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Effective Strategies and Interventions: environmental health and the private housing sector



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Introduction

Environmental Health Practitioners (EHP) and their colleagues routinely deliver high quality, partnership based strategies and interventions based on local evidence of how and why health inequalities pivoting around housing are being tackled. Working closely with partners in health, social care and others EHPs have pioneered innovative solutions to meet local need. Already Joint Strategic Needs Assessment are taking housing – including private sector housing – into account in delivering increasingly more effective strategies and interventions where health and wellbeing outcomes have been factored in from early design stages of strategic development which are demonstrably cost-effective.

At a time when we have to increasingly bid for and account for the work we do, establishing evidence of proactive and cost effective interventions will be more important than ever. In housing, we need to be able to demonstrate through research and evidence the importance and value of our work across a range of indicators and outcomes with our partners: improved housing and living conditions; community development, social capital and stability; cost effectiveness to the NHS and other public services; enhanced quality of life; reduction in home accidents; contribution to social care packages to those with in need; enhanced intervention packages for children or those discharged from hospital; to name but a few.

The forthcoming changes to our public health system and the Health and Wellbeing Boards offer environmental health practitioners (EHPs) and their partnerships a new opportunity to demonstrate effective, evidence based, proactive and health informed strategies and interventions in the private housing sector.

Why focus on private sector housing

Working in private sector housing, the majority UK tenure, can be one of the most challenging, but ultimately most rewarding, areas of environmental health work. Whilst the sector to a large extent regulates itself, housing EHPs and their colleagues work every day to address poor and unsuitable conditions facing both private sector tenants and owner occupiers against a complex social, legal and political backdrop.

Contemporary challenges for private sector housing include a return to personal responsibility for conditions and enforcement provisions and demographics are of particular relevance. 'Ageing in place' has major consequences for owner occupiers and tenants, as housing, social and care needs will rise and need to be resourced now and in the future. New health and social care provision alongside safety features and technologies may need to be designed into existing housing interventions as our population ages and increasingly experiences high levels of degenerative illness, such as dementia.

EHPs will also need to assess the nature of their local authority's private rented housing stock as numbers in the sector continue to increase and this trend looks likely to continue. EHPs and their colleagues continue to regulate some of our poorest housing conditions in the private rented sector for some of our most vulnerable tenants, many of whom are faced with few housing choices and options.

Why housing, health and wellbeing?

There are established links between housing, health and wellbeing and the importance of private sector housing in the economy, health, environment, education, society and quality of life is evident. However measurability of health improvement from housing can be complex as regeneration also has exported costs and gains to education, health and policing and needs to go hand in hand with need for housing interventions and community development and quality services, access to healthy food, crime reduction, job promotion and poverty reduction (Ambrose, 2001).

Despite some of the complexities, monitoring and evaluating health and wellbeing in housing strategies has become more commonplace, both in terms of accountability, value for money and to help justify arguments for additional resource. There is a growing body of literature helping to guide us in evaluating the effectiveness of strategies and interventions (see for example Taske et al, 2005; Thomson, Petticrew and Morrison 2001 and 2002) as well as programmes designed to help measure health and wellbeing effects of regeneration interventions (see for example Egan et al, 2010).

The public health, wellbeing and localism agendas, as well as the Housing Health and Safety Rating System (HHSRS) have helped environmental health refocus on how our work can contribute and how we can ensure that health is factored in at all stages. We now have tools in health needs and impact assessment and a requirement to contribute to Joint Strategic Needs Assessments. We need to continually develop our evidence based to ensure credibility and to influence decision making and resource allocation for private sector housing.

In addition a host of policy and publications have helped us in our task and providing a renewed interest including evidence on the costs to society of poor housing and the benefits of interventions (see for example BRE and CIEH, 2008). It has been estimated that poor housing in England costs us all over £600 million annually and the total cost to society in excess of £1.5 billion per year (Davidson et al, 2010). This alone provides us compelling evidence for interventions. The equation is simple: improving housing improves public health.

Identifying and using relevant evidence

Effective interventions in environmental health and housing work necessitate a range of methods and approaches to research and understand social and economic issues, how the complexities of peoples' changing lives are represented in their housing and communities and the involvement of others in their housing, health and social care needs. Developing our evidence base and its application in practice can help deliver available resource to where it is most needed in addressing the complex needs of some of the most vulnerable members of society. In so doing we need to recognise housing as a fundamental determinant of health, taking a wide approach to research and the development of our evidence base that considers social constructs including power relationships in society.

