Metrics and measures for tackling the social determinants of health – the example of mental health and housing

Key words:
to come

This paper is an account of the discussions and recommendations by the expert advisory panel on potential metrics and 'sentinel indicators' for improved outcomes in housing and mental health, as part of an inter-agency seminar called to advise on the development of metrics and measures for community mental health, for *Fair Society, Health Lives: The Marmot Review* (Marmot, 2010). The seminar was focused on mental health in both its broadest and narrower senses.

Much of the background material for these discussions, therefore, cuts across familiar knowledge silos between the fields of health and housing. Where necessary to elucidate the text, references are included to relevant research and policy frameworks that may be unfamiliar to the general reader. This paper is not, however, intended as a general literature review nor is it an evaluation of the available research.[1]

The conclusions from the discussion are presented in four main areas, reflecting the need to specify metrics across the wide-ranging interface between housing and mental health, while still keeping the task manageable. Five current or potential health service metrics were proposed as having particular value as signal indicators. Two of these (relating to primary care prevention and public health) have no precision at yet, partly as new services and approaches are still evolving. Among existing health datasets, the Mental Health Minimum Dataset (MHMDS), SITuation REPorts (SITREPS), and the Summary Care Record data were singled out, though each is thought to need more work to improve the current data categories as well as data collection.

One more fundamental point made was that the identifying, assessing and encouraging effective inter-sector partnership work will be the key to tackling health inequalities. The use of other, non-health services' data therefore holds great potential for a better recognition both of needs and of successful partnership work, especially where this can be interpreted at local level. These wider comments are elaborated in the context of housing, but may be applicable to all efforts to evidence and work with the social determinants and the social outcomes of mental health. For the future, a combination of well-crafted nationally sanctioned metrics and the 'soft intelligence' of locally identified meaning may be most effective.

Subsequent developments confirm the potential in cross-sector development work, and indicate the potential for further collaboration via the local performance framework. As policy frameworks continue to evolve rapidly, the article ends with a Codex, updating the relevant policy

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frameworks context since the seminar (in Spring 2009) and especially in the context of a new coalition government with aspirations to articulate and promote public health in the context of the local performance framework and the 'new localism' agenda. This final section and comments are therefore entirely the responsibility of the author.

> *'The simple term "research" actually covers a number of distinct activities, such as locating examples of innovation, elaborating conceptual frameworks to help in thinking about the field, isolating research questions, disciplined data collection to answer those questions, clarifying what constitutes good practice, identifying exemplar services and forming a hub for the acquisition and dissemination of knowledge about the topic under scrutiny…'* (Bates & Hankinson, 2005)
>
> *'We have no money, so we will have to think.'* (Rutherford, undated)

This paper reports on the process and conclusions on The Places we Live, the housing and neighborhood's sub-group of the Mental Health Inequalities: Measuring what Counts Partnership seminar of 16 March 2009, convened by the Sainsbury Centre for Mental Health on behalf of the Department of Health, Royal College of Psychiatrists (RCP) and Care Services Improvement Partnership (CSIP).

The purpose of the day was to help formulate the Department of Health's submission on mental health for the *Marmot Review* (Marmot, 2010). In addition to the housing sub-group, there were five other sub-groups meeting in parallel, covering early years and families, working lives, later life, financial security, and body and mind. The housing expert group[2] had representation from all key areas, from mental health policy-makers with an interest in housing, to housing policy-makers with an interest in mental health, service providers of both sectors, service users, analysts and statisticians.

The groups' main findings were summarised and collectively agreed on the day. The detailed notes of the event and conclusions were subsequently circulated to all attendees for further feedback, and finally submitted as part of the seminar report. This paper is a reworking of those findings in a style suitable for publication, with no change in the content, other than an addition of a Codex to locate this work in the context of new policy frameworks with the creation of a coalition government.

The task

The allotted tasks of the housing and neighbourhood's sub-group were to identify any achievable consensus between agencies representing the two sectors of housing and mental health on the areas with greatest need and potential for improvement. The sub-group also had to suggest, where possible, suitable future metrics on housing that could be recommended (ie. adopted and/or developed) to 'measure what counts' in housing, inequality and mental health.

