Community Housing Cymru

Demonstrating the value of housing: health & care toolkit

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Contents

Purpose

This toolkit has been developed as a resource to support housing association members when working alongside health and social care colleagues, including on Regional Partnership Boards.

There is an increasing body of evidence showing the value of housing to public services, especially health and social care. Research demonstrates the importance of investing in housing for the significant health and well-being benefits that can be achieved, and the considerable cost savings that can be made. This briefing summarises evidence, research and case studies that demonstrate the role that housing plays, both to the individual and to the public purse. It also outlines the pressures and outcomes that our partners are held accountable to and drive their activity.

While this toolkit does include research and evidence regarding the COVID-19 pandemic, it does not look at the impact of housing on health and wellbeing solely in this context.

This document will be periodically reviewed and updated, and you can find the most recent version on our website. If there are any reports or research that do not feature here but you feel would be valuable, please do let us know.

Key messages

- Investment in good quality homes means that people can be healthier and can live independently in their own homes for longer. This helps individuals and families but also saves public money by relieving pressure on the NHS and other public services.
- Social housing tenants include people on low incomes and those with complex needs. Housing associations can play a key role in closing health and wellbeing equality gaps, supporting tenants with their personal, social and financial wellbeing.
- Housing associations are rooted in communities across Wales, and have unique assets, insights, resources and relationships. They are well placed to support people to be healthier, as well as to amplify the work of health and social care partners.

Headline statistics

- It is predicted that, between 2017 and 2035:
    - the number of people aged over 65 admitted to hospital because of a fall will increase by 63%
    - the number of people aged over 65 unable to manage at least one domestic task on their own will increase by 46%
    - the number of people aged over 65 unable to manage at least one self-care activity on their own will increase by 46%.[1]

- People in homes that lack necessary adaptations are between 1.5 and 2.8 times more likely to suffer a fall than those where interventions are in place.[2]
- Falls prevention interventions are among the most cost-effective, with initiatives paying back in less than 3 years.[3]
- A Housing LIN study estimated that for each person living in housing with care settings, the financial benefit to the NHS was approximately £2,000 per person per annum.[4]
- Research suggests that sheltered housing tenants consistently strive to maintain their health status and well-being through individual and collective action.[5]
- The full cost to society of leaving people living in poor housing in Wales is estimated to be around £1 billion per annum.[6]
- The average age of a homeless person at death is just 40–44 years old.[7]
- Research by Crisis shows that preventing homelessness can result in savings of around £9,266 per person compared to allowing homelessness to persist for 12 months.[8]

Sector commitments

- In our Home! Manifesto, we called on the Welsh Government to improve systems, partnerships and processes to make it easier to work together on the issues that determine our chances of living well. We also called for a right to adequate housing, supported by the resources and tools to deliver it, and the implementation of the recommendations of the Homelessness Action Group to end homelessness in Wales.
- We are working in partnership with the Welsh NHS Confederation and other health and social care partners, calling for cross-government action to reduce health inequalities and highlighting the wider social determinants of health.
- We commit to taking action against shared challenges, including:
    - continuing our work to end homelessness from social housing;
    - widening access to social housing;
    - ensuring our homes are affordable;
    - investing time and resources into building community trust and engagement; and
    - promoting digital inclusion.[9]

Section 1: Homes & services

Promoting good health through high quality, warm housing

The quality or condition of a home is one of the more direct ways in which housing can affect health: a home could be cold or hard to heat, contain hazards such as fall risks or faulty wiring, or be damp and mouldy.[10]

Poor housing can seriously damage people's physical and mental health and affect their future well-being and prosperity. Investing in improvements to people's housing can prevent the adverse health consequences of poor housing and cost to the NHS and other agencies. If the most severe hazards were removed from housing in Wales, there would be benefits to the NHS of some £95m a year in saved treatment costs.[11]

Looking at the costs to society as a whole, which takes into account the wider impacts of housing related illnesses and injuries, such as distress, reduced economic potential, life-long care and increased burden on welfare finances, the full cost to society of leaving people living in poor housing in Wales is estimated to be around £1 billion per annum.[12]

Similarly, BRE research on housing in England found that:

> *It is costing the NHS some £1.4bn per year to treat those people who are affected by poor housing.*
>
> *These are first year treatment costs alone. For many hazards there may be ongoing treatment beyond the first year. There will be 'societal costs', such as those relating to care, which in some cases may continue for a lifetime. There will be a loss of economic potential (poorer educational achievement, loss of productivity, career prospects) for victims of hazards, family carers and employers. There will be the mental health cost of suffering and trauma.*
>
> *When these societal costs are included, it is estimated that the full cost to society of leaving people living in poor housing is some £18.5bn per annum.*[13]

Wales has the oldest housing and, proportionately, the highest treatment costs associated with poor housing in the UK.[14] 65-70% of the UK's dwelling stock in existence in the 2050s is likely to have been built before 2000.[15] Housing which is not energy efficient can lead to excess cold and related health conditions, as well as financial hardship and fuel poverty. The percentage of households in fuel poverty in Wales has decreased from 29% in 2012 to 12% in 2018.[16]