The CIEH Private Sector Housing Evidence Base provides firm foundations for further research and associated work and allows us to reflect, share knowledge and develop good practice so that our strategies and interventions become increasingly recognised and effective and available to share with others.

This publication draws together a range of methods and good practice in adding to the environmental health and housing evidence base. Here, colleagues demonstrate how they use established evidence to enhance practice and continue to develop our evidence base in disseminating work on effective strategies and interventions. In continually building on this evidence we can justify our activities and continue to develop capacity to deliver high quality services.

We showcase examples of innovative environmental health practices including partnership working to demonstrate the fundamental importance of re-focusing on housing as a social determinant of health and the potential for improved health outcomes and impacts. It draws together practical examples founded on a range of evidence sources from those working at strategic and practitioner level in the private housing sector in demonstrating how early, proactive interventions are successful on both economic and social fronts in supporting the case for additional resource for these fundamental front line services.



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Enforcement led interventions: the private rented sector and HMOs

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Figure 1 – once grand but now poor condition housing

Introduction

Governments since the 1980s have continued to favour the private rented sector in its potential to offer flexible and short term accommodation. For many it provides good quality living accommodation without the long term commitment of owner occupation and can suit households who prefer to remain relatively mobile.

However for many tenants living in the sector has substantial shortcomings and many have no choice but to live in unsatisfactory privately rented housing. The private rented sector can be expensive (for individuals, families and the government), insecure, often of poor quality and has substantial shortcomings at the bottom end (see figure 1). It is highly complex in practice absorbing abnormally high numbers of mobile and newly formed households (e.g. due to relationship breakdown). Little is known about the dynamics of moving into and out of the sector (Kemp and Keoghan 2001) and it disproportionately houses poor tenants in non-decent conditions who generally fare worse than those in social housing. There is more pressure on the sector to cater for those who lack alternate choice, feel trapped and who are likely to bear the brunt of cuts to housing benefit payments (Kemp and Keoghan 2001; Kemp 2011). It contains the highest proportion of non-decent homes and lacks secure tenure (Conway 1988; Parliamentary Office of Science and Technology 2011) with many tenants unable to secure accommodation elsewhere, whilst attempts at securing improvements can lead to rental increase and sometimes eviction (Emanuel 1993; Crew 2008).

Many EHPs working in this sector daily, try to tackle poor conditions in addressing such housing and health inequality against a range of odds. Some landlords are disinterested in their properties and tenants. Some tenants do not want intervention, fearing eviction, rental increase or homelessness and working in this sector can sometimes be a thankless task. However, it is at the bottom end of the private rented sector, including HMOs where some of our most acute and stubborn health inequalities exist and perpetuate. In this paper we put forward the case for the need for more evidence to help EHPs effectively manage properties at the lower end of the private rental sector, particularly HMOs.

The need for more published research

Whilst there is a body of literature around private renting, there is very little around the bottom end of the housing market where housing EHPs operate in trying to regulate this sector. The dilemma of legal intervention by EHPs, possible rental increase and loss of a tenants' home means that this sector of housing stock requires careful handling so that the consumer's right to be heard and kept informed can be both secured and enhanced (Emanuel, 1993). Although there have been many changes to housing legislation, many of these issues remain relevant, and insecure tenure and high rents remain particularly problematic.

Interpersonal aspects of enforcement services should be enhanced through better communication and involvement of all parties throughout intervention stages (Emanuel, 1993). The practical difficulties of dealing with housing and health inequalities at their most acute are clear. Dealing with disadvantaged communities, sometimes difficult relations with bureaucrats and even basic contact with tenants to establish multiple occupancy and determine relevant works whilst keeping communication open can be enormously time consuming and frustrating for all when the ultimate aim is to protect and improve housing and health.

More recently studies have focused on the mental health of tenants in HMOs (including bedsits). Mental health is sometimes overlooked and public health now offers the potential for greater partnership strategies to explore new ways of working with some of our most vulnerable communities occupying poor housing (Barratt, Kitcher and Stewart, 2012). An innovative Knowledge Transfer Partnership in Essex has published findings about the relationship between mental health and bedsit accommodation (Barratt et al, 2012b). They found that HMOs can offer a positive environment in which to live when they are well managed. Many residents found themselves residing in a HMO due to challenging life events such as relationship breakdown, job loss and mental illness. Poorly managed HMOs often served to increase tenant's stress and anxiety due to regular exposure to excess noise, violence and drug and alcohol misuse.