Bearing in mind the growing interest in public and preventive mental health, as indicated by *New Horizons* (Department of Health, 2009a), the group's brief was to take a broad overview of the whole of community mental health, encompassing severe and enduring mental health needs, common mental health problems of anxiety and depression, substance abuse and personality disorder; and also those factors that support recovery, resilience, and positive thriving. Likewise, the discussion was to cover the whole field of housing service activity, from the role of high-support housing for those with greatest needs, through housing stock management practice and homelessness resettlement work, to issues of housing design and quality, and the effects of neighbourhoods as social entities.

The discussion was, however, able to build on a significant amount of recent work in this field that has identified measures of housing disadvantage among those with severe and enduring mental health problems (Social Exclusion Unit (SEU), 2004; Johnson, 2004), especially serious levels of mental health problems of all kinds among those who are homeless or insecurely housed (Rees, 2009; Maguire et al, 2010). It has also identified measures of poor mental health in the population at large, with significant concentrations in areas of deprivation and in areas where not-for-profit, state-regulated 'social' housing is most active (Hills, 2007).

The sub-group was also able to build on inter-sector work undertaken in the previous five years by the National Institute for Mental Health for

England (NIMHE), and later the National Social Inclusion Programme (NSIP) within CSIP, in bringing together disparate agencies for cross-sector work in implementation of the recommendations of the Social Exclusion Unit's report of 2004 (SEU, 2004b; Johnson, 2005).

Four priority areas

The housing sub-group therefore had initially a free and wide-ranging discussion, reflecting the very broad spread of perspectives and participants. The discussion was guided by the two given key tasks or themes.

1. Identifying the areas where there would be both greatest challenge and greatest potential for tackling inequality in housing and mental health, ie. those areas where meeting needs had either not been addressed, or had not yet been achieved, but yet where significant improvement was thought to be achievable.
2. Developing the potential both in health and social care and in other services' knowledge and datasets for useful evidence on the current circumstances of those with poor mental health (factual), and on the success of health and social care services' efforts to promote well-being (evaluative), were society to act on the areas where significant improvement was deemed possible.

Four key priority areas for future work then emerged, ranging from 'upstream' prevention work to mental health service modernisation and/or alternative approaches for those with most significant mental health needs. The four key target populations/areas for action are:

1. those with high levels of need in secondary mental healthcare
2. those with high need but marginalized or excluded from secondary care
3. those failing to thrive in and benefit from primary care
4. those interactions between people at all levels of health which reflect aspects of housing and neighbourhood management and design, for promotion of positive public mental health.

For each of these target areas the effective role of housing and especially of social housing services was therefore explored, as was the availability – or the negotiability, between agencies - of suitable metrics. It was suggested that, for each of these key areas, sentinel indicators could in principle be developed. In some areas, the material was already available, or could be adapted to be useful. In others, with emerging policy and funding frameworks, it may be possible to consider the advantage of such data, as new datasets emerge.

Priority areas and available data

Secondary care

For those in secondary mental health care, securing suitable accommodation, with support as need be, has already been identified as a major concern in a series of reports and UK government policy statements (SEU, 2004: Appleby, 2004). But developing and evaluating effective action has been hampered by a lack of good quality data on the actual housing circumstances of those with significant, moderate or low-level mental health needs.

Recent work originally to support Public Service Agreement (PSA) 16 (Cabinet Office, 2009) has meant the introduction of new data items in the Department of Health's Mental Health Minimum Dataset (MHMDS), which have the potential to provide a wealth of information never before collected on the actual housing and employment circumstances of all individuals in secondary care in any locality. These data were required for national monitoring of local efforts to maintain individuals with more severe mental health problems in sufficiently stable 'settled' accommodation. But the data codes chosen were crafted in order to offer greater utility for local commissioning to meet unmet needs that the monitoring would reveal.

The housing circumstances data in the MHMDS can be analysed against a number of other socio-demographic and clinical features also included in the MHMDS, such as gender, ethnicity, age, diagnosis, frequency of admissions and Care Programme Approach (CPA) status. This clinical data can in principle be anonymised, aggregated and cross-correlated with data that housing services and others[3] already collect on the quality of housing stock and other neighbourhood features. Between them, these datasets can then give a far richer picture of the housing circumstances of people with major mental health problems – and also of the concentrations of particular mental health needs in certain neighbourhoods. This would provide a picture of community mental health need, analysable by both social groups and geographical areas, to inform local commissioning to meet priority needs.

