HOUSING VISION

How well do homes in Oxfordshire support the population's health and wellbeing? Stakeholder insight

Final Report

June 2025

www.housingvision.co.uk

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1. Introduction

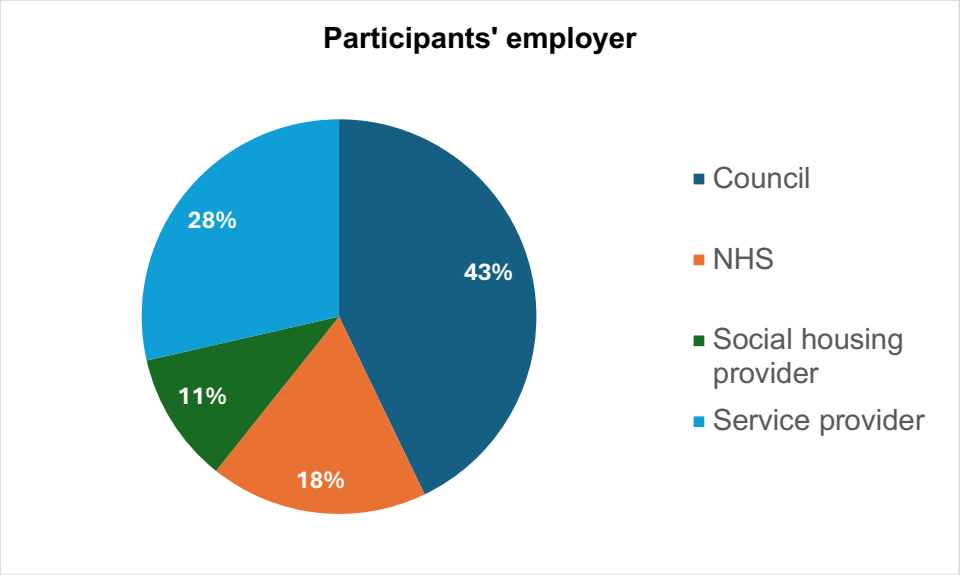
This report presents local perspectives on the health of homes in Oxfordshire from a broad range of people and organisations, drawn from interviews, four facilitated thematic discussions and Housing Vision attendance at meetings.

Engagement sought to answer the question "*How well do homes in Oxfordshire support the population's health and wellbeing?"*.

This report should be read alongside the Housing and Health Needs Assessment. Where available, data drawn from this Assessment was used to inform interviews and thematic discussions.

An estimated 76 people contributed their insight, with 54% of these holding a 'population-focused' role, and 46% holding a 'housing-focused' role, employed by a local authority, the NHS, a social housing provider or service provider. 13 of those contributing worked for a voluntary and community sector organisation.

Figure 1: Employer of those contributing to the research



The report represents findings from engagement with the 'coalition of the willing' (those stakeholders who agreed to participate to participate in interviews and/or thematic discussions). Further information about the approach taken to stakeholder engagement, and limitations, is provided in Annex A.

Where relevant, reference is also made in this report to the Housing and Health Needs Assessment ('the baseline assessment'), alongside additional information drawn from the Housing Vision team's experience and knowledge of housing, health and care systems nationally.

2. Recommendations and findings

The primary recommendation from both the engagement work, and assessment, is for Oxfordshire to adopt, plan and deliver, a 'health in all home, home in all health, policies' approach. All subsequent recommendations form part of this.

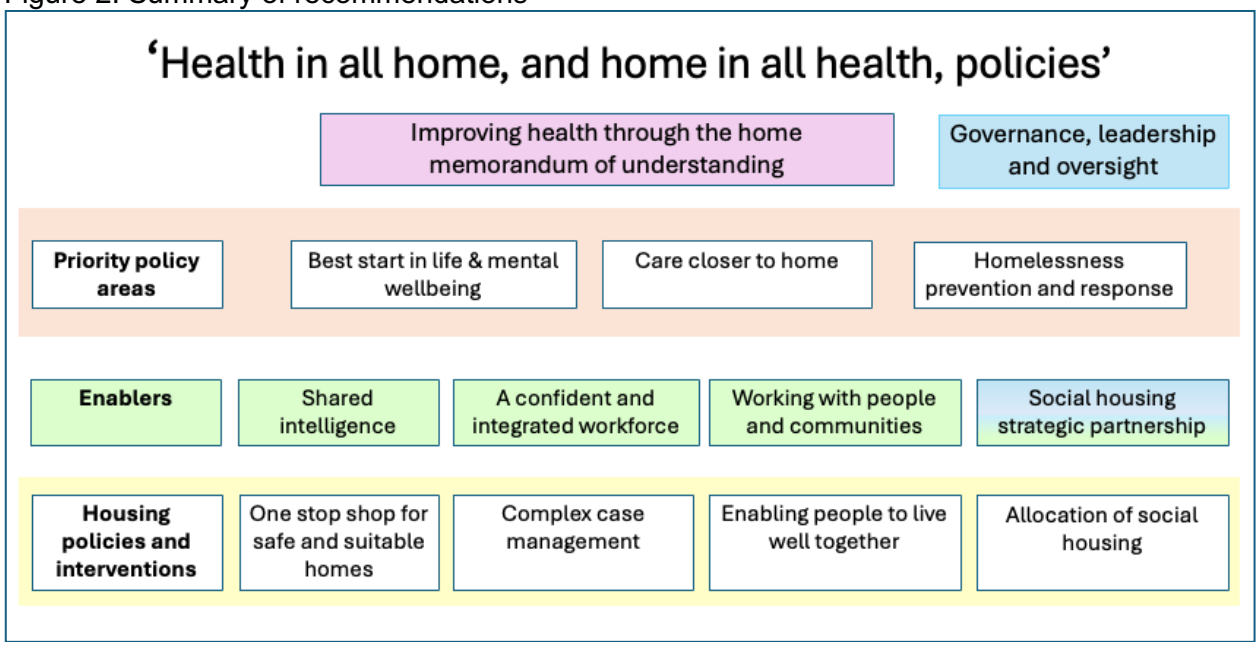
The report is structured around the common themes and areas for action identified through engagement:

A) Governance and collaboration
B) Priority policy areas
C) Enablers
D) Housing policies and interventions

These are interrelated eg, to deliver on 'start well' or 'care closer to home' priorities, it's essential to address the lack of an up-to-date understanding of the condition and suitability of homes in Oxfordshire ('shared intelligence', an enabler).

The following is a visual representation of the report's recommendations and structure.

Figure 2: Summary of recommendations



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A: Governance and collaboration

The primary recommendation from both the engagement work, and assessment, is for Oxfordshire to adopt, plan and deliver, a 'health in all home, home in all health, policies' approach. All subsequent recommendations form part of this.

A 'health in all policies' approach (HiAP) seeks to improve health equity through collaboration and consideration to health in decision-making across sectors and policy areas.[1]

Sir Michael Marmot has long advocated for this approach - for health equity to be at the heart of what governments, councils and public services do – and that this must include considering health in decisions that affect the conditions in which we are born, grow, live, work and age in, the social determinants of health, or 'building blocks'. As a Marmot County, Oxfordshire has already acknowledged that health in all 'building block' policies is essential to reducing health inequalities.

The government also advocates for a HiAP approach; the Devolution White Paper introduces a new bespoke duty on Strategic Authorities, in relation to health improvement and health inequalities, to drive this.

Adopting such an approach, as Oxfordshire and district councils decide their future, has the potential to offer several benefits. These include:

Increasing confidence in the effective use of available resources to deliver impact, particularly to improve equity.

A strong theme from engagement is that unhealthy homes have a much greater cost than is currently visible, to people and communities, workforces and organisations across all sectors concerned with health and wellbeing, not just housing. There's also a strong sense that available resources are not necessarily targeting people who could benefit the most, those who are experiencing the greatest inequalities, for example: vulnerable families; communities, including the East Timor community, who would benefit from culturally aware responses; the increasing number of people living in 'mobile' home settings (including boats).

Providing a clear and transparent, outcomes focussed, basis for discussion between the County Council, the districts and stakeholders about the future strategy for homes in Oxfordshire.

Local government reorganisation and devolution necessitate discussions about where policies and public service decisions will be made and for which geography; this will include decisions about housing and related matters that have potential to impact on health outcomes.

[1] The World Health Organisation definition is "An approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity".

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A1: Develop a memorandum of understanding

It is recommended that 'an improving health through the home, and homes through health' memorandum of understanding is developed, adopted by homes, health, care and support partners and professions, and monitored, with appropriate oversight (see A2).