However in well managed properties where problems with tenants were quickly rectified, the property well maintained and relationships between landlords and tenants were good, tenants had a positive experience and reported benefiting from the sense of community in the property. The challenge for EHPs is being able to effectively regulate HMOs so that standards can be enforced. However the current legislation used (HHSRS) focuses on protecting the physical health of tenants and makes taking action on ground of mental health much harder when mental health may actually be a more pertinent issue for those housed in HMOs (Barratt et al, 2012a).

An additional challenge is that unless a property is recognised as being an HMO is cannot be regulated which places tenants at greater risk and makes the work of EHPs more challenging. There also remains the vexed question of how we establish that a property actually is an HMO. A recent informal study led by the London Borough of Hillingdon in January 2012 via EHCNet (an online message board, available to Members of the CIEH to seek advice and information on relevant issues from other members across the country). The initial issues related to problems in presenting evidence relating to HMO offences under the Housing Act 2004 and highlighted the fact that HMO tenants often do not have rent books or tenancy agreements and often pay rent by cash, so the situation is 'informal'. EHPs need substantial evidence on which to take cases forward, not hearsay. Local authorities have relied on a range of sources to be able to proceed with the property on the basis that it is an HMO, for example, housing benefit or council tax records and correspondence (where data protection allows), copies to tenancy deposit or agreements, direct questioning of a landlord, inspection notes of occupation at time of visit, photographic or video evidence of rooms (not occupiers), PACE interviews or statements from tenants (although this can be difficult). This informal survey's initial findings demonstrate the need for more substantial research in this vexed area both in categorisation as an HMO and then best practice in ensuring required standards are met without adverse affect on the tenant.

Summary

The Rugg Review emphasised a need to pool resources, knowledge and skills to develop more effective policy and joint working to address conditions in the sector (Rugg and Rhodes 2008). Local authorities have been charged with prioritising activity in this sector (Audit Commission 2009) and although enforcement remains highly challenging we must ensure the health and safety of communities occupying some of the poorest privately rented living accommodation. The generation of evidence about what works in this area could provide valuable assistance for EHPs looking for effective strategies. In the present context of limited time and resources the importance of sharing good practice across LAs should also be recognised and knowledge sharing encouraged through the professional networks that already exist.

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The problem with HMOs; Reading Borough Council's approach to ensuring a safer private rented sector

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Abstract

Houses in Multiple Occupation provide affordable housing. Reading Borough Council has a significantly higher percentage of HMOs in its private rented sector than the national average. The Local Authority faces a number of problems with the ongoing attempts to maintain this tenure of housing. These problems include an ageing housing stock, high tenant turnover and an increasing demand for affordable housing. To address these issues Reading Borough Council has developed a dual approach that includes enforcement of statutory powers and the enablement of the landlord.

Introduction

Characteristically, HMOs are perceived to be poorly maintained and heavily over crowded, with a high turn over of tenants. However in truth, HMOs provide affordable accommodation to thousands of households who would otherwise be forced to live in alternative housing for which there simply is not enough stock.

The current definition of an (HMO) is prescribed in the Housing Act 2004 as a dwelling that is occupied by three or more unrelated people, forming two or more households, sharing one or more basic amenity. Furthermore, if an HMO is occupied by five or more people over three or more floors, then the landlord is obligated to apply for a mandatory HMO licence under Part 2 of the Housing Act 2004.

Background information

According to the 2006 Housing Stock Condition Survey carried out by Reading Borough Council. Reading has a private rented sector of approximately 51,100 dwellings of which it is estimated that there are approximately 3,500 HMOs. This equates to an HMO stock of 6.9%, which is significantly higher than the national average of 2% (Department for Communities and Local Government, 2009).

The 2006 Housing Stock Condition survey also reports that 33% of the private rented sector in Reading was built pre 1919, compared to 24% nationally. Houses built pre 1919 are notoriously difficult to heat, maintain and manage, especially where listed status is granted.

With an aging housing stock, high tenant turnover and an increasing demand for affordable housing, the HMO team at Reading Borough Council have had to implement a variety of methods to ensure the continued well being of the tenants residing in the private rented sector.

Approach and methods

Reading Borough Council takes a dual approach to ensuring the private rented sector is maintained to a safe standard; firstly there is the enforcement approach, which includes the service of notices and legal proceedings leading to prosecutions where applicable. This approach is often, as with other Local Authorities, a last resort as the entire exercise can be very timely and very costly.

The second approach is to enable landlords to carry out remedial action through education and advice. This approach is often preferred as it can achieve quicker results and goes some way to ensuring future compliance. Furthermore, by taking informal action there is a reduction in the regulatory burden on landlords, which helps maintain a suitable supply of affordable housing. Reading Borough Council offers a number of enabling tools, which are discussed below.