Welsh residents aged 60 years and over benefiting from upgraded council houses (receiving a range of housing improvements under the Welsh Housing Quality Standard) were found to have 39% fewer hospital admissions for cardiorespiratory conditions and injuries compared to those living in homes that were not upgraded.[17]

The Welsh Government's Warm Homes Nest scheme provides energy efficiency advice and improvements to vulnerable households. Evaluation showed that the number of GP visits for respiratory conditions decreased by 3.9%, compared to a 9.8% increase for the control group.[18]

Evaluation of the Warm at Home programme by Sheffield Hallam University, which improved energy efficiency and helped vulnerable households keep warm, estimated that for every £1 of funding distributed to vulnerable households there were £4 of health benefits.[19]

Preventing hospital admission through accessible and adapted housing

Analysis by Care and Repair Cymru of the Rapid Response Adaptations programme identified that every £1 spent generated £7.50 of cost savings for health and social care associated with quicker hospital discharge, prevention of people going into hospital and prevention of accidents and falls in the home.[20]

For older and disabled people, access to aids, adaptations and equipment promotes their independence and can allow them to remain in their own homes - close to the people and places that matter to them. For the government, a one-off capital outlay can prevent the need for more intensive, costly interventions.

Evidence suggests that, unless the cost of the adaptation is very high compared with the life expectancy of the person concerned, adaptation (and independence) will nearly always be the better value option. Rapid response adaptation/ equipment supplies of £350 that prevent a hospital stay of one week produce savings of £2,490 per person. Over 16,000 people use this service per year In Wales, with estimated savings between £4m and £40m.[21]

It is predicted that, between 2017 and 2035, the number of people aged over 65 admitted to hospital because of a fall will increase by 63%. Those unable to manage at least one domestic task on their own will increase by 46%, and those unable to manage at least one self-care activity on their own will increase by 46%. See table below for more detail.[22]

Table 6: Population aged 65 and over various metrics, projected to 2035 (Wales)

Variable	Estimated number of people aged 65 or over		Estimated change from 2017 to 2035
	2017	2035	
People	646,960	860,300	+33%
Mobility impairment	117,667	178,134	+51%
Limiting long term illness	228,907	316,540	+38%
Falls - hospital admission	15,024	24,429	+63%
Dementia	44,275	72,769	+64%
Unable to manage at least one domestic task on their own	261,320	381,580	+46%
Unable to manage at least one self-care activity on their own	214,363	312,907	+46%
Living alone	292,380	388,608	+33%

Source: Welsh Government (2018e)

Around one third of older people aged 65 and above will suffer a fall each year, with 2% of falls resulting in a hip fracture. Around half of those aged 80 and above will fall in a given year. Adults lacking necessary adaptations are between 1.5 and 2.8 times more likely to suffer a fall than those where interventions are in place.[23]

The most cost-effective interventions are in the area of falls prevention, with initiatives paying back in less than 3 years.[24] Hip fractures are a major public health problem in terms of patient morbidity, mortality and costs to health and social care. The incidence of hip fracture increases steeply with age due to higher rates of osteoporosis and falls in the elderly population. One study estimated hospital costs to be £14,163 and £2139 in the first and second year following fracture, respectively. Total UK annual hospital costs associated with incident hip fractures were estimated at £1.1 billion.[25]

Adaptations commonly produce improved quality of life for around 90% of recipients. Factors contributing to this improved quality of life include reduced pain, reduced anxiety and fear, being able to bathe, being less dependent on others (with consequently less strained relationships) and not having to leave home. Adaptations also improve the quality of life of carers and of other family members.[26]

A delayed transfer of care is experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. The StatsWales Delayed Transfers of Care (DToC) census is a monthly snapshot that measures the trend in numbers of delayed transfers. Between September 2019 and February 2020, an average of 402 inpatients per month experienced a delay in the arrangements for them to leave hospital and go home.[27]

Promoting independence through housing with care and support

Our homes are 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.[28] Housing does not just provide shelter and space for indoor living; it makes a vital contribution to the physical and social environment of a neighbourhood. Housing is the root that connects people to communities, and the platform that enables full participation in community life.[29]

Home becomes increasingly important to older people as they retire, spending more time at home, particularly if they become ill or frail. Warm, safe, accessible housing in decent neighbourhoods enables older people to live safely and independently for longer, and contributes to their health and wellbeing, rather than compromising it.[30]

The Housing & Ageing Alliance, a not for profit, independent group in England, has stated that ‘buildings last much longer than people or policies’. Their paper outlines how an integrated

approach is needed, working across national government, local government and the NHS, to make homes and communities good places in which to grow old. The Alliance advocates embedding population ageing considerations into every decision about housing, and embedding housing considerations into every decision about older people, particularly health and care integration.[31]

A 2017 evaluation of the extra care sector in Wales found that nearly all Extra Care schemes in Wales (45 out of 47) were managed by social providers such as housing associations. Residents valued the independence that extra care affords, but welcomed the safety and security of living within a scheme. High levels of satisfaction were reported with accommodation, and communal facilities were providing valued opportunities for social interaction.