Collaboration across sectors is essential to the success of a HiAP approach, and this starts with acknowledging that whilst homes make a difference to health, health also makes a difference to homes. It is a two-way street; for the benefits of collaboration to be realised, decisions on health, care and support services must consider where someone lives, and how such services enable people to call a house a home. This will be essential to making progress in Oxfordshire.

It is positive that the Health and Wellbeing Board has recognised action on housing as a priority in the health and wellbeing strategy, but there is much work to be done before the Board can be confident that housing policies and interventions are contributing to improving health equity.

The position in Oxfordshire is not unusual and stems from central government policy. Whilst this broadly recognises that the home makes a difference to health, the health of the population, and equity, has not been a systematic and explicit consideration in national (or local) housing policy decision making, nor have homes been a consideration in health, care and support policy. In this context, data available to Oxfordshire's Health and Wellbeing Board is only able to provide an overview of the key features of unsafe, unsuitable and precarious homes eg, number of households in temporary accommodation. It is not possible to know what impact these are having on Oxfordshire's population, or whether housing policies and interventions are making a difference.

There is however action Oxfordshire can take; developing a memorandum of understanding is a first step.

Memorandums of understanding (MoU) play a pivotal enabling role in HiAP, formalising cross-sector collaboration. They provide the basis for developing trust and long-term relationships. They:

- Raise the profile of specific strategic areas of priority, in this case HiAP
- Clarify roles and responsibilities (preventing 'everyone's responsible = no-one's responsible')
- Signal senior buy-in from all partner organisations
- Provide the basis for governance structures
- Enable resource pooling
- Enable consistent assessments of impact across partners
- Can steer relevant commissioning activity

There is a model that can be adopted and adapted. In 2014, then again in 2018, Public Health England led the development of a national 'improving health through the home' memorandum, signaling collaboration across a range of agencies, including the NHS and housing sector. Recent government policy still refers to this as a good practice model way of working, and it is one that has been successfully adopted by several two-tier areas including West Sussex, Warwickshire, Lincolnshire and Nottinghamshire. Memorandums have been accompanied by an action plan with reporting mechanisms through purpose-specific governance structures and/or the Health and Wellbeing Board.

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A2: Governance, leadership and oversight

It is recommended that, whichever approach Oxfordshire takes to enabling Priority 9 in the Health and Wellbeing Strategy (if not a MoU), there needs to be clear leadership, governance and accountability in place for the stated ambition ("Everyone should have access to quality and affordable homes to improve people's health and narrow health inequalities") to be achieved.

The research has revealed that there is no Oxfordshire and population-wide direction or oversight of either housing activity that contributes to improved health and equity, or health, care and support activity that impacts on homes. Instead, there are multiple policies, mechanisms and people (including many non-housing stakeholders) delivering outputs in silos, but with no sense of the outcomes or impact this investment is collectively making.

Stakeholder engagement suggests that this is deeply frustrating for everyone involved, coupled with a clear desire to be more preventative, to plan, to target. A shift to this position, away from firefighting, necessitates cross-sector (systems) leadership. A health in all policies approach can be beneficial in this regard as it will strategically link both the homes and health agendas together.

One governance mechanism to create leadership and accountability could be via a memorandum of understanding which is a tried and tested approach recommended by Housing Vision.

The recently refreshed Prevention of Homelessness Directors Group is discussed in policy priority B3.

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B: Suggested shared policy priorities

World Health Organisation guidance suggests there are three policy situations that a 'health in all policies' approach lends itself to; 'wicked' problems eg, equity, climate change; wider determinant of health policy areas, such as housing; political priorities. Common across all are the potential for impact on health and wellbeing, and the need for intersectoral collaboration.

The three priorities for a 'health in all policies, home in all policies' approach suggested here, drawing on the research, fit more than one of the WHO's three policy situations.

B1: Give every child best start in life

As part of taking a health and home in all policies approach, the following actions should contribute to this priority, and those for improving mental wellbeing:

- *Governance for children's health and wellbeing to hold 'housing' to account: the basis for this needs to be developed but should cover the three aspects of a healthy home*
- *Identify a senior strategic housing lead, able to represent the districts, to regularly participate in governance for children's health and wellbeing – a 'best start in life' housing lead*
- *Enable a working group to lead action on 'health and home in all policies' for children, drawing on cross-sector participation*
- *Develop improved pathways to information, advice, guidance, support and interventions, beginning with action to make visible existing routes to improving the home environment (for example address issues of home safety), including protocols for escalation*
- *Explore the potential to improve relationships, including multi-disciplinary working, between housing professionals and those supporting the most 'vulnerable' families to enable more effective targeting and use of resources to achieve impact.*

<u>Rationale</u>

Giving every child the best start in life is one of two priorities for Oxfordshire as a Marmot County, reflecting local priorities expressed in the Children and Young People's Plan ('*more children are safe at home and in their communities'* is one of the outcomes), the Neglect Strategy and Buckinghamshire, Oxfordshire and West Berkshire's Integrated Care Board Plans. However, the absence of action in these plans to improve the health of the home is notable; there is a strong case for 'home to be in all children's policies'.[2]

The baseline assessment highlights strong evidence of the negative impact a poor home environment can have on the physical and mental health and wellbeing of children and young people. These conditions can contribute to premature mortality or ill-health which lasts a lifetime[i]. It's also worth noting that research consistently demonstrates that childhood poverty is a significant factor in predicting adult homelessness.

A poor home environment comes at a cost to public services: recent evidence suggests that nationally more than one in five social workers supporting children and families have been involved in cases over the past three years where children were removed from their families in part due to unsafe or inappropriate housing conditions.[ii]

[2] The home conditions toolkit is discussed later.

Despite the evidence of impact, it's not common for housing policy and practice to explicitly focus on the child or young person. This starts with national legislation; governments in England have not, for example, replicated the Welsh government's position that the impact of homelessness on children is so great that the practice of finding families intentionally homeless must end.

Health and care policy also assumes an adult carer will enable a healthy home environment. In this context, data is not captured by these systems locally to understand the extent to which the home environment impacts health. It may be that there is some data available from those working with families, for example through the 'strengths and needs' form. If there is, this hasn't previously been shared with district housing colleagues.

'Early years' stakeholders have been amongst those most engaged in the research, in interviews and attending thematic discussions on several topics. Stakeholders are those working with families already identified as 'vulnerable' in some way, for example a referral for assistance has been made by the community midwife. They often make home visits and see the home environment.

Stakeholders provided numerous stories of families, their poor home environment and the impact this is having on the child, and parents', health and wellbeing. These included stories of:

- Extreme cold, damp and mould, infestation and falls from windows, and long waits for repairs
- Overcrowding and unintentional injuries
- Hoarding (Home-Start is proactively sharing a hoarding checklist with families so they can identify their situation before it gets out of hand)
- Homelessness placements in hotel accommodation without access to amenities or services, and often overcrowded
- Frequent moves between accommodation and the impact on access to services and education
- Lack of homes large enough and/or suitable to those families whose children have additional needs, including disabilities and autistic children.

There are further examples provided in the 2024 qualitative study of energy advice and support in Oxfordshire (Better Housing Better Health), for example:

Figure 3 Story extract from 2024 qualitative study of energy advice and support

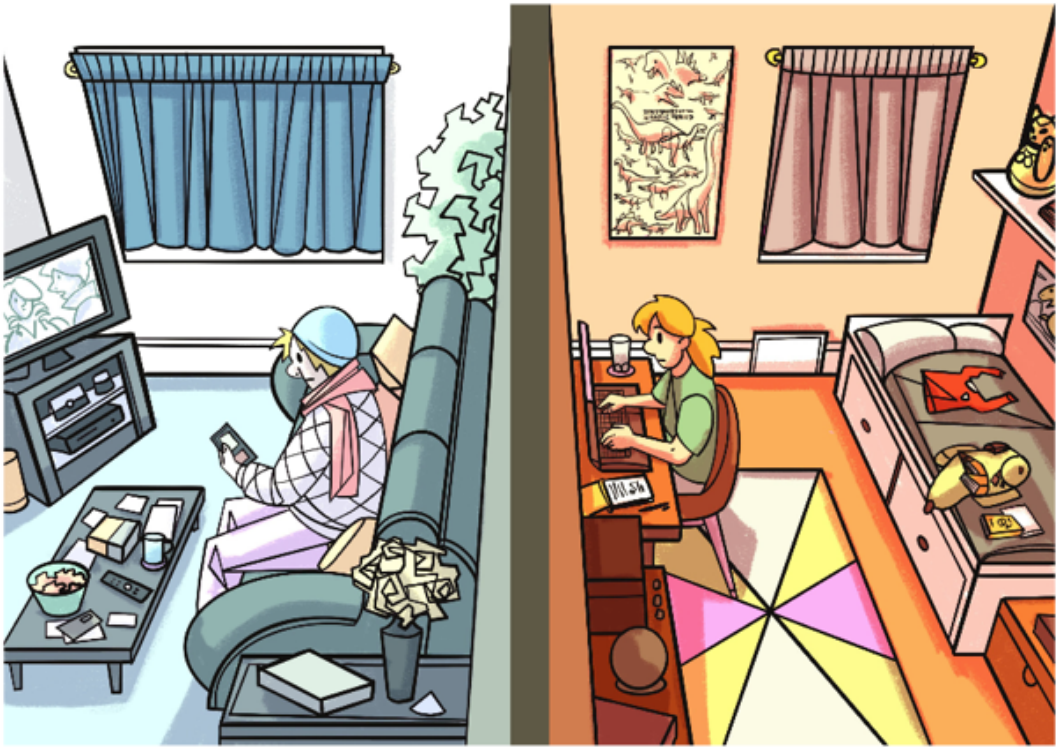


Figure 6 'I could not put my heating on in my living room. I have a child who is 12. I had to heat her room, obviously. We would argue as a parent that their welfare is more important than the adult. It's not, of course, but that's our logic. So I'd heat her room, but not heat the living room.' (H7)