Case Study

One such case that demonstrates the effectiveness of The Council's approach to HMOs is an investigation into a pre 1919 semi-detached Grade II listed dwelling divided into 10 bedsits. The occupants residing at the property were all considered vulnerable, with most of them having some form of substance dependency. At least two of the tenants had Chronic Obstructive Pulmonary Disease (COPD) as well as mental health issues, including depression and anxiety.

Officers noted during an inspection that there was a range of non-compliance with the Management of Houses in Multiple Occupation (England) Regulations 2006, the regulations that detail the duties placed on the manager of an HMO to maintain the dwelling. In addition several hazards were identified and assessed using the HHSRS, including a category 2 Damp and Mould hazard and a category 1 Excess Cold.

The result of a poor attic conversion and the nature and age of the property presented significant issues when considering the thermal efficiency of the dwelling. In addition the Grade II listed status would pose certain limitations when asking for remedial action. Furthermore, whilst the property was equipped with gas radiators, controlled from a central boiler, the landlord had begun removing this facility in favour of portable heaters.

To further compound the hazard there was an existing damp problem in the basement stairwell of the property. The continually leaking rain goods had caused a high level of penetrating damp and salt deposits. Furthermore the windows throughout the property were single glazed, double hung, sash windows, which were in a poor state of repair and offered very little thermal insulation.

In line with the council's enforcement policy, the landlord was afforded the opportunity to complete the necessary remedial works on an informal basis, providing that compliance was achieved within an agreed timescale. In addition the landlord was provided with a copy of the Council's HMO Management Pack; an information pack that details what is expected of a landlord in order to comply with the relevant legislation. The information pack provides information to enable landlords to prove their due diligence and offers a structured approach to helping them understand the relevant legislation. This pack remains very popular with Reading landlords and is often referred to during inspections and is available to freely download from the Council's website.

Prior to the expiration of the timescales, the landlord was invited to attend the Council's Landlord Information Evening; an annual event put on by the HMO team in partnership with other Council services and external companies, to encourage the interaction between the Local Authority and the local landlords and letting agents. The event is organised in partnership with one of the local universities and offers the opportunity for landlords to attend seminars on current topics and to obtain information from a variety of stalls. The event is attended by an average of 75 landlords, and feedback continues to prove the interventions worth.

Whilst revisiting the property it was discovered that a managing agent had been employed by the landlord and the repair works had been completed. However the work to reduce the excess cold hazard remained. It was at this stage that officers could choose one of two paths; they could either take an enforcement approach, or they could assist the landlord in achieving compliance.

Having considered the landlord's history of compliance, the risk to the occupants of the property and the public interest, it was decided to work with the landlord in order to achieve compliance. The decision was based on the need to have the works carried out in a timely fashion, which could have been delayed had formal enforcement action been brought against the landlord, and the cost of the work required was such that any fine administered by the courts would detract funds away from the property.

The Council offer a number of grant funded schemes, including the mandatory disabled facilities grant and a Landlord Renovation grant. The grant was introduced in recent years to reduce homelessness and secure the availability of valuable accommodation. In order to qualify for a grant a category one hazard must have been identified in a property, and a legal notice must have been served on the landlord. If this criterion has been met, the Council will consider an application to fund half of the cost of the work, up to the value of £20,000.

Whilst a category one hazard had been identified, no such legal notice had been served. Therefore, in agreement with the landlord, an Improvement Notice was served and charged for in accordance with the Housing Act 2004. This enabled the landlord to apply for the grant assistance to help improve the property.

After delays in obtaining planning permission for the replacement of the double hung sash windows, an application was received by the Council and processed. Following a means test, the landlord was offered grant assistance of £7,500; half the cost to replace the windows. During this period fixed electric space heating was installed in the property and top-up insulation was provided to the roof space. The windows are now being manufactured and will be installed shortly, thus reducing the excess cold hazard to an acceptable level and bringing the property up to the decent homes standard.

Had the Council taken an enforcement approach the landlord may have decided that remedial action was not cost effective and as such could have evicted the occupants making ten vulnerable adults homeless.

Other Approaches

The Council also offers a number of other enabling tools which include a partnership between the National Landlords Association (NLA) and the Local Authority. The Council offers landlords who are accredited through the NLA accreditation scheme a discount on their HMO licence fee. This work is done in an attempt to professionalise the private rented sector and encourage a higher standard of accommodation through an educated landlord. In addition the Council has imposed a licence condition on the mandatory HMO licence requiring landlords with a poor history of compliance to attend the NLA training course, which focuses on all aspects of running a private rented property, from starting and ending tenancy agreements, to