The research suggests that extra care would be a relevant and appropriate housing option for a sizable number of the older person population, given the prevalence of long term health problems and disabilities and incidence of mobility and self-care issues. Projections of demand generated by employing a range of different prevalence rates suggest that demand outstrips supply of extra care housing across Wales. This gap is likely to widen given that the population of older people is projected to increase dramatically in the future.

This evaluation recommended that the Welsh Government clarify the role specialist provision (including extra care) will play in meeting the housing needs of an ageing population. Local authorities need to have a clear understanding of the housing needs of older people and of local provision of specialist housing and support in order to plan strategically and work cooperatively to ensure people have access to appropriate and affordable housing in older age.[32]

Social isolation and loneliness can act as risk factors for the development of frailty and change in frailty severity.[33] Housing associations' supported housing can play a key role in alleviating such isolation; older people living in specialist age-specific housing tend to report being less lonely than their peers.[34]

One study found that sheltered housing tenants felt a personal responsibility to maintain their well-being, and consistently strived to maintain their health status and well-being through individual and collective action. The communal environment supported this and their sense of safety and security, and they drew on the social capital that existed in their communities to improve their daily experiences. The findings suggested the need for multi-professional health, social care and housing services to facilitate the sheltered housing tenants' aspirations to live well and independently in their own homes, while still providing support to maintain and address conditions before the need for emergency hospital admission. Sheltered housing officers/wardens can play an important role in identifying early signs of deterioration, in particular frailty, respiratory and circulatory problems and supporting tenants to approach health professionals to attain early intervention, thus pre-empting potential crisis and emergency situations.[35]

A study of ExtraCare Charitable Trust schemes in England found that:

> *...over the 5-year period since moving in, significant improvements can be found in ExtraCare residents' health and well-being. Notably, residents are exercising more and have improved their memory and cognitive abilities. Importantly, in some critical health factors where a downward trend might normally be expected with age[...], no such trends are emerging.*
>
> *Further, usual age-related changes in frailty status are delayed in ExtraCare residents, which demonstrates that frailty is indeed malleable and that positive changes in physical, cognitive and social health can influence the progression of frailty. Levels of depression are low among residents while social well-being is high, with lower levels of loneliness than national averages.*
>
> *Further, ExtraCare residents have changed the way in which they use health care resources and we note that there is a cost saving to the NHS of just under £2000 per person, over 5 years. This is in contrast to the usual expected increase in NHS costs as people age.*[36]

Clear financial benefits are delivered by sheltered housing to local authorities and the NHS, not least in increasing independence and reducing or delaying the need for older people to enter formal care settings. Sheltered housing and extra care offer a cost-effective alternative housing provision to residential care. Local authorities are able to reduce their provision of (relatively expensive) residential care homes, if alternatives such as extra care housing are developed.[37]

A Housing LIN study estimated that for each person living in housing with care settings, the financial benefit to the NHS was approximately £2,000 per person per annum (calculated as a cost benefit to the health care system). This includes reductions in the number of GP visits, community health nurse visits and non-elective admissions to hospital, as well as reductions in hospital length of stay, delayed discharges and ambulance call outs.[38]

Sheltered housing in England provides an estimated total cost saving of £486m per year, including reduced inpatient stays; reduced immediate care costs of falls prevented; reduced health and care costs of hip fractures prevented; and reduced health service use by reducing loneliness.[39]

Research by the Strategic Society found that a new specialist retirement housing unit may result in the savings to the state, per person, as set out below. New retirement housing also releases housing stock onto the market and enables younger people to get on the housing ladder and to fund their housing and care costs in retirement.

Health and care needs	£ 9,700
Local authority social care entitlement	£18,600
First time buyers & future retirement wealth	£54,800
Total	**£83,100**

Reducing health inequalities through affordable, secure housing

As a social determinant of health, better housing and greater security and affordability is key to addressing some of the structural drivers of health inequality.[40] Housing exerts a substantial influence on health and wellbeing through several linked routes, including: the affordability of homes; the quality of homes; and the role of the home as a platform for inclusion in community life.[41]

Social housing can provide a missing piece of the jigsaw in protecting wellbeing. Housing association staff have a great deal of contact with tenants on a day to day basis, including entering their homes - for repairs, housing officer visits, financial inclusion, digital support - and may observe 'warning signs' in residents' health, wellbeing and safeguarding that other services cannot.

In addition to quality and condition, the affordability and security of housing are key for ensuring health.[42] Housing costs are a major factor in determining not only the degree of control over where they live and the quality of the home that they can afford, but also the amount of money that they have available to support their health and wellbeing after paying housing costs.