Also relevant here could be data from other related services such as the local housing benefit section, which will have information on individuals'

benefits claims, including late return or non-renewal of claims. Non-renewal of claims, it was suggested, may often be an indicator of deteriorating mental health; and the closure of a claim after non-renewal is itself a major additional stress, often precipitating breakdown. Such information would not be suitable for performance management, as achieving lower scores on the usage of the information channel, for example, could not be seen as positive. This example is an indication of the way other agencies' data can provide useful feedback on problem areas and so help achieve longer-term goals. Similar information-sharing protocols between agencies[4] have been shown to be effective in intercepting risks to vulnerable individuals in the secure enjoyment of a home (Housing Corporation, 2006).

Among those in secondary care, there is however also an especially important sub-set of those most in need of a better co-ordinated inter-agency response, that is to say, those stranded on a hospital psychiatric acute ward with nowhere suitable to be discharged to – those who are, in medical terms, subject to 'delayed discharge'. This group is an important sub-set of those whom PSA 16 addressed, partly for the emotional and psychological cost to individuals involved, and partly for the high cost of maintaining such individuals inappropriately in hospital. Delayed discharge is identified by both Monitor and the Care Quality Commission as a particularly useful sentinel indicator of how effective local commissioning has been, in ensuring the complex inter-agency funding and planning necessary to create seamless pathways for those with the highest needs.

MHMDS monitoring, which for those in secondary care is recorded quarterly, cannot be either sufficiently prompt or sensitive to identify the more specific needs of this group with the level of detail needed for effective commissioning. Delayed discharge is however already recorded on a daily basis by SITREPS (SITuation REPorts), potentially providing very finely detail data on high profile needs, and at locality level. Nevertheless, the current SITREPS definitions of need and the cause of delayed transfer of care are still based on those originally developed for older persons' services, and do not, for example, include codes for supported accommodation needs – thought to be the biggest single unmet need accounting for occupied bed days in mental health (Sainsbury Centre for Mental Health, 1998; Greater London Authority et al, 2003; Lewis & Glasby, 2006). They are therefore not yet appropriate to mental health needs and pathways. The current SITREPS reporting is in urgent need of revision, to make it suitable for both audit/performance management and local commissioning purposes (National Social Inclusion Programme, 2006a).

Exclusions from secondary care

The evidence is mounting for significant levels of untreated mental health problems in homelessness services (Rees, 2009), including high levels of mental illness, personality and stress disorders, or '*complex trauma*' (Maguire *et al*, 2010), often compounded by substance abuse. Despite the publication in 2003 of *Personality Disorder: No longer a diagnosis of exclusion* (NIMHE, 2003), the roll-out of the NIMHE personality disorder pilots, and the *Reaching Out* work (Social Exclusion Task Force, 2006) currently being led by Communities and Local Government (CLG) on adults at risk of chronic exclusion, there are relatively few secondary care services that actively seek to engage those with the most complex needs, such as those who are to be found in homelessness services. New guidance issued jointly by CLG and the National Mental Health Development Unit (NMHDU) on meeting the psychological and emotional needs of homeless people further raises the profile of this multiply excluded group, with practice examples of effective interventions (Communities and Local Government, 2010).

The datasets for homelessness assessment and outreach services, and for specialist supported housing and resettlement, such as the Supporting People Client Record Data, may, therefore, offer the best available evidence for these unmet needs, rather than health service data. But for those who are not well engaged in health and social care services, frequent use of accident and emergency (A&E) departments and other crisis management services are also typically a part of the presentation at high cost to local health services (Rees, 2009). The use of Summary Care Record data (Greenhalgh et al, 2008), including individuals' presentations at A&E, may therefore need to be joined up with other non-health information, to help identify the needs of those most marginalised. 'Social prescribing', to broaden the range of possible interventions for complex and cross-cutting needs (Friedli, 2004), does not as yet have any data collection by which to assess the efficacy of immediate access to support services.

However, it is consistently argued that social housing and support services, alongside primary care, may be better able to engage those most reluctant to engage with conventionally structured

secondary mental health services, such as refugees and asylum seekers, women escaping domestic violence, and vulnerable young people. The Department of Health (2007) guidance on Joint Strategic Needs Assessment (JSNA) explicitly states that housing services may often be aware of the needs of those marginalised and excluded from current service provision. (There is also anecdotal evidence that some problems such as obsessive compulsive hoarding or paraphrenia are encountered and managed in practice more by housing staff than by clinical services (Johnson & Griffiths, 2006; Johnson, 2010a.)