Source: Better Housing Better Health: a qualitative study[iii]

The impact of unhealthy homes on the parent/carers' and child's mental health and wellbeing, and child development was frequently raised as an issue.

It is evident that stakeholders spend a considerable amount of time and energy in trying to support and/or directly seek assistance to resolve 'home environment' issues, often without success, and no knowledge of how to escalate matters. This comes at a cost; time spent on matters of the home means less time supporting families in other areas.

There's no means by which stakeholders can share their insight on the home environment on a regular basis, to inform housing policy and service delivery. It's not thought there is housing-specific representation on the Neglect Strategy group.

There's been some recognition of the need to act by those working in early years, for example the Oxfordshire Safeguarding Children Partnership's development and revision of the 'framework for recording the condition of the home' tool. However:

- Whilst there has been some district housing input to this, it's not known what difference this made
- Housing Vision provided additional suggestions to improve the tool during this work; we don't know what difference this has made
- It's unclear how the information collected will be used, practically and strategically

Home-Start and The Branch

Offering support to families (and others) in Oxford, Banbury and Chipping Norton, Home-Start and The Branch contributed insight from their work.

Their stories include a mother struggling with mental ill-health and maintaining a healthy home environment, and another family struggling for months in a bed and breakfast with damp and vermin.

In these instances, Home-Start provided emotional and practical support to clean the home, whilst The Branch navigated complex housing and benefit issues, enabled a house move and practical tasks to be completed in the new home such as painting and furniture assembly.

B2: Care at home or closer to home

Annex A describes the limitations of this research, including that it was not possible to reach as many adult social care stakeholders as we would have liked, which may reflect the capacity and the recent change in housing leadership in the County Council. That said, the needs assessment, engagement and known national priorities (expected to be described fully in the government's ten-year plan for health) are sufficient to warrant this as a priority for Oxfordshire.

As part of taking a health and home in all policies approach, the following actions should contribute to this priority:

- *Governance for prevention and promoting independence should be able to hold 'housing' to account: the basis for this needs to be developed but should cover the three aspects of a healthy home*
- *Enhance the integrated and joint health and social care commissioning function by appointing to a housing specific integrated role (could be public health) which could include oversight and system leadership (links to A1)*
- *Enable a working group to lead action on 'health and home in all policies' to enable 'care closer to home'. Priorities for action are:*
    - *For a focus on people with a long-term condition and integrating home considerations into pathways, building on existing work to improve matters for people with a respiratory condition led by NHS colleagues*
    - *The exploration of models/ways of working to better identify and address home environment issues that affect health care outcomes, in primary and acute services, for example co-location of housing professionals in health care settings and/or tools and training to enable those working in health care eg, social prescribers, to better support patients*
    - *To raise the profile of the top home environment issues that can impact social care outcomes and publicise routes to seeking resolution (relates to D1)*
    - *Enabling clarity around who should pay for what in terms of safety and suitability improvements for patients, and building this and assurance into new commissioning activities, reinforcing and embedding the health and home in all policies' agenda (also links to 'enablers' (C)).*

- *Learn from and build on community approaches such as Age UK Oxfordshire (locally based, in people's homes), expanding the commissioning and delivery model to a wider range of populations eg, people living with mental health conditions*

Recommendations under 'enablers' (C) and several of those recommendations in D (housing policy and interventions) will also contribute to this priority, for example a better understanding of housing conditions and impact on residents' health and care needs, and a one-stop shop for home safety and suitability.

Rationale

The Oxfordshire Way and Marmot County population health and neighborhood level strategic drivers, provide a timely and important focus on care closer to home for health and adult social care in Oxfordshire, to ensure people can stay in their homes for as long as possible. The standard and quality of the home – in effect a 'health setting' - being a key enabler.

The baseline assessment particular draws attention to:

- The projected growth in the older population in Oxfordshire, currently by almost one third over the next 20 years (projections for those aged 80-89 is in the region of 80%)
- The increased risks the home presents to the health and wellbeing of people in later life, and people living with a disability and/or long-term condition. Increased risk of falls is the main risk factor; the major cause of emergency hospital admissions for over 65s, and a leading factor for entering social care services, including residential care.[iv]
- Almost half of all single-person households in Oxfordshire (a quarter of all homes) are lived in by residents aged 66 years and older: loneliness and isolation may be a risk. In under-occupied homes, the cost of heating and maintaining these may be challenging.
- Older residents are far more likely to own their homes outright, but this does not mean that they can all afford to pay for services, including social care.
- Disability is strongly associated with tenure, in turn affecting access to healthy, suitable and stable housing. 14% of Oxfordshire's population are disabled under the Equality Act: this rate doubles for people aged 65+. Disabled people are less likely to own their own home than non-disabled people; people renting social housing have the highest rates of disability, over twice as high as owner-occupiers.

'Care closer to home' has been the ambition of NHS strategy since 2006 and continues to be so.[v] Essential to achieving this is an understanding of how healthy the home is, and collaboration with others to enable improvements. For people with health, care and support needs, integrating these services with those to improve the home environment is recommended in health and social care legislation: housing is defined as a 'health-related service'.

Nationally it is estimated that 17.5 million patients live in an unhealthy home environment, and unhealthy homes also affect the NHS workforce.

Estimates of the cost of unhealthy homes to the NHS described in research vary (described in the baseline assessment); all are under-estimates, based as they are on poor quality and out-of-date data. The effect of the high cost of housing, in the context of high cost of living, on NHS staff recruitment and retention is something BOB and Frimley Integrated Care Systems have particularly explored.

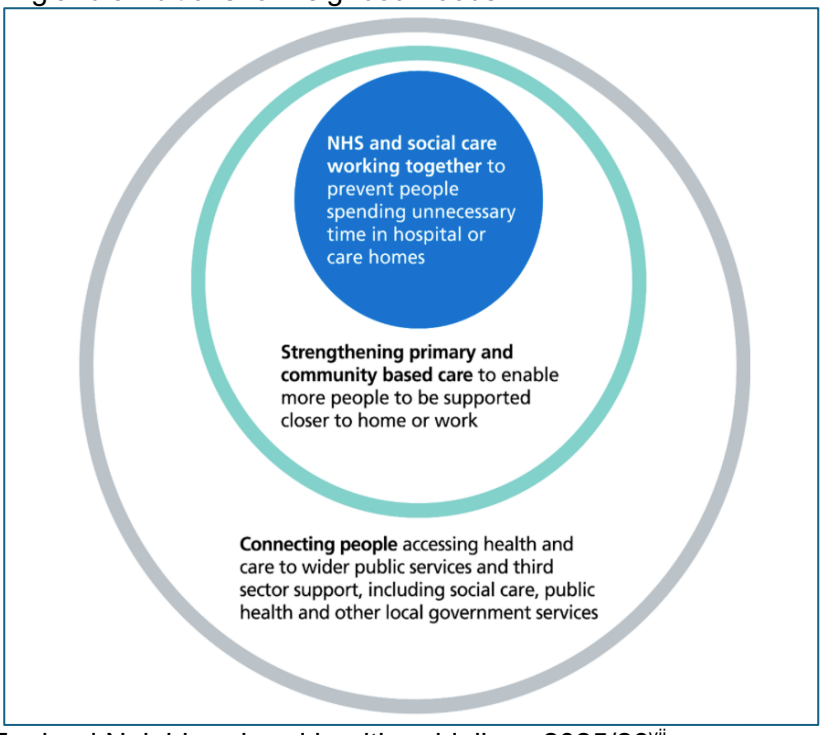
Not only does the home environment contribute to poor health, for example respiratory conditions arising from damp and mould or unintentional injuries arising from a fall in the home, the home can make a difference to a patients' access to, experience of and outcomes from health care – the effectiveness of treatment. This is particularly the case for people in inclusion health groups who often experience a combination of unsafe, unsuitable and precarious housing circumstances.