Increasing the supply of affordable housing helps to tackle inequalities by reducing child poverty and homelessness and by providing inclusive, sustainable housing options.[43] PWC estimated that for every £1 invested in solutions to move people directly out of homelessness, £2.80 will be generated in benefits.[44] Research for Crisis found that preventing homelessness can result in savings of around £9,266 per person compared to allowing homelessness to persist for a year.[45]

Homeless people have a higher risk of physical and mental health problems. They are more likely to die from cancer or commit suicide, and their average age at death is just 40–44 years old. They also have higher rates of alcohol and substance misuse, smoking and tuberculosis.[46]

Homelessness is not randomly distributed across the UK population and instead there are factors which weigh certain individuals with a greater probability of experiencing poor or insecure housing arrangements. These factors include poverty, a lack of social support networks, pre-existing health problems, unemployment, older adulthood and young childhood, as well as having adverse experiences during childhood.[47]

Poor health outcomes in this population are both a cause and a consequence of homelessness. The homeless population often suffer poor mental health, physical illness, and substance dependencies, reduced life expectancy, and excess preventable morbidities. The causes and consequences of homelessness exist as part of complex systems and so are difficult to dissociate.

The direct consequences of poor housing include unhealthy home environments (i.e., cold, damp, mould, indoor toxins), unsuitable housing (e.g., unsafe for children and older adults), food and fuel poverty, overcrowding, infestations, noise and environments conducive to substance misuse. Consequences of homelessness also include the erosion of protective factors such as maintaining

social support networks, as well as societal issues such as stigmatisation, and difficulties accessing services such as housing and healthcare.

The cost of NHS health care activity between January and July of 2020 amongst those with lived experience of homelessness was £11 million more than the general population comparison group and the majority of the difference was contributed by emergency care. Individuals with lived experience of homelessness had increased levels of activity in emergency care. (See tables below)

Figure 6. Numbers per 1,000 testing positive for the virus causing COVID-19, COVID-19 related death and hospital admissions within individuals who were homeless during the pandemic and those in the general population comparison group (see Appendix 5)

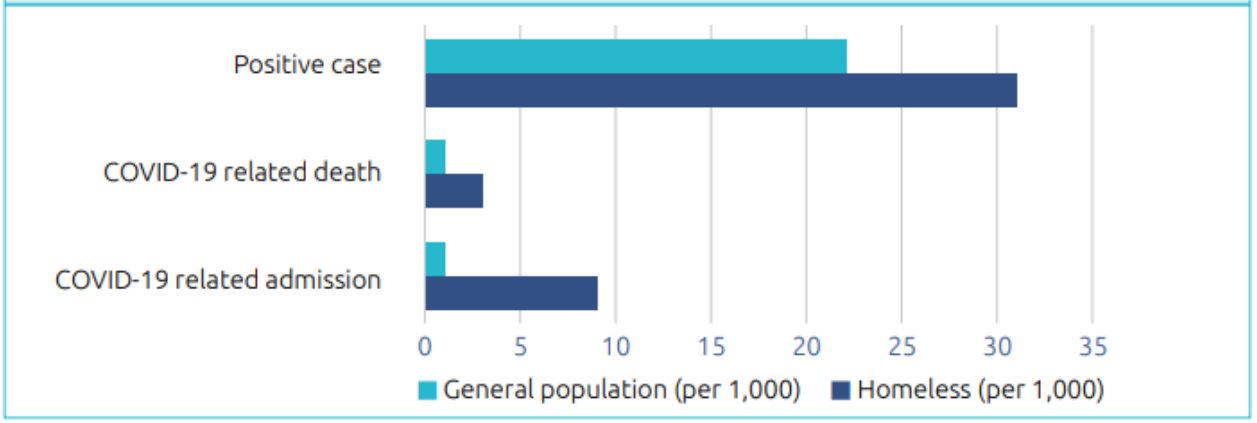


Figure 4. Age-sex standardised healthcare activity rates per 1,000 population within the e-cohort with lived experience of homelessness and the population comparison group, January to July 2020 compared to January to July 2019

