for housing to be considered in many other areas of policy, both devolved and reserved. To name but a few examples, good housing has the potential to play a central role in poverty reduction and social security; early years and education; mental health and wellbeing; substance misuse; rural development; and environmental sustainability.

Public health and housing can support the development of pro-health policies in housing and other areas in a number of ways: through responding to consultations; providing specific support to policymakers, for instance in the form of evidence briefings or impact assessments; or advocacy in the professional and lay media.

Case study 7 illustrates how health impact assessment methodology might be used to maximise the health benefits, and minimise the risks, of the Scottish Government's commitment to building 50,000 new affordable homes.

11. National and local organisations, and representative forums, from both sectors should reflect on how they might support the development of healthy housing policy in Scotland, and in particular where there are areas of mutual priority where joined-up advocacy and input may be beneficial.

12. NHS Health Scotland should explore the potential to extend our scoping exercise into a full-scale Health Impact Assessment of the Scottish Government's housebuilding commitment, in order to inform the programme as it develops.

Case study 7. Scoping the health impacts of 50,000 new affordable homes

The Scottish Government has recently committed to build 50,000 new affordable homes over the next five years, 35,000 of which will be in the social rented sector. If achieved, this would represent a substantial increase in the supply of affordable housing in Scotland.

A group of representatives from public health, academia, housing associations, advocacy organisations, and the voluntary sector, met as part of this project to explore the potential health impacts of this initiative, using an existing guide to Health Impact Assessment for housing developments (page 24).

The group identified a range of affected populations, including:

- people who move into new homes (whether new build or others freed up by the provision of new stock), with particular reference to those who are currently homeless or in insecure housing; members of 'Generation Rent' who are currently in private rented accommodation but would prefer other tenures; and those with specialist housing needs;
- communities in areas of house-building, where new developments may bring a sense of positive change or disruption and uncertainty; and
- those working in the construction industry or supply chain, through an 'economic multiplier' effect.

Potential areas of impact include:

- rates of homelessness, which is associated with very poor health outcomes;
- direct health effects of changes in occupancy, security of tenure, housing suitability for needs, warmth and energy efficiency;
- indirect effects on health via educational performance of children, household financial status, access to labour markets, and environmental impact;
- active travel and other opportunities for physical activity, depending on design and location of developments;
- social mobility and social status associated with housing; and
- community cohesion, social networks, and empowerment among those affected by developments.

The group concluded by identifying a number of potential actions to maximise health benefits and minimise health harms, including:

- a strategic approach that prioritises areas with high levels of housing need and ensures high quality, sustainable housing and places;
- close involvement of local communities at each stage of design and delivery of the new developments;
- partnership working to ensure developments are accompanied by the necessary infrastructure and amenities, such as public transport, shops, health services, and greenspace;
- use of place-making principles and the Place Standard (page 25) in design to support walkability, active travel and social cohesion;
- recognition and incorporation of the needs of people with long-term conditions, disabilities, and other support needs; and
- a framework for monitoring progress towards the target and evaluating short, medium, and long-term impacts on health.

Housing and health as settings for intervention

As well as these strategic opportunities, the benefits of good housing for health can also be realised through initiatives at the operational level.

Case studies 8, 9 and 10 describe examples of how housing providers can act as both a setting for, and enabler of, initiatives to improve health. Other possibilities for action on the social determinants of health in housing settings might include offering financial inclusion services to ensure people receive the benefits to which they are entitled; access to high-quality childcare; and education and training initiatives.

13. Staff from both sectors should reflect on potential collaborative opportunities to undertake health improvement activity in housing settings.

Case study 8. Moogety Grub Hub

In Govan, on the south side of Glasgow, a partnership between Elderpark Housing Association, NHSGGC Health Improvement and a third sector organisation called Urban Roots has developed a capacity-building project centred round a community garden, food hub, and co-operative greengrocers. Through the garden, local residents can access cookery classes, affordable food, family meals, and training and skills development (such as certificates in food hygiene and preparation). There are also plans to develop a sensory garden for people with people with dementia and a specific initiative on food for young people.

Since its launch in 2014, the project has reached more than 1,700 people, as well as 75 volunteers and community mentors. It is used by a broad cross-section of the community, including individuals with learning or physical disabilities from the local Mainstay Trust and vulnerable families involved with Govan Help. The benefits of the project include improved access to affordable healthy food; opportunities for socialising and physical activity; and skills development and employability.