Housing agency datasets were not originally, and are not currently, constructed with a view to identify mental health needs, or to support commissioning for services for unmet needs; nor do they typically 'join up' with other datasets in health care. But for the future, there is no reason why housing services' datasets could not be adapted to develop a vocabulary better suited to identifying such health and well-being issues. This data, combined with the experience of housing staff on what is working in developing more effective partnerships[5] may then be used as part of JSNAs to help identify the healthcare needs of those currently excluded.

Primary care 'recidivism'

The estimates for the numbers attending GP appointments with mental health, or mental health-related complaints, vary according to the breadth of definition of 'mental health-related'. But as diseases stemming from lifestyle issues now replace accidents and genetically-based disorders in accounting for the greatest burden of ill health nationally (NHS Information Centre, 2010; Young Foundation, 2009), and medically unexplained symptoms (Patient Plus, 2010; Read, 2005) account for a significant level of the costs of healthcare, there is growing urgency to better identify and address the social and environmental determinants of poor health.

There is now ample evidence that socially impoverished and socially stressful environments can trigger, exacerbate and/or prolong ill health and preclude recovery, in physical and mental health, and in the grey area between (NSIP, 2006). Medical priority rehousing is, for example, already known to be particularly effective at relieving mental health problems (Blackman *et al*, 2003), and housing-related support is effective in relieving the practical and emotional stresses that can arise in problematic housing (Quilgars, 2000). Interventions based on social needs, such as housing problems, are likely to be more effective than medication in resolving such underlying social problems.

The Darzi (2008) reforms encouraged the creation of multiservice, primary care-based teams to provide more flexible and holistic services. Current policies also endorse practice-based commissioning (Department of Health, 2009b), and allow for '*social prescribing*' (Friedli, 2004), where budget holders can agree criteria and procedures for accessing non-health budgets from better integrated local commissioning. But at this stage in the evolution of policy and practice, these processes have not yet produced the datasets for eligible conditions, innovative provision or mechanisms for commissioning that can respond to needs. Although social prescribing in particular remains in its infancy, analysis of the use and effectiveness of social prescribing practice that address housing-related needs and support would provide fertile ground, both for monitoring of effective preventive work and for research.

For the future, by marrying up area-based measures of need, including housing services' information, we may seek to develop an area-based, population-based measure of anticipated need with greater refinement for local determinants and resilience factors. This measure can inform future calculations at local level for resources to meet needs available to primary care, and for the delegated budgets for practice-based commissioning.

Built environment, social capital and public mental health

The places we live – housing and neighbourhoods – are generally seen, alongside employment and family and close social networks, as one of the key focuses and determinants of a sense of belonging and well-being (SEU, 2004). The role of housing services in the construction (and/or subsequent remodelling) of estates and areas as 'social spaces', in which social capital can be 'designed in', just as crime may be 'designed out,' has recently become an area of increasing interest (CABE, 2008).

But there is similarly growing awareness of the extent to which careful management of the existing housing stock, working in and alongside community development approaches, can also foster a sense of local engagement and belonging, with social housing services in particular able to operate consciously as '*community anchors*' (Housing Associations Charitable Trust, 2006), especially with the more vulnerable, marginalised and excluded. The concentration of social housing stock

in areas of greater deprivation may then represent not only a problem but also an opportunity to address inequality and exclusion through more effective partnership with those services already most focused and 'present' in those areas.

Area-based survey measures of community quality already form part of the National Indicator Set (Communities and Local Government, 2007), on which local authorities are required to report. Current measures of trust and security in neighbourhoods could therefore readily be given greater weight in local area Comprehensive Area Assessments (CAAs), which replaced individual service or sector assessment from April 2009 (but see the Codex). For the future, the same or comparable measures could also be considered in (Care Quality Commission, 2009) and/or Audit Commission assessments of healthcare commissioning for public health, as an indicator of the effectiveness of efforts in public mental health.