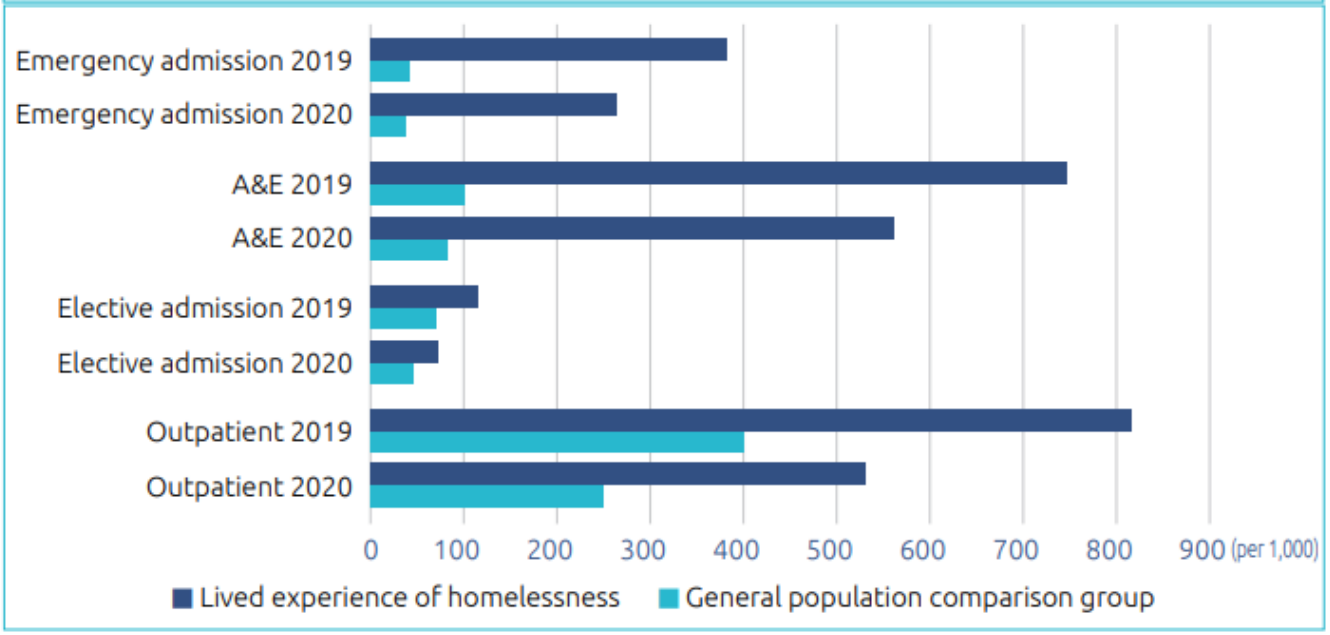


Table 2. Cost of healthcare activity during 2020 (January to July) within individuals with lived experience of homelessness and the population comparison group (crude unadjusted)

		Individuals with lived experience of homelessness	Population comparison group
Emergency department	Attendances	8548	1281
(Unit cost = £186)	Cost	£1,589,928.00	£238,266.00
Emergency admissions	Admissions	3340	600
(Unit cost = £3,514)	Cost	£11,736,760.00	£2,108,400.00
Total emergency care cost		£13,326,688.00	£2,346,666.00
Elective admissions	Admissions	699	692
(Unit cost = £4,612)	Cost	£3,223,788.00	£3,191,504.00
Outpatient services	Visits	7035	3849
(Unit cost = £134)	Cost	£942,690.00	£515,766.00
Total planned care cost		£4,166,478.00	£3,707,270.00
Total		**£17,493,166**	**£6,053,936**

The need for security in relation to having and keeping a home and being surrounded by a safe and consistent home environment, and its impact on both physical and mental health and well-being, has long been recognised. During times of uncertainty, such as in the COVID-19 pandemic, a home can provide a secure and stable base for individuals and households to help them respond to and recover from the pandemic and its effects.[48]

The impact of reduced incomes and eligibility for some benefits has been felt hardest by the most vulnerable population groups (e.g. those already in insecure and poor quality housing, living on low incomes and/or with existing health problems). These households and individuals are particularly susceptible to homelessness and fuel poverty because of higher housing costs, higher energy costs (due to energy-inefficient housing), and the higher cost of other household bills.[49]

Going into the pandemic, one in three households in England (32% or 7.6 million households) had at least one major housing problem relating to overcrowding, affordability or poor-quality housing. These factors increase exposure to poor living conditions, reduce financial resilience and exacerbate susceptibility to COVID-19 through overcrowding.[50]

Overcrowded housing has long been identified as having detrimental effects on physical and mental health, childhood development and education and familial relationships,[51] all of which have been highlighted and exacerbated by the COVID-19 pandemic. Overcrowded housing increases the likelihood that households develop symptoms and a disproportionate impact on low-income and BAME communities who have a higher likelihood of living under such conditions (Barker, 2020).[52]