"I have epilepsy, and volunteering has been a major help with that...I get to explore more – I've been to places I've never seen. I've actually left my scheme…I'm actually more independent than I thought….I realised I can smile – I'm not as angry any more. I've made great friends. I would recommend here to anybody who's struggling or who just wants somebody to talk to. Makes me feel good about myself. It's given me work opportunities and I got training for the Food Hygiene certificate, and I'm involved in the Moogety catering."

Service user (age 21)

Case study 9. Revitalise/Silver Deal

This partnership between the Wheatley Group, a local housing association, and NHSGGC, offers physical activity classes and arts & crafts sessions to residents aged over 60 years of age, including those in sheltered housing.

Case study 10. Galloway Gateway

In Dumfries & Galloway, a social prescribing programme has been developed through partnership working between Loreburn Housing Association, Let's Get Sporty, Stewartry and Wigtownshire Health & Social Care localities, and Dumfries and Galloway Council.

'Galloway Gateway' aims to combat social isolation and improve health and wellbeing in older people in rural areas through outdoor activity, social prescribing, and other events. A pilot programme for older people in three sheltered housing complexes has just concluded, and the evaluation is now underway. Funding was provided by the housing association, with other partners providing in-kind support.

The project is co-led by young people currently in supported accommodation or receiving outreach housing support, who receive skills training and mentorship to deliver activities for older people from sheltered housing. These activities include sports, gardening, and visits to local attractions. Potential benefits for young people participating in the scheme include increasing self-confidence, participation in physical activity, access to training opportunities, and greater employability.

Initial evaluations have suggested that the project has helped increase participants' physical activity and social connections, as well as feelings of health and wellbeing. The element of intergenerational working was felt to be especially successful. There are now plans to roll out the initiative across the region.

Similarly, encounters in the healthcare setting offer an important means of delivering interventions to improving housing circumstances and preventing homelessness.

The principle that healthcare encounters offer opportunities to identify and address life circumstances which may adversely affect health has been used to great effect in other areas, such as financial support for families with children, and may also be applied to patients with other housing needs relevant to health. Case study 3 provides an example of this approach for people newly diagnosed with cancer.

Equipping staff with the knowledge and skills they need to routinely enquire about housing circumstances and to follow-up with appropriate advice, signposting or referral offers new opportunities to address unsuitable, poor-quality, or insecure housing which may be contributing to individuals' poor health. This may be especially

valuable in services where patients may be at greater risk of poor housing, or be in need of home aids and adaptations, such as paediatrics, mental health, and care of the elderly.

Such opportunities might, at least in the first instance, be most fruitfully realised through existing initiatives in both primary care (for instance, through social prescribing and links worker programmes) and secondary care (for instance, through the Health Promoting Health Service's new recommendations on routine enquiry for vulnerability[53]).

14. Public health staff should work with housing colleagues to explore the potential for interventions in healthcare settings to identify and support those experiencing housing need.

Other potential local opportunities

Previous sections have highlighted opportunities arising from existing structures or strategic planning processes. However, smaller local initiatives outwith these formal structures may also provide a means to initiate cross-sectoral conversations, build relationships, and work on areas of mutual priority. Some of the established methods of public health, such as health needs assessment and health impact assessment (see page 24), or specific tools, such as the Place Standard (see page 25), can be particularly useful in this regard.

Case study 11 describes how public health input into a strategy on tower block housing identified new opportunities for health improvement interventions and led to the production of a community documentary.

Case study 11. Improving health in Lanarkshire's towers

In North Lanarkshire, 11% of council housing stock is within multi-story blocks of flats. A multi-agency Tower Strategy was therefore developed to ensure that all tower blocks were as safe, secure, energy efficient, and attractive to tenants as possible. Public health staff contributed to the development and implementation of the Towers Strategy, in order to integrate health improvement into the daily life of residents.

One project resulting from the Tower Strategy was the production of a documentary on life in the Motherwell tower blocks from past to present. This project aimed to build community cohesion, promote a sense of ownership, and develop the knowledge and skills of tenants and residents.

As case study 12, and the long-standing GoWell project in Glasgow's East End, illustrate, collaborations between housing and public health on research and evaluation projects can be extremely fruitful. Such initiatives – whether funded locally through participating organisations, or externally through research councils or governments – offer opportunities to:

- understand each others' priorities, language, and organisational cultures;
- engage with communities about their experiences of housing and neighbourhoods; and
- contribute to the wider evidence base about 'what works' in housing and health.

Evaluability assessment methodology may be especially beneficial in this regard, by providing a systematic guide to deciding whether and how to evaluate projects, and to incorporating stakeholder feedback at all stages of evaluation design[54]. More information on evaluability assessment, and other tools which can support evaluations in the area of health and housing, can be found in Section 5.