However, there is still a need for caution regarding simple population-based measures of social cohesion, as it is feared that strong, cohesive communities may nevertheless exclude those who are not seen as full or legitimate members of the community. It may be necessary to seek to include, in such surveys and measures in the future, further questions that ask how successful a community and its services are seen as being in welcoming and supporting newcomers, or those more vulnerable.

An initiative from the Royal College of Psychiatrists Centre for Quality Improvement (CQI) (RCP, 2009) is currently attempting to derive and pilot a single set of common values and standards by which environments of all kinds, from acute wards to supported housing to communities, may be assessed (and self-assessing) for the extent to which they are truly enabling of the emotional well-being of participants. This CQI initiative is an attempt to create an evidence-able qualitative measure. The initial consultations on this methodology are encouraging (Northern Housing Consortium, 2009). The intention is that adoption of any such 'quality mark' should be voluntary; but it could also be recognised and treated as a passport measure for other, more sector-specific quality assurance measures.

Wider considerations

In an era of community-based care, where successful outcomes for those with complex needs may often be the product of good partnership work, the efforts of any one agency will be conscribed or supported by the efforts of another. Recognising and working with the social determinants of health, as with the wider social impacts or outcomes of healthcare services, will involve both broader and subtler metrics that can recognise, in performance management of healthcare, both the appropriate contribution of health care to other services' efforts, and the appropriate contribution of other services and factors to health, care and well-being outcomes. Therefore, much depends on the sophistication with which such metrics can be interpreted, in context, and it may become increasingly necessary to interpret all services' performance management data in the light of local knowledge of the ecology of provision and pressures in each area (Department of Health, 2007).

For the future, the combination of well-crafted, nationally-sanctioned metrics with the 'soft intelligence' of locally identified meaningfulness may prove most effective. Any new metrics must be developed with a view to consistency, for overall national priorities and performance monitoring, but also for specifically local priorities, local knowledge, and contextual interpretation. Similarly, in local evaluation, it is necessary to hear a range of local stakeholders' views, to ensure that the improvement of performance measured on any set of metrics is not achieved simply by distortion of more rounded and sustainable priorities area (see: http://www.audit-commission.gov.uk/caa/guidance/index.htm, especially Section B12.1). The 'triangulation of data' can be seen as a form of quality assurance, to ensure that performance management data is not merely submitted, but meaningful.

The scope for developing new and more meaningful metrics therefore depends in part on the opportunities presented as services evolve and new datasets emerge,[7] and in part on the extent of political will and partnerships at both national and local level. JSNA however allows local authorities and primary care commissioners to determine and review all data that they find most relevant to identify both strengths and weaknesses in their areas. The new local integrative mechanisms such as JSNA make possible more contextual interpretations of data than were possible under single sector accountability approaches, whilst still providing objectivity and external verification. These new integrating structures are therefore seen as the key to guaranteeing the meaningfulness of any nationally set metrics and measures, and preventing distortion of services and other such perverse outcomes of measurement.

Nevertheless, this ambition may need to involve some discussion with other agencies, such

as national and local housing services, over the terminology they adopt for their own data, just as it has involved discussions to ensure that the housing terminology that health uses (such as in MHMDS and SITREPS) marries up more effectively with that of other agencies. This may be a challenge, but it is one that it seems other agencies are more likely to welcome than to resist, as there is a mutual advantage in recognising unmet need (Johnson & Robinson, 2008; see also the CSIP Housing LIN website: http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/).

Finally, although local evaluation of services in context is likely to be most informative, there is still a need for more objective, external assessment of effective practice via more formal research, especially on costs and benefits and user preferences. There is also a strong case for further large-scale research to help identify how far various housing problems exacerbate or actually create mental health issues in their own right, and/or how far they may stand proxy for other social disadvantage and environmental pathogens (Halpern, 1995; National Social Inclusion Programme, 2006b).

Codex

Following the Measuring What Counts seminar, the Northern Housing Consortium (NHC), which represents social housing services across the three northern regions of England, undertook a desktop survey to assess how far its members had, in fact, been consulted in any depth over the development of local JSNAs. Few reported that they had been, and housing associations in particular were least involved. The NHC are now consulting with members on developing a standard reporting measure on unmet health needs, that all social housing services can use in future strategic needs assessments.