What we were able to glean from our research was that in Oxfordshire older owner occupiers are at risk of living in a poor state impacting their health and wellbeing. Unfortunately, data is not routinely collected in relation to this in Oxfordshire but the assertion is backed by the Centre for Better Ageing; State of Homes report (more data due to be released in 2025).[vi]

Local insight from the voluntary and community sector reflects an understanding that accessibility challenges can lead to isolation that consequentially have a profound effect on health, cognitive decline and early death. One case was mentioned whereby an older man living in a flat on the 3rd floor, with no lift, had a dog. As the dog aged, he was worried about carrying it down the stairs and therefore decided not to socialise.

The government's imminent ten-year health plan, ensuring an NHS fit for the future, is centred on three shifts: moving care from hospitals to communities; making better use of technology; focussing on preventing sickness, not just treating it. Each shift will necessitate consideration to the home environment, and – in line with policy to date - the expectation will likely be that this consideration happens locally. Suggested recommendations will support the three shifts, and ambitions for neighbourhoods for the next five to ten years.

Figure 4 NHS England ambitions for neighbourhoods



Source: NHS England Neighbourhood health guidelines 2025/26[vii]

A review of Buckinghamshire, Oxfordshire and West Berkshire's Integrated Care Board (BOB) plans for the NHS in Oxfordshire demonstrate a high-level understanding that the home environment makes a difference to health and wellbeing.

It is also evident that healthcare professionals are identifying housing issues in their work, and seek a resolution, whether this be through referrals to a council housing service, Better Housing Better Health, or writing a letter in support of an application for social housing. Stakeholders operating in the mental health field repeatedly cited difficulty in dealing with issues with homes once identified, at times escalating to crisis and an inpatient stay. One contributor is cited as suggesting that only at crisis point, were people engaging to make improvements, and 'throwing everything but the kitchen sink at it' to get it ready for discharge. Confidence that investment from health and care professionals is making as positive a difference as it could is lacking, particularly if the response is not timely and preventative.

There is some positive practice evident in BOB's approach to long-term conditions, particularly respiratory, and potentially in the emerging Integrated Neighbourhood Teams. There is interest in how primary care can more effectively enable access to improvements in the home.

Also of note in Oxfordshire is the approach taken to the Better Care Fund, and specifically the allocation of resources to the Health and Homelessness Inclusion Team, an integrated and multi-disciplinary approach to improving health, equity and reducing homelessness. This model of pooled resources and way of working could be adopted to benefit other populations.

There are several tensions commonly found in joint-working between the NHS and housing system, and these are evident in Oxfordshire. These relate to resources (what's available, how these are allocated, timeframes for intervention and targets/measures of success), and the medical versus social model.

BOB and primary care stakeholders engaged in the research would like to do more but lack knowledge of the housing system, how decisions are made, and who to work with across the five districts. The research suggests the need for governance and leadership to enable collaboration, shared understanding, a safe space to explore ways of working, and to develop more shared, integrated, solutions.

Without linking the HiAP approach to commissioning there is a risk of losing system join-up, particularly where delivery is not in-house (either NHS or social care). Making HiAP everybody's business will having a last impact on culture change and ultimately health outcomes for people in later life.

There is positive practice in Oxfordshire to build on. Worth noting is the value of localised knowledge and expertise, particularly in the voluntary and community sector in enabling solutions.

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Age UK Oxfordshire

Voluntary and Community sector organisation Age UK Oxfordshire, a County Council commissioned service, are delivering local, community based hands-on practical support for older people. Housing is cited as not an insignificant factor as to why people are referred.

One strength of Age UK's model is the locality of the workforce; staff are dedicated to specific 'patches' enabling them to have enhanced knowledge of housing and support agencies in their area include housing associations (social housing providers) and district councils.

The role of the Home Improvement Agencies (discussed in D1), and access to enabling home adaptations through the Disabled Facilities Grant (DFG) are recognised as enabling care closer to home, although equity across the county was cited as a concerned.

B3: Homelessness prevention

Annex A describes the approach to, and limitations of, this research: the focus of engagement was to answer the question *'how well do homes support the health and wellbeing of residents?*'; local capacity to engage in this research was a challenge - stakeholders working in homelessness are likely the most hard-pressed for time.

That said, it is widely recognised that homelessness is everyone's business, that it is public health matter and that the common experience amongst everyone described as belonging to an inclusion health 'group' is precarious housing; homelessness is evidence of inequity.[viii] For this reason, and that it is the primary priority for district councils, this policy priority is suggested.

As part of taking a health and home in all policies approach, the following actions should contribute to this priority:

- *Governance for homelessness prevention should be able to hold 'health and care' to account: the basis for this needs to be developed but should cover people experiencing homelessness across the life course (for example children), physical and mental health conditions.*
- *Commissioning plans in homelessness and mental health should build in home quality indicators to start to triangulate intelligence and act (D1); driving the culture change to better make the link between homes and health to improve outcomes.*
- *Joint work should focus on*
    - *Identifying opportunities, and enabling, greater consideration to precarious home circumstances in the design and delivery of health, care and support services to people living in precarious home circumstances – this should include primary care, and services focused on children and families*
    - *Exploring options to develop integrated models of home, health, care and support for other populations experiencing homelessness or at high risk – not just those experiencing rough sleeping and/or time in hospital (building on the effective Health and Homelessness Inclusion Team model)*
    - *Working with non-homelessness voluntary and community sector organisations to appraise options to more effectively mitigate the impacts of living in temporary accommodation on health eg, access to basic amenities*

Action to deliver policy priorities for ‘start well’ and ‘care closer to home’ should contribute to homelessness prevention, as will recommendations under ‘enablers’ (C) and several of those recommendations in D. For example, developing an integrated workforce, exploring options to enable people to live well together, and the strategic, health and wellbeing focused, partnership with housing providers.

Rationale

Homelessness is a priority for the five district councils, reflected in the existence of a countywide steering group, an alliance (joint commissioning of services for people sleeping rough) and recently refreshed Director’s Group. This is the only existing ‘governance’ relating to healthy homes.

The chronic shortage of genuinely affordable homes to rent in Oxfordshire is recognised by almost all stakeholders engaged in the research. The considerable difference between Local Housing Allowance (LHA) and market rents not only presents a challenge to accommodating households; stakeholders also report that households on LHA have little choice but to live in the poorest condition homes in the private rented sector.

District councils are severely constrained in their efforts to prevent homelessness, and in their response when this is unavoidable. The use of temporary accommodation continues to grow, and this is not expected to change quickly in the short term.

District council stakeholders acknowledge the challenges, but feel they are doing everything they can and that, given ongoing use, they (and others working in homelessness) feel that health and social care stakeholders need to acknowledge this in the design and delivery of services, particularly as ill-health can be contributory to, and exacerbated by, homelessness. There is however a health perspective, for example health visitor insight highlights the challenges in supporting families who move frequently because of homelessness; missed home visits undermine early-years support.

Stakeholders external to district councils, working with adults, families and children, all cited the challenges associated with stays in hotel accommodation where basic amenities such as food storage, the ability to reheat food and laundry, were not available. The costs associated with needing to travel from hotels, which can be located outside urban areas and away from health and community services, were also highlighted.

Examples of community-led approaches to meeting the needs of households in temporary accommodation were cited, for example enabling access to food and laundry facilities. There may be scope to better harness this resource, which sits outside the homelessness ‘sector’.

Stakeholders feel there would be merit in exploring the development of a model akin to the existing health and homelessness inclusion team for other households experiencing or at high risk of homelessness, including families with children.

A case study of multi-disciplinary working

Pam (not her real name) was living in a social housing tenancy and had a diagnosed mental health condition. She became unwell, attended A&E and was subsequently detained in hospital for mental health treatment.

Prior to her hospital admission, Pam's neighbours reported concerns about the condition of her home, including a flea infestation. The landlord had attempted to engage with Pam, and on failing to engage, had contacted Pam's GP and mental health team.

During the hospital admission, severe self-neglect and concerns regarding the home environment were also identified and the process of engaging agencies involved with Pam was started to enable house cleaning and extensive repair works (the latter included removing stripping the walls back to brick work to deal with the infestation, such was the extent of the problem). During this time, Pam was supported to return to the community, moving from hospital to step-down supported accommodation to begin with.