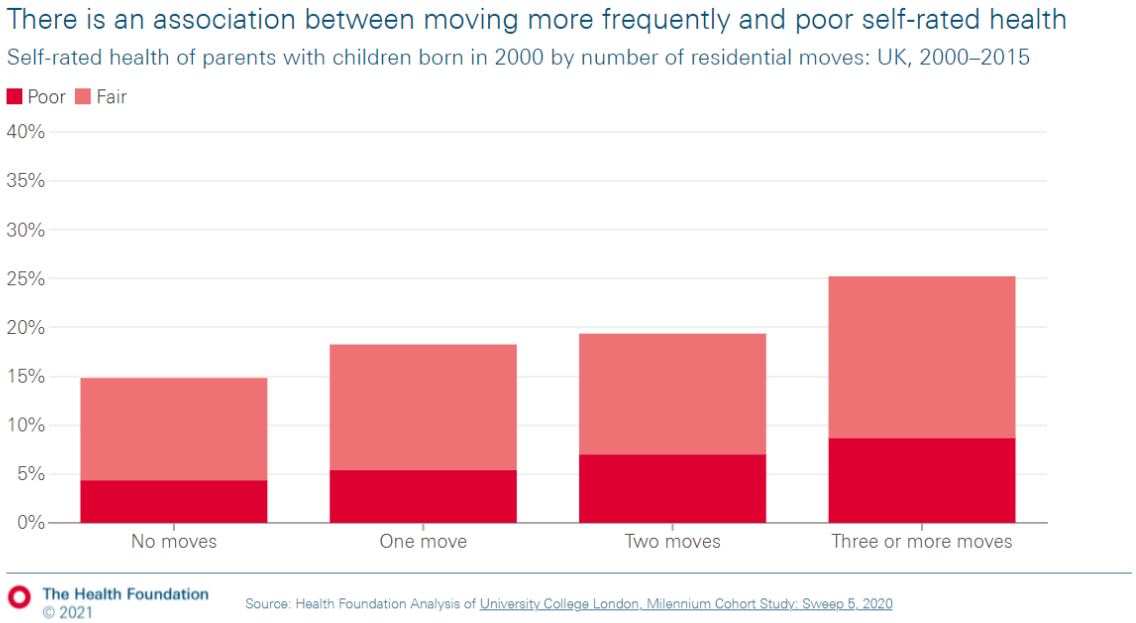
In his 2020 paper for the UK Collaborative Centre for Housing Evidence, Dr Craig Gurney remarked that:

> *...Any disappointments in home will not be evenly experienced. Housing insecurity, economic precarity, lack of access to decent housing - where home is taken for granted – with no space for self-actualisation nor to flourish constitutes a bedrock of harm upon which the uncertainties of a global pandemic will be deposited much more deeply than upon those who have experienced a lockdown in a decent home with a garden, with more rooms than people living there, with internet access, in a mutually respectful and nourishing relationship whilst experiencing good physical health and wellbeing.*[53]

Research has found that entering unaffordable housing is detrimental to the mental health of individuals residing in low-to-moderate income households.[54] Feeling secure in your home can provide a sense of continuity and stability for other areas of life. While difficult to measure directly, home moves and duration of tenure can be used as proxies for general security. Of course, people can move for many reasons, including positive ones (such as moving to better accommodation), but frequent relocations can also indicate insecurity.[55]

Housing security can be described in terms of insecurity of tenure, including homelessness; feeling unsafe at home; and ontological security (consistency of one's environment, home as a secure base). Reduced security of tenure and transiency impact an individual's ability to set down roots, and develop a sense of belonging, in their local communities..[56]

The graph below shows the link between moving homes and health for the parents in a study by the Health Foundation. By the time the children were 15, there was a clear association between those who moved the most and parents with the worst self-rated health, with statistically significant differences between each category (except between one and two moves). The data do not show that moves cause poor health, or vice versa – simply that there is an association between the two.[57]



Section 2: Assets, resources & relationships

We know that resources are under pressure and that statutory services are stretched and responding to crises. We can help. Better join-up with community partners, such as housing associations, could provide support at a much earlier stage, preventing an escalation to crisis point, keeping people in their homes and communities for as long as possible.

Research

Despite concerted efforts, poverty levels remain stubbornly high: Wales has consistently had the highest levels of poverty across the UK for over a century. The West Wales and the Valleys region is one of the poorest in the whole of Europe and productivity in Wales is the lowest in the UK. Increasing jobs alone is not enough. Of the 420,000 working age adults living in poverty in Wales, 60% live in households where at least one adult is in work.[58]

The gap in the number of years people live in good or very good health between the most and least deprived areas in Wales is 18.2 years for men and 18.4 years for women.[59] This pattern between the most and least deprived areas of the country is repeated across many areas of health. There is a close link between poverty and health inequality, and housing associations work in and with communities where there are high levels of socio-economic disadvantage. Social housing providers are important community anchors which are well placed to support anti-poverty strategies and lead economic and social cohesion at a community level.[60]

Research on 'community anchor organisations' in Wales found that anchors are well placed to respond to what might be needed locally and have the ability to respond swiftly, effectively and appropriately. Anchors are the builders and nurturers of connections and relationships, which are the bedrock – the 'social capital' – of local community-building and place-making. Anchor organisations can support co-production with statutory bodies, having access and trust from a cross-section of local communities and access to familiar, non-threatening settings.[61]

Another (forthcoming) publication states: "Community organisations finesse rules with policy-makers where individuals cannot. They translate for, and facilitate conversations between, regulatory bodies and local groups and individuals. Community anchors, then, form a web of techniques and practices that act as conduits, roads, pathways and channels – in short, a socio-political infrastructure that can create flows." (McDermont et al, forthcoming)

The third sector provides an invaluable link between local government and the community. Third sector groups are often trusted by the community and understand their needs but also have access to the local government structures and networks.[62] The third sector also has invaluable insight into the overall needs of the community, having built up strong links with the area over time, and this allows them to deliver more personalised and responsive services.