The Marmot review, *Fair Society, Healthy Lives* was published in February 2010. The published review evidence and assessments stressed the need to work with and through other agencies to address inequalities, albeit with the health services taking a lead role. However, the final recommendations then focus primarily on early intervention and preventive work with children and young persons' mental health. Social housing is mentioned only as one among many voluntary sector agencies with which the health service may work, and the potential for penetrating into areas of greatest deprivation marginalisation and inequality via social housing agencies is not pursued.

A joint Social Exclusion Task Force and Department of Health (2010) paper *Inclusion Health* on the role of primary care in addressing health inequalities refers to the unacceptably low life expectancy of the homelessness hostel population as a key area for future health equality work to address. The joint NMHDU/ CLG guidance on meeting the psychological and emotional needs of homeless people was published in July 2010 (Maguire et al, 2010)

The analysis published in March 2010 jointly by HM Treasury and CLG of the 13 initial Total Place pilots (HM Treasury, 2010) indicates strong continuing support for local priority-setting and collaborative working to transcend old barriers in service delivery and budgetary ring-fencing. All three of the main political parties have expressed support for the local performance framework. With the arrival of coalition government after the general election of 2010, the twin dynamics of cross-sector integration and decentralisation from Whitehall towards local councils gathers pace. The CLG is tasked with leading on promotion of the Big Society, and the location of responsibility for public health henceforth within local authorities.

Meanwhile, the new Secretary of State for Health announced an overhaul of the health service structure in order to remove national and regional controls over frontline services. Although technically a national priority and not a local target as such, PSA 16 is abolished along with other targets; but current thinking is that it remains a priority concern. The changes to the MHMDS to gather consistent data on housing circumstances will remain, and the possibility of local interpretation enriched with other local data therefore is retained (and perhaps considerably enhanced). The need for better quality SITREPS data on delayed discharge similarly remains.

The new health policy places still greater stress on GP-based commissioning. Although at the time of writing (mid July 2010), the role and full extent of '*social prescribing*' by GPs has not yet been clarified, '*where practices choose to provide services outside their core contracts, those services will be commissioned directly by the new commissioning board*'. The new stress on primary care commissioning and public health, combined with specialist commissioning, may mean a strengthening of early intervention in mental health. But only time may tell whether social prescribing is about to achieve maturity, and whether it will then provide data which can give us new insights into the role of 'social' factors in public health.

Although it has been stated that primary care trusts will cease to exist as the principle local commissioners of health care services at locality level, joint strategic needs assessment remains as a statutory responsibility shared between the local authority and the health service – in whatever guise or form may now need to emerge – with the need for high quality cross-sector local data on needs and impacts that this entails.

Endnotes

[1] An initial, pre-review draft of this paper, *The Impact Of Housing Circumstances And Housing Interventions On Mental Health And Well-Being: A review of best evidence in the UK context*, is currently available at: http://www.rjaconsultancy.org.uk/page9.html (accessed July 2010).

[2] Membership of the sub-group comprised representatives of: Department of Health; Communities and Local Government; Homeless Link; Tenant Services Authority; Audit Commission; Healthcare Commission; National Housing Federation; National Social Inclusion Programme; NSIP Service Users Reference Group; NHS Information Centre; Mental Health Providers Forum; Northern Housing Consortium; Care Services Efficiency Delivery; Care Services Improvement Partnership.

[3] For example, the National Indicator Set includes measures of neighbourhood quality. Regular Office of National Statistics surveys, including especially the Adult Psychiatric Morbidity surveys, explore both facts and views of respondents' housing and neighbourhood circumstances. The Joseph Rowntree Foundation also publishes regular reports on area-based poverty.

[4] There is clearly a need for great care over data protection and client consent to any sharing of information relating to individuals. The seminar group however expressed a clear preference for common terminology for improved information sharing protocols and channels, between agencies, rather than attempting a single register or mainframe database.

[5] See especially the CSIP Housing LIN and NHC briefings on housing in the JSNA: http://www.northern-consortium.org.uk/Page/QualityOfLife/briefingreports.aspx (accessed July 2010). http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/AboutHousingLIN/ (accessed July 2010)

[7] For the future, the removal of the 'ring-fence' around Supporting People funding allows SP-funded services to identify needs with new flexibility and new language. Similarly, the creation in 2008 of two new social housing regulators – now to be amalgamated to one – brought with it potentially new procedures and criteria for measures of need (for new housing) and of effective service delivery (in housing management) in social housing.

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