Staff from the NHS, Oxford City Council, Oxfordshire County Council and Connection Support worked collaboratively throughout the process, including members of the Mental Health Team, Older Adult Community Mental Health Team, Adult Social Care Team, Oxford City's landlord service and housing options service.

Source: Case study provided by Oxfordshire Health and Homelessness Inclusion Health

C. Enabling activities

These could be adopted to have population-wide benefit and/or be undertaken to contribute to a specific shared priority areas (section B).

C1: Shared intelligence

The baseline assessment emphasises limitations in the availability of data and information to answer the questions:

- 'How well do homes in Oxfordshire support the population's health and wellbeing?'
- 'What difference are housing (and related) policies, plans, services and interventions making to the population's health and wellbeing?'

This extends from the lack of effective working definitions to the quality and quantity of data available to connect population, homes and health in service provision. In this context data linkage drawing on existing data is likely to have a very limited value.

Recommendations made in this section are to improve intelligence through data. These should be considered alongside recommendations C2 (workforce) and C4 (working with people and communities); this research highlights that qualitative insight is invaluable but is not routinely captured and used to inform decisions.

Commission a countywide stock condition and household survey

The assessment highlights that, whilst there's some positive practice in seeking to better understand housing conditions in some parts of Oxfordshire at a service level, this is in the absence of an up-to-date stock condition and household survey (an example of positive practice is provided in the baseline assessment). There may be value in such a survey being cross-tenure ie, encompassing social housing; this should be discussed with providers.

Stakeholders emphasise that there is an urgent need for this survey; the lack of up-to-date information is preventing council teams from ensuring that their resources are targeted most effectively, not just to improve health and wellbeing but to address related issues such as improving climate resilience.

There is potential for improvements in service data collection and reporting to better inform progress on 'improving health through the home'. The assessment describes several opportunities, ranging from enforcement, home improvement and adaptation activity to temporary accommodation and the need for/allocation of social housing. This work would benefit from strategic oversight so that, together, data informs a system overview (see recommendations A1 and A2).

Design an effective approach to data collection, analysis and use, capable of informing governance, policy, commissioning and service delivery decisions, drawing on housing and non-housing specific sources.

Stakeholder engagement suggests that a considerable amount of non-housing specific resource is concerned with, and seeks to intervene in, improving the home environment. This isn't currently possible to quantify, nor is its impact ie, does stakeholder input make a difference to the home environment, health and wellbeing? This resource also generates insight; if this is captured, it isn't shared.

It would make sense to consider how non-housing specific 'service' information could be more effectively captured and used, alongside improvements to housing data, beginning with a focus on policy priorities described in section B and asking the question "how can we improve our collective data to better inform how we collectively improve health through the home?". The thematic discussions suggested that there's interest in the potential for data linkage between services such as health visiting, enforcement and hospital admissions.

This work will undoubtedly lay bare differences in definition, and approaches to assessment. Although challenging to manage, enabling a shared understanding and common approach is essential to making progress to address complex problems (a health in all policies approach acknowledges this). A common approach to assessment is discussed in workforce development, next.

C2: A confident and integrated workforce

Although the housing workforce is described as the 'wider public health workforce', nationally, workforce planning for improved health and equity does not consider the role of professionals working to improve health through the home.[ixx] This has been long been advocated for, particularly to enable the integration described in social care and health care legislation in support of 'care closer to home'.

Health and care workforce planning activity for Oxfordshire should incorporate an audit of professionals engaged in improving health through the home, and a projection of demand for services (*see next recommendation)****.***

As a minimum this should include environmental health practitioners and occupational therapists, and those working in housing-related support services in all sectors (commissioned and non-commissioned).

The aim of an audit would be to understand what capacity and capability already exists, and to what end, and what's needed going forward. It would likely consider qualifications, experience and skills, the number of interventions delivered (to whom and where) and outcomes (if possible; local data systems rarely record this). The characteristics of the workforce, such as age, gender, ethnicity, disability/ill-health should also be considered to inform planning.

Review and revise environmental health practitioner capacity to respond to changes in legislation relating to improving housing conditions

The Chartered Institute of Environmental Health has been drawing attention to the lack of environmental health practitioners for some time, and in more recent times considering new legislation. Engagement locally also suggests that capacity is already challenged (see D2: complex case management). This can lack of capacity can be negatively experienced, for example through unhappiness with the timeliness of responses to referred hazards.

There are two pieces of legislation that can be expected to increase the demand for services to improve housing conditions: Awaab's law comes into effect in October 2025 (requiring social landlords to act on damp and mould); the Renters (Reform) Bill is expected to come into effect between October 2025 and January 2026 (the most significant reform of the private rented sector since 1988, and expected to introduce a 'decent home standard' to the sector for the first time).

A better understanding of the condition of homes in Oxfordshire through a survey (recommendation C1) should inform councils capacity and capability requirements to respond to new demands (and the shape of services determined by local government reorganisation in the future).

A review should also consider the role of qualified environmental health practitioners in developing capability, and capacity, in the wider workforce. This is also a conversation to have with occupational therapists (see next).

Develop and deliver a 'health through the home' capability and capacity building programme offer to the wider workforce

A training programme should be offered on an ongoing basis to recognise staff/volunteer turnover, and changes in legislation, evidence and practice.

Such an offer would need to be developed locally, drawing on partners' own training offers, and their knowledge and use of existing training platforms. For example, the Housing Ombudsman offers online training to social housing provider members, covering topics such as damp and mould. Shelter offers training for non-housing professionals about homelessness. NHS England's e-learning portal includes programmes covering 'helping people living in cold homes, housing and homelessness.

Engagement suggests that many non-housing stakeholders either make home visits and/or have a trusted relationship with households whose health and wellbeing is particularly at risk from the home environment. This includes social prescribers working in primary care. They are in a unique position to enable change, and invest time in doing so, yet feel this does not always result in action and they do not understand why.

There's scope for non-housing stakeholder resources to be more effectively used; developing capability could enhance Oxfordshire's capacity to act.

There are examples of environmental health professionals and Better Housing Better Health providing training to non-housing professionals on an ad hoc basis.

We were unable to speak with occupational therapists (OTs) as part of this work[3]. A registered health care profession, OTs are highly effective in enabling people to participate in the everyday activities of life, including through – but not limited to - the home. They must be involved in taking this, and other recommendations forward; their person-centred, outcomes focussed, approach has potential to add significant value, strategically and in delivery.[xi]

Explore options to enhance capacity in housing services

Engagement has identified that there are different perspectives within Oxfordshire's housing workforce, and within the wider workforce, as to housing issues, what action is needed and when.

[3] One OT attended a thematic discussion.

There are several options available to enable this:

- Access to consistent information, advice and guidance (recommendation D1)
- The development of a common approach to assessing the home environment, adopted across workforces and supported by protocols and monitoring (this could build on the home conditions checklist developed by Oxfordshire's Safeguarding Childrens' Board)
- The development of a trusted assessor model to carry out a holistic assessment of needs, avoiding duplication and speeding up response times. Such models exist elsewhere in the country in relation to housing option services (for example in Sheffield) to assessments for home adaptations and hospital discharge.[xii] There are courses eg, on minor adaptations and guidance eg, from the CQC, on such a model.

Identify a 'home' for action to address challenges in the construction workforce that are a barrier to improving housing conditions.

Engagement with environmental health colleagues identified a lack of qualified and experienced retrofit installers, citing cases where poorly installed external insulation has caused damp and mould. Also, that contractors appear to be self-selecting easier urban homes to retrofit (related to additional barriers such as planning - conservation areas and listed buildings, for example). This issue should be of particular interest to those concerned with enabling climate and carbon zero ambitions.

C3: Strategic partnership with social housing providers

Develop a strategic partnership between social housing providers, health and care partners.

The baseline assessment suggests that in line with the national picture, social housing in Oxfordshire is generally in a better condition than homes in the private sector (rented and owner-occupation). It is also home to fewer residents.

There are however two issues:

- Although generally in a better condition, there remain some social rented homes in Oxfordshire that are not offering a healthy environment.
- Many households in social housing experience poorer health than in other tenures: the tenure provides affordable homes for those on lower incomes; decisions on allocation consider a range of other 'vulnerabilities' including health and care needs. In eight of eleven of Oxfordshire's most deprived neighbourhoods there are more social rent than private rent homes; in six of these neighbourhoods two-fifths or more of homes are social rent. Rates of disability are twice as high for social renters than owner-occupiers in Oxfordshire.

There are multiple reasons why strategic partnerships with social landlords can contribute to improved health outcomes and equity and these are expanded upon below.