Memorandums of Understanding

In recent years there has been a growth of local housing, health and social care partnerships in England developing their local Memorandums of Understanding (MOUs) or equivalent documents. Examples include West Sussex Health and Care in Housing MOU, and a MOU to support joint action in Lincolnshire on improving health through housing.[63]

In 2020 Caerphilly County Borough Council, Linc Cymru, Pobl Group, United Welsh and Wales & West Housing Associations signed a MOU committing to work collaboratively to find local housing solutions, with a particular focus on the delivery of new affordable housing.[64]

In 2019 the University of South Wales (USW) and Hafod Housing Association signed a MOU, agreeing to strengthen their collaboration and work towards developing and enhancing professional practice to promote improvements in health and social wellbeing.[65]

Sector case studies

Newydd & Hapi

Hapi (Happy, Aspiring, Prosperous and Inclusive) is a health and wellbeing project providing local communities with free resources and access to workshops to positively impact their mental health and wellbeing. The aim of the Hapi project is to provide participants with the skills and knowledge to empower them to make healthier life choices.

Hapi works with tenants and residents to improve their general wellbeing by delivering free 1-2-1 advice and group workshops in several themed areas:

- Emotional wellbeing - e.g. mindfulness, stress management
- Physical activity - e.g. sports, pilates, family fitness
- Food and nutrition - e.g. cook-a-longs, weight management
- Education, employment and training - e.g. online accredited courses

Hapi is run by the community team at Newydd housing association and funded by the Big Lottery People and Places Fund. The project has been running in Rhondda Cynon Taf since 2016, based in the Rhydyfelin Community Hub in Pontypridd. Since March 2020 workshops have been delivered virtually, with participants joining in from around the world. Hapi has been academically evaluated by the University of Wales Trinity Saint David.

In 2021, the project received funding from Cardiff and Vale University Health Board to run similar activities free to all communities living in and around Cardiff and Vale of Glamorgan.

CCHA & Muslim Doctors Cymru

Cardiff Community Housing Association (CCHA), the Loudoun Health Centre and Muslim Doctors Cymru worked together to promote and oversee a COVID-19 Vaccination Hub in Butetown, Cardiff in June 2021:

> *We are uniquely positioned to have a meaningful role in supporting health initiatives, as our homes are occupied by some of the most disadvantaged in society, those more at risk of experiencing health inequality. We often have a wealth of knowledge about our tenants, both documented and through the key relationships that are developed through a range of staff interactions.*
>
> *As the vaccination programme rollout commenced, we offered our community space (including our two other Centres) to support local delivery. Whilst this was not taken up at the time, we saw a further opportunity arise with the development of more localised 'pop-up' centres.*
>
> *Linking with Citizen Wales, Muslim Doctors Cymru, Community Leaders/Champions and the Testing and Mass Immunisation Team from Cardiff and Vale Health Board, we progressed this opportunity, hosting a pop up vaccination Centre over a weekend in June.*

Outcomes:

- Pop-up operated for 2 days over 5th and 6th June, 09:30– 17:45 on both days
- 3 staff from the NHS attended each day
- 15 staff from CCHA volunteered
- 25 individuals 40 or older attended, receiving their first vaccine
- CCHA spoke with hundreds of local residents over the weekend
- All those who attended for the vaccine were from ethnically diverse groups

ClwydAlyn I CAN Hub

In partnership with Betsi Cadwaladr University Health Board, ClwydAlyn housing association opened an I CAN Community Hub in Rhyl, North Wales. Rhyl is a coastal town where the impact of health inequalities mean that healthy life expectancy can vary by up to 12 years compared with other areas of the country.

The aim was to establish a community hub to support citizens' positive mental health and emotional well-being. The primary objective is to provide preventative and early intervention support to enable individuals to prevent the deterioration of their mental well-being and to alleviate social distress/crisis. The Hub is managed by ClwydAlyn with support from I CAN volunteers and statutory and non-statutory services.

A core element to the Hub is 'Welcome Wednesday', which brings partner agencies together under one roof. Individuals can then access a range of services within a non-stigmatised community setting. Engaged partners include GPs, mental health teams, third sector partners, housing officers and even vets and hairdressers.

Since reopening the Hub following an easing of lockdown restrictions, the staff team and volunteers have provided support to 96 individuals with referrals coming from GPs, probation service, police, hospitals, CAB and voluntary organisations.

Section 3: Pressures, drivers and outcomes

This section outlines key drivers of health and social care activity, including outcomes our partners are held to account on and pressures they face when making decisions.

RPBs will soon be required to submit their Population Needs Assessments (PNAs) and Market Stability Reports (MSRs). Generally speaking, PNAs and MSRs deal, respectively, with the demand and supply side of the social care market. PNAs and MSRs are produced on a five yearly cycle, with both due in the first half of 2022, so that they can inform and shape the next set of strategic Regional Area Plans due in 2023.