Case study 12. Evaluating the impacts of external wall insulation

In Ayrshire & Arran, a collaboration between the NHS, local authorities, Scottish Government, and the Energy Agency is building on mutual priorities of climate change, health, and inequalities by evaluating the impact of domestic insulation retrofits.

The project is planning to use both quantitative and qualitative methods to evaluate how improvements in wall insulation may affect energy efficiency and the health of residents, and how such retrofits are experienced by people participating in the schemes. A key aim is to collect self-reported changes in health – particularly respiratory health and mental health – can be collected, rather than relying solely on economic modelling, as is often the case in energy efficiency projects. The project team also intend to develop a methodology for continued evaluation that can be incorporated into future schemes.

15. Staff from both sectors should proactively seek opportunities to collaborate on ad-hoc projects and initiatives in areas of mutual priority, including research and evaluation.

16. Staff from both sectors should enhance the value of joint working through the application of existing tools and resources, using their outputs to inform planning and decision-making.

Each local area will encounter unique opportunities and obstacles in their efforts to improve health and reduce inequalities through housing. However, there are several specific challenges that are likely to be common to all, or most, local areas.

Integration of data on housing and health

In our engagement exercise, there was a widely acknowledged need for more robust information on the overlap between housing and health needs, to support processes such as Housing Need and Demand Assessment. For instance, although data may be available on the prevalence of specific health conditions, disabilities, or demographic characteristics, there are very few data on the housing circumstances or housing needs of those populations, and most population surveys which collect data on both housing and health do not have the coverage to be useful in planning at the local level.

One exciting development is a national linkage exercise between local authority homelessness data (the HL1 record) and health data, which aims to quantify health service usage and mortality among people applying for statutory homelessness support across Scotland[55]. Initial results are expected to be available in spring 2017. Similarly, there are pilot schemes underway to incorporate data on homeless households into a new data system produced by Information Services Division Scotland to support Health and Social Care Integration, known as SOURCE[56]. Though these initiatives focus on homelessness, rather than housing more broadly, their outputs are likely to be extremely useful for informing joint working on homelessness and housing insecurity at both local and national levels.

Unlike homelessness, there is no standardised collection of individual-level housing data across Scotland that can be directly linked to health data. However, a number of routine health datasets – in both primary and secondary care – collect information on housing which may be usable for this purpose. There may also be local housing datasets which could be linked to health data. For instance, researchers at Stirling University are exploring the potential of linking data from RSLs to health records in order to better understand health and housing need among people in the social rented sector.

A better understanding of data already collected in population surveys, primary healthcare, secondary healthcare, and housing settings could identify opportunities to address this knowledge gap in a rapid and cost-effective way.

17. NHS Health Scotland should consider the expansion of the section of the Scottish Public Health Observatory (ScotPHO) website dedicated to housing, to raise awareness of key policies and available data

18. NHS Health Scotland, through ScotPHO, should consider undertaking a scoping exercise to investigate potential data sources that may support joint work on health and housing.

Engaging with the private rented sector

Despite the substantial growth of the private rented sector in recent years, and persistent problems of affordability, security, and quality, it remains very difficult to engage directly with this area of the market.

This is partly down to fragmentation: although all private landlords may be registered with their local authority, in any one local area there may be hundreds or even thousands of private landlords, most of whom own only one or two properties[57]. There is therefore no clear point of contact or means of co-ordination. Though organisations for landlords exist e.g. the Scottish Association of Landlords[58], their membership is not comprehensive and may not include those mostly likely to be responsible for sub-standard or hazardous properties.

Though some of the opportunities highlighted above may help address some of the challenges posed by the private rented sector, in particular, the potential of advocacy coalitions on issues such as the Common Housing Quality Standard, greater joint working between public health, environmental health, and housing may also offer 'ways in' at the local and national level.

19. At a national level, NHS Health Scotland could explore opportunities for public health to engage with the private rented sector alongside other housing partners, for instance through existing organisations such as the Chartered Institute of Housing and the Scottish Landlords Association.

20. At a local level, public health teams should seek to develop an awareness of the private rented market in their area and to identify opportunities for engagement; for instance through local private rented sector forums and partnership working with colleagues in environmental health.

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ScotPHN report

For further information contact:

ScotPHN
c/o NHS Health Scotland
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

Email: nhs.healthscotland-scotphn@nhs.net

Web: www.scotphn.net

Twitter: @NHS_ScotPHN