In terms of priority, findings and recommendations suggest that initial work should centre on:

- Addressing damp and mould, and other child safety matters (B1 and D1)
- Joint work to better support households with long-term conditions (B2 and D2)
- Improving responses to complex cases eg, people who hoard (B3 and D2)

Additionally, although social housing providers are regulated by the national Regulator of Social Housing, this operates a model of co-regulation ie, only providers are asked to evidence how they meet standards. There is no opportunity for local stakeholders to contribute their experiences to the regulatory process (tenants and residents views would be captured and shared by the provider: the Housing Ombudsman has called for the establishment of a new national tenants' voice organisation), and district councils. Engagement suggests that the latter's workload, in environmental health and housing options teams, is impacted by social housing providers. A strategic partnership offers an opportunity for a shared understanding of social housing provision and the organisations who own and manage homes, and shared accountability.

Improved housing conditions

There are several legal standards related to damp and mould that social landlords must adhere to, including Awaab's Law[4] which set clear legal expectations about the timeframes within which social landlords must take action to make homes safe where they contain significant hazards.

Despite these standards, and the Regulator of Social Housing, council environmental health teams and non-housing stakeholders describe situations where standards are not being met and efforts to escalate these do not change the situation. Nationally, the Housing Ombudsman has reported that there has been a 474% increase in complaints in the last five years to 24/25, with repairs representing 45% of its workload and the single biggest driver of complaints.

Figure 5 Housing association story reported in 2024 qualitative study of energy advice and support, Oxfordshire

Figure 7 'But I am in a long battle, and it's been four years believe it or not I'm still battling with this housing association to try and get me some decent heating that I can turn a switch on and it will heat the whole property, and it won't keep shutting down, and it'll be sufficient to heat the property... I have fingers crossed, but I just don't know. I've taken it to a complaint and they are dealing with it at the moment, but they're extremely slow, and I've said to them many times, please try and do something for me before the winter. But they just take forever, four years, I'm on the fourth year now.' (H9)

Source: Better Housing Better Health: A qualitative study of energy advice and support in Oxfordshire, April 2024[xiii]

[4] Awaab's Law was due to comes into force in October 2025 but an extension has been granted to providers to October 2027.

Although assurances have been sought by Oxfordshire's Director of Public Health from social landlords about their approach to damp and mould, this did not yield a response. It's not thought there has been any other specific work with Oxfordshire's 37+ social landlords (see baseline assessment) to understand why safety standards are not being met and what needs to be different to improve matters.

In relation to damp and mould, reasons cited during the research include that the construction and fabric of the home can't be improved, that households are unable to afford to heat and ventilate their home, overcrowding and hoarding. In relation to wider home safety matters, there can be tensions between fire safety and other standards eg, installing window locks.

Improved suitability

The baseline assessment draws attention to the disability rate of social rent tenants in Oxfordshire; it is over twice as high as those of owner-occupiers.

There are different approaches by social landlords to improving the suitability of the home through adaptations across Oxfordshire and within districts, for example through adaptations. It is felt to be a postcode lottery as to if a tenant may be able to access an adaptation, and the timescale (some landlords employ their own occupational therapist to enable assessments).

District councils also experience challenges in meeting the need for adaptations, because of the allocation of resources for the Disabled Facilities Grant (allocated by the government) and lack of local capacity to assess needs (particularly a challenge for children).

A recommendation would be to engage social landlords in a conversation about suitability and how collective resources could best be used. See also B2 'care closer to home' and D1 (recommendation to develop a one stop shop for home safety and suitability).

Improved stability: enabling new tenants to turn a house into a home

Stakeholders supporting families and people who have experienced homelessness described stories where, on being allocated social housing, these households were unable to afford to pay for floor coverings, white goods and curtains. Some also needed support to understand how to manage the home, including paying the bills; this kind of support may be needed for a few months as a household settles in.

One stakeholder described a family already experiencing financial difficulties getting into further debt as they set up their home. Another highlighted that, in the absence of home comforts and support to settle, households can choose to remain connected to their homelessness community and the risks associated with this. There was a general view that lack of support on moving into a new home can lead to tenancy failure, impacting not just on the tenant and their household, their health and wellbeing, but also homelessness services and the landlord's business.

Stakeholder knowledge and experiences of available support vary, and discussions suggest that improving visibility across the County of what's on offer to help households as they move into a new home would be beneficial. This includes the County Council's residents' support fund and offers from the voluntary and community sector. During thematic discussions knowledge of other support offers were shared, for example funding for white

goods and volunteer decorating services accessed by people moving on from recovery houses, and the practical support provided by the Branch Trust when a family moves into a new home.

Whilst improved information and access to support offers has the potential to benefit households moving into a home in all rented sectors, this is a topic social landlords should have a particular interest in.

Improved health and equity for social housing residents' through better access to, experience of and outcomes from health and care services

The baseline assessment gives an indication of the level of health, care and support needs of new social housing tenants; of 2,845 new lettings in 2021/22, 9.9% of households required disability related adaptation whilst 26.6% reported a physical or mental health condition. Engagement with stakeholders suggested increasing acuity amongst new tenants.

Housing provider stakeholders report being unable to meet their tenants' health, care and support needs in the absence of health, care and support services, including in some neighbourhoods where there is a high concentration of homes.

Unmet health, care and support needs can impact on housing provider workforces', and services eg, repairs and maintenance, community safety. Stakeholders cited 'high-cost complex cases' that would benefit from an agreed multi-disciplinary and partnership approach, with a lead professional. One such story was of a tenant with mental ill-health who was hoarding, which contributed to a flea infestation so severe that fumigation of the entire block of flats was required. In this instance co-ordinated action was needed across environmental health and mental health services.

Paradigm Housing and support to tenants who hoard

Recognising that some residents are hoarding, and are not receiving support from elsewhere, the Association initially partnered with a specialist charity offering person-centred support grounded in two key principles: Psychologically Informed Environments (PIE) and Trauma-Informed Care (TIC).

The charity's approach recognises that everyone's experience is unique, and their support model reflects this by creating safe, understanding environments that empower individuals to take control of their futures. While this holistic model has been impactful, the charity's capacity was limited to a specific area, which restricted access for many residents.

To broaden our support, Paradigm has introduced a second approach, working with an organisation whose team is trained in both trauma and hoarding, with professional backgrounds in commercial cleaning. This case-by-case model has already shown promising results. Residents have responded positively, particularly to the workshops and open support groups being offered—some of which have even welcomed friends of residents who are not part of Paradigm.

The new provision is helping Paradigm reach more individuals with tailored, practical, and trauma-informed support, and the Association is encouraged by the early feedback and progress.

The Regulator of Social Housing standards include an expectation that landlords will develop a more robust understanding of their tenants and ensure that characteristics and needs are reflected in their services. There's not an expectation that landlords can meet these needs alone but will work in partnership.

Health and care professionals report investing a lot of time in seeking to improve housing conditions, or to enable house moves, for example providing evidence to support applications for social housing (to increase priority awarded). This input is felt to have had little effect; people would like greater certainty that their time is being usefully spent.

Not discussed with stakeholders, it's known that many social housing providers offer services that support and enable health promotion, including access to smoking cessation support (this also improves households' ability to afford their housing costs) and activities to reduce loneliness and social isolation.

Models of practice

There are models of positive strategic partnerships elsewhere in the country, some involving providers who also work in Oxfordshire eg, Peabody and Green Square Accord. There has been public health leadership in some of these.

- The Greater Manchester Housing Providers have a tripartite agreement with the GM Combined Authority and Integrated Care Board, which is based on seven strategic commitments, including supporting health creation for future generations, creating safe places for people to start, live and age well in, focussing on those who need the most support
- Bedford, Luton and Milton Keynes working with housing associations on the issue of asthma, damp and mould (ADaM)
- The Cheshire and Merseyside Housing and Health Partnership focusses on healthy homes, mental health and specialist housing solutions, public health promotion and engagement and increasing opportunities for tenants to work in health and social care jobs
- The Gloucestershire Homes and Communities Partnership

C4: Working with people and communities

Enable people and communities, in partnership with the voluntary and community sector, to have a voice: to share lived experiences and insight; to innovate; to lead.

Collaboration with communities is a central principle of Oxfordshire's Health and Wellbeing Strategy, and the County is looking to apply the Oxfordshire Way (an approach to social care, enabling people to live well in their community for as long as possible) more widely. It has taken a collaborative approach to developing Community Profiles.

It is evident from engagement that non-housing specific voluntary and community sector organisations are interested and active in improving the home environment, particularly working with residents who experience inequalities in health.

It appears that community insight, capacity and capability is not evidently harnessed to best effect. In addition to the time spent supporting households to seek help for their housing issues, several pieces of community-led research have, or are generating insight and

recommendations to improve health through the home, yet it's not possible to understand what difference this research will make. Examples include testimonials gathered by the OX4 Food Crew on experiences of households in temporary accommodation without access to cooking facilities.

It's also important to note that Healthwatch Oxfordshire have generated insight on healthy homes through several pieces of work, including Hearing from men in Oxfordshire, Leaving hospital, Food and the cost of living in OX4, Health and wellbeing in Ambrosden, Arncott, Blackthorn and Piddington and Oxford's new and emerging communities' views on wellbeing.

There are many examples of community-led housing initiatives that are delivering improved health and equity in the country. In Oxfordshire, Oxfordshire's Community Land Trust's current focus is on increasing the availability of affordable housing. Community First Oxfordshire through its Collaborative Housing Initiative is also offering practical support and guidance to all kinds of community-led approaches, but with a particular focus on supporting new homes in rural areas.

These are not the only community-led solutions to meeting housing needs that could also improve health outcomes; there are shared and co-housing, regeneration and home improvement models. A later recommendation suggests that shared and co-housing models are explored in more depth to meet both housing needs and improve health and wellbeing outcomes and equity.

HOUSING VISION

D: Housing policies and interventions that impact health

The research suggests there is potential to improve health through the home by focusing on several housing policies and/or interventions. These all have the potential to contribute to one or more priority policy areas.

Recommendations should be viewed in the context of Local Government Reorganisation and the government's expectation that "all councils to work for their residents and fulfill their shared responsibility to design and implement the best local government structures for efficient and high-quality service delivery".[xiv]

D1: One stop shop for safe and suitable homes

Enable a one-stop shop for:

- ***Consistent information, advice, guidance and support on housing and health matters, to households in all tenures***
- ***Assessments for housing-related interventions***
- ***Interventions aimed at improving home safety and suitability***

A quick win would be to enable a directory of provision on Oxfordshire County Council's Livewell webpages, and testing/updating/promoting the county's 'improving your home' webpage.

Engagement suggests non-housing stakeholders, typically working with households who are likely more vulnerable to unhealthy homes, can – broadly speaking - identify housing issues that need resolution eg, damp and mould, the need for improvements to access or space. However, they struggle to navigate the housing 'system', as do those they are supporting. Time spent on these matters detracts from providing other types of household support, and if unresolved, risk damaging the relationship and trust the stakeholder has with the household.

Oxfordshire is home to a multitude of services and interventions aimed at improving safety and/or suitability. These include:

- Better Housing Better Health (BHBH, see text box)
- Home improvement agency (HIA) and other related offers such as small grants and 'handy persons services' in each of the five districts
- 'Dementia Oxfordshire', funded by the County Council, helps with practical, small items, such as signage and whiteboards for daily messages.

Although HIAs vary across the county, and concern was expressed about equity, there's positive practice; Oxford City Council's HIA has won national recognition of its work on home adaptations, including its proactive approach to tackling housing issues to assist hospital discharge.

There appears a difference in opinion as to the length of time it takes to get an assessment for a Disabled Facilities Grant, with some district councils and social housing providers employing their own occupational therapists for adult assessments. Assessments for adaptations for children were cited as taking up to two years. Anecdotally (data was not easily available) two thirds of older people who receive a DFG do not go on to require further support.

Engagement suggests that effective offers would:

- Recognise that trust is essential to effectiveness: branding, accreditation, staff capability and a relational, person-centred, approach would be some of the means to achieve this. The latter is something that BHBH is felt to offer and is a reason why the service is approached for interventions it can't offer.
- Recognise the opportunity to empower people who contact the service, enabling them to address other issues. An example was given of someone who sought help to use new storage heaters but, having received advice and an online manual via BHBH, felt more confident to speak directly to the energy companies about their tariff.
- Be able to offer leadership/co-ordination to resolve complex approaches requiring multi-agency involvement. Such an example was cited by South and Vale, where refugees have been housed in unsafe ex-Ministry of Defence accommodation

Oversight is being strengthened with closer quality assurance and transparency with the Home Improvement Agencies. The county has a home improvement agency working group seeking to improve access to adaptations. Recognising access challenges a portal has been created (oxfordshire@adaptmyhome.org.uk). It's also understood work is underway to better understand effectiveness.

Although some work has been done to improve referrals to existing services, notably Better Housing Better Health and referrals from health care professionals (a referral process was better embedded as a pathway in 2022), it's reported that referrals aren't always appropriate and, over time, this has contributed to a 'drop-off' in referrals.

Oxfordshire's Fire and Rescue Service also makes referrals to housing services where hazards or related safeguarding matters are identified by frontline staff or home and community safety advocates. It does this through an established referral form but it is currently unable to provide data-driven insight as to the number of homes that are felt to be unhealthy, and outcomes of referrals; OFRS plans to review referrals and develop a mechanism to better understand performance. OFRS's practice of mapping households at risk because of hoarding was cited as positive.

Better Housing Better Health in Oxfordshire (BHBH)

BHBH is unique in National Energy Foundation terms; there were few examples commissioned by a local authority and Oxfordshire was the first to pilot 'home visits' instead of just offering a helpline; these became core delivery from late 2021.

BHBH is an example of an integrated approach – for example the Low Carbon Hub links to and subscribe to the Better Housing, Better Health one stop shop, which gives citizens advice on the best route to access support dependent on circumstances. health and climate change retrofit.

The 'BHBH' service takes a 'whole homes' approach to retrofit. The team focusses on 'fuel poor' households (with an income of less than £39K per annum), and targets those who are low income, low energy efficiency plus people with a long-term health condition.

Tackling the root causes of many issues requires more in-depth, complex work, which is not always manageable with resources available. A 'case worker' approach is better for vulnerable people with chaotic lives for example or are too unwell to take up standard services.

An 2024 qualitative study of the service is available here.

The Centre for Ageing Better advocates for Good Home Hubs: a comprehensive local offer that covers home repairs and maintenance, aids and adaptations and energy efficiency.[xv] It's guidance suggests that this should build on the services already in place, and be delivered in partnership by local authorities, charities and businesses but crucially, from a consumer perspective, the services:

- must be coordinated to operate as a one-stop shop
- should include support and signposting through every step in the process including finding trusted tradespeople, identifying what work needs to be done and how to finance repairs
- should be open to people from all tenures, including landlords
- be offered regardless of an individual's ability to pay (although some services could be charged).

It's clear from the baseline assessment, and stakeholders, that home improvements and adaptations cannot improve health through the home for everyone. The age, construction and design of some homes, in all tenures, may not be suited to improvement, for example older small homes with narrow and steep staircases, or those which can't be adequately insulated or ventilated leading to condensation and mould growth. A 'one stop shop' will need to consider its role in enabling people to explore options to move house.

D2: Complex case management

Agree a multi-disciplinary approach to complex cases, for example cases concerning people living with a mental health condition where, without support, the home environment can be unhealthy eg, hoarding (links to priorities B2 & B3).

During interviews and all four thematic discussions stakeholders described complex home and health scenarios that would benefit from an agreed approach to collaboration.

Environmental health teams appear to carry a caseload of households whose complex circumstances would benefit from coordinated interventions yet professionals struggle to get input from other services. In the absence of this, the only option is to take an enforcement (legislative) approach. This was 'a sledgehammer to crack a nut' for many cases, for example where there may be a person living on their own, with mobility issues restricting their ability to clean up a house.

Most notable amongst complex cases were those featuring hoarding; almost all stakeholders could describe cases, including those involving children (see B1 Start Well), in social housing (see C3, including a case study of Paradigm's approach), private sector housing and as a factor in homelessness. An example was given of hoarding preventing the safe use of oxygen to enable someone with a long-term condition to remain living at home. It was felt that hoarding is on the increase; although data is not available to support this, it matches experiences reported elsewhere in the country[xvi].

Stakeholders felt the following needed to be a feature of an effective approach to hoarding:

- A commitment to coordinated action from social landlords, environmental health, housing options/homelessness, mental health, social care and support services (children and adults), and the VCSE
- Pooled resources: partners have different powers and funding available to them, at different times
- An individual who led the case/enables co-ordination and resolution. This could be a lead professional model where an individual from one of the agencies leads with input from others, and/or dedicated complex case workers
- A means by which hoarding can be identified and managed before it reaches 'crisis' point, for example by building in a hoarding risk assessment into home visits made by any agency.
- Funded training on hoarding for those working on the frontline, visiting and supporting households, including children and families (see also B1 start well and C2 workforce)
- A 'rapid response' protocol that enabled immediate action including pest control, cleaning and clutter management services
- Sustained, longer-term, support to households (short term 'fixes' such as clearances are rarely felt to prevent a recurrence), including regular visits, access to cleaning assistance and therapy
- Recognising hoarding is a mental health condition, access to timely mental health support before crisis point and increased risk to the public's health.

Although there is a self-neglect and hoarding protocol in place, led by Adult Social Care, this was rarely referred to, and there is a view that eligibility requirements for support are too high, by which stage the household and wider community's health and safety is at significant risk.

Cherwell District Council has introduced a new hoarding grant called 'Clean and Clear': a grant of up to £2,500 is available to those who are in Council Tax bands A-C following a simple application process. This is felt to allow other essential works such as home adaptations and essential repairs to happen.

Positive practice elsewhere in the country was also cited, particularly Gloucester and Tunbridge Wells: the latter's 'Home Straight' grant of up to £3,000 assists people with hoarding and self-neglect issues and covers essential works such as cleaning and repairs. It is available for owner-occupiers and tenants, is not repayable and there is no requirement for a financial assessment.

It is understood that a county-wide hoarding group has recently been established to explore options to improve the offer. Exploring how hoarding impacts on different housing, health, care and support services will be essential to enabling a better use of collective resources.

D3: Allocation of social housing

Section C3 presents the case for a strategic partnership with social housing providers, including increasing acuity of tenants' and residents' health and wellbeing, and that needs are not felt to be met by health, care and support services. This raises questions about the role of social housing.

Providers do not have full responsibility for the allocation of social housing; the district councils are legislatively required to operate allocations schemes and for these to follow statutory guidance on priorities, for example households awarded 'reasonable preference'. Most social housing in Oxfordshire will be allocated through these schemes, which must be reviewed at least every five years. South and Vale District Council has previously asked for Oxfordshire's public health team to comment on their policy (positive practice), although the outcome of this isn't known.

Social housing providers do retain the ability to allocate homes outside these schemes, including a practice referred to as 'direct management lets' which can be used for a range of scenarios, from the need to move someone whilst major works are delivered to urgently moving a household whose safety is at risk.

Access to social housing is a mystery to people working outside housing options and to the public. Enabling a shared understanding of this, and the role these homes play in the population's health and wellbeing, should contribute to improved support for this model of provision, for investment in improvements and the need for an increase in new homes that are genuinely affordable to rent.

Take a 'health in all social housing allocation policies' approach.

To better understand, and manage, the impact of social housing allocation on the health and wellbeing of residents (new and existing), OCC's public health team should support and enable:

1. Health considerations in the review and revision of district councils' policies and practice, and those of housing providers ('health in all policies')
2. A review of the role of health and care professionals, and approach taken to, awarding medical priority to applications
3. A mapping exercise to understand the accessibility of health, care and support services available to social housing residents, particularly in neighbourhoods with a high concentration of this tenure

D4: Enabling people to live together well

Appraise options to enable households to live together, making use of existing homes.

There's an acute shortage of genuinely affordable homes in Oxfordshire, yet the baseline assessment suggests high levels of under-occupation, particularly amongst single and older homeowners, and that living alone in a home that is too big for your needs can present risks to your physical and mental health and wellbeing. Moving to a smaller home, even if this may be better suited to changing health and care needs, is not something everyone wants to, or is able to, do.

Stakeholders suggest that there's a desire to house share amongst people who have been living together whilst they receive support following a period of homelessness; it's felt that tenancy agreements in the social housing sector prohibit this option.

Co-living, community led cohousing, and cooperatives are of increasing interest to policy makers seeking to improve access to affordable homes, particularly for smaller households. Co-living is of particular interest to institutional investors in urban centres, including through 'build-to-rent' models, whilst community led alternatives are bottom-up models that seek to enable affordability, resident governance and social wellbeing across age groups.

Alongside increasing interest is research, which currently suggests that there are health benefits from community led and cohousing models of housing, by strengthening social ties, fostering agency and reducing isolation. Peer and community support is thought to prevent and reduce the need for reliance on care and support services, whilst for people later in life, there can be benefits from intergenerational schemes.[xviixviii]

Oxfordshire already operates a Shared Lives model, enabling homeowners (the 'carer') to share their home with someone who needs additional support to be independent. This model can also benefit homeowners who may need assistance as their needs change.

Homemaker Oxford has also been operating, since 2017, working with communities and stakeholders to explore how existing homes can better meet housing need. Their 'Room to Stay' model, a network of homes with spare rooms in a defined neighbourhood, made available to single people experiencing homelessness and applying learning from cohousing would be worth exploring in more depth.

'Care closer to home' describes the increasing older population in Oxfordshire, many of whom are homeowners, living on their own and under-occupying. Intergenerational housing models may also be of interest to Oxfordshire. 'Right-sizing' (also referred to as down-sizing) and equity release were also mentioned by a few stakeholders as potential solutions to enable households in later life to improve the health of their home environment.

HOUSING VISION

Annex A Approach to stakeholder engagement and limitations

Oxfordshire County Council's Public Health team:

- Provided an initial list of 90 potential interviewees/participants, drawn from existing contacts and attendees at a recent housing summit.
- Identified local leaders and priority contacts (those who could assist in navigating local systems and accessing data) from within this list.

Housing Vision developed a stakeholder management spreadsheet, updated throughout the research with additional stakeholder information, including participation in interviews and thematic discussions. The final stakeholder list includes 169 contacts.

Analysis of this suggests:

- In total c. 76 people participated either in an interview or in a thematic discussion.
- During the project, 117 people were approached
    - This included 93 invitations to interview; 56 people were interviewed, of which
        - 26 people were in a housing-focussed role; 30 were in a population-focussed role
        - 24 people worked for the LA (two in an integrated role with NHS); 10 people worked for the NHS; 6 people worked for a housing provider; 16 people worked for a service provider (13 from the VCSE)
    - Across the four thematic discussions there were attendances from 52 people, including 20 people who had not previously engaged with the research:
        - 13 attended precarious homes (seven new)
        - 17 attended social housing (six new)
        - 14 attended 'start well' (five new)
        - 8 attended 'care closer to home' (two new)

Housing Vision also attended three stakeholder meetings (number of attendees not known):

- The Countywide Homelessness Steering Group (online)
- Equal Start Oxford/OX4 Food Crew team meeting (online)
- The Oxfordshire Health and Homelessness Inclusion Team (in person)

Housing Vision developed and agreed a project flyer and PowerPoint slides; this was shared with all those invited to interviews and with meeting attendees.

<u>Thematic discussions</u>

The original proposal was for four thematic discussions, on topics drawn from the baseline assessment. The approach was adapted when it became clear that there were challenges in the local data; in conjunction with Oxfordshire Public Health Team, we agreed themes that interviews suggested would benefit from further and intersectoral discussion.

<u>Limitations</u>

The report represents findings from engagement with the 'coalition of the willing' ie, those who understand and/or feel strongly about the impact of unhealthy homes on Oxfordshire's population.

It is likely many more people care about this topic. However, in line with experience of working elsewhere in the country, engagement with people working in public and voluntary and community sector roles was limited by their capacity. Those interviewed often talked about 'firefighting' or reacting, and having significant priorities to attend to eg, managing temporary accommodation and associated budgets (although homelessness is a recognised public health matter, there was limited engagement with those working in this space). The project timetable was extended by a month to enable greater engagement.

There was an expectation that the project steering group, representing local authority housing services primarily from a strategic officer perspective, would be more actively involved in enabling and directing the project. A combination of officer capacity and local priorities meant that this did not come to fruition. The role of this group going forward is something to be considered as part of future governance.

It was anticipated that a greater proportion of engagement would occur through attendance at local partnership meetings. In practice, there were few opportunities in the project timeframe and/or crowded agendas as partnership meetings do not occur frequently.

As a greater reliance was placed on interviews, the thematic reviews were used to sense-check what had been heard through these interviews and the research findings draw on those we understand are widely supported; it is possible that individual's views expressed through an interview are not reflected here if we were unable to corroborate in some way.

Because of engagement limitations, we were unable to explore several issues in depth:

- Healthy homes from the perspective of those working in social care (adults and children) including SEND, learning disabilities and dementia, and healthy homes in relation to later life generally
- Opportunities to work with social housing providers; despite contact with 29 people representing nine providers, only four providers contributed including the City Council.

As the project's focus was on the health of existing homes, we did not seek to engage those working in spatial planning. However, one local authority colleague routinely attended and was able to describe how findings from this work could inform planning policy going forward. It would be beneficial to carry out further work to enable this to be more widely understood amongst all spatial planners and those working in development control.

There are clearly opportunities to improve health through the home and contribute to Oxfordshire's ambitions to be carbon neutral by 2030. Resource limitations meant this was out of project scope, although environmental health practitioners contributed relevant perspectives, for example on retrofitting.

HOUSING VISION

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