The partnerships landscape in Wales is complicated and, arguably, cluttered. It is also changing and evolving rapidly, which takes up capacity and resource for all involved. One such change is the advent of Corporate Joint Committees; you can see our briefing on this topic here.

Statutory considerations

Social Services and Well-being Act

The Social Services and Well-being (Wales) Act 2014 ('the SSWB Act') provides the legal framework for improving the well-being of people who need care and support, and carers who need support.

The SSWB Act seeks to transform social services in Wales by:

- promoting the integration of health and social care
- encouraging people to become independent to give them stronger voice and control over their lives
- giving people greater freedom to decide what support they need
- promoting consistent, high-quality services across the country.

Well-being of Future Generations Act

The Well-being of Future Generations (Wales) Act 2015 ('the WBFG Act') aims to improve the social, economic, environmental and cultural well-being of Wales. It describes seven national well-being goals that provide a shared vision that public bodies listed in the WBFG Act must work towards.

The social services national outcomes framework complements the WBFG Act. Both the SSWB Act and the WBFG Act set expectations and requirements for public bodies to work together to improve outcomes, recognising that the needs of people, families and communities are met by multiple organisations.

The SSWB Act is about people who need care and support and carers who need support, whereas the WBFG Act is set at the Wales population level.

Socio-economic Duty

The Socio-economic Duty came into force in March 2021. The Duty places a legal responsibility on bodies when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage.

The overall aim of the Duty is to deliver better outcomes for those who experience socio-economic disadvantage, and applies to public bodies including Welsh Ministers, County Councils/County Borough Councils, Local Health Boards and NHS Trusts.

Strategies & frameworks

A Healthier Wales

A Healthier Wales: Our plan for Health and Social Care, 2019 is the Welsh Government's plan for ensuring that people stay healthy and independent for as long as possible.

There are five main ways that Welsh Government want to change health and social care:

1. In each part of Wales the health and social care system will work together so that people using them won't notice when they are provided by different organisations.
2. We want to shift services out of hospital to communities, and we want more services which stop people getting ill by detecting things earlier, or preventing them altogether.
3. We will get better at measuring what really matters to people, so we can use that to work out which services and treatments work well, and which ones need to be improved.
4. We will make Wales a great place to work in health and social care, and we will do more to support carers and volunteers.
5. To make our services work as a single system, we need everyone to work together and pull in the same direction.

Public Health Outcomes Framework

The Public Health Outcomes Framework (PHOF), 2016 links closely to other outcomes frameworks, including those for the NHS and the Social Services National Outcomes Framework. There is a direct overlap with some indicators that are shared across these frameworks, whilst there are some indicators which are complementary to others. All of the frameworks are overarched by the WBFG Act.

The PHOF is informed by the broad context of a health in all policies approach, and also in the context of specific relevant legislation such as the SSWB Act.

Outcomes are grouped under three domains:

A. Living conditions that support and contribute to health now and for the future
B. Ways of living that improve health
C. Health throughout the life-course

Within the framework, each outcome has individual indicators. Some indicators are also national indicators to monitor the well-being goals of the Wellbeing of Future Generations (Wales) Act 2015. The PHOF provides both a summary (page 9) and detailed outcomes (from page 12).

The PHOF reporting tool contains 40+ key indicators for monitoring health and well-being.

Social services national outcomes framework

Social Services: The national outcomes framework for people who need care and support and carers who need support, 2019 was developed to fulfil a requirement in the SSWB Act to describe well-being for people who need care and support (and carers who need support) and provide a consistent approach to measuring well-being.

The key objectives for the national outcomes framework are:

- To set the national direction to promote the well-being of people who need care and support and carers who need support in Wales.
- To describe the important national well-being outcomes that people who need care and support and carers who need support should expect in order to lead fulfilled lives.
- To provide greater transparency on whether services are improving well-being outcomes for people who need care and support and carers who need support in Wales using consistent and comparable indicators.

There is collective accountability for population outcomes (measured by the Social Services national outcomes framework) but each service has direct accountability for their service delivery. To measure direct accountability for local authorities, a performance measurement framework has been developed for local authority social services functions. There will also be implications for partner bodies, including local health boards, the third and independent sectors and for people who need care and support and carers who need support in Wales. Annex A in the code of practice (from page 17) maps out well-being outcomes, quality standards for local authorities and measures.

NHS Wales

Ministerial priorities for the NHS in Wales, as reiterated in the NHS Wales Annual Planning Framework, 2021-2022, are:

- Prevention
- Reducing health inequalities
- Primary and community care
- Timely access to services
- Mental health
- Decarbonisation
- Social partnership

The NHS Wales core values are:

- Putting quality and safety above all else – providing high value evidence based care for our patients at all times.
- Integrating improvement into everyday working and eliminating harm, variation and waste.
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partners and organisations and with our staff.
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

To discuss this briefing or the evidence within it, please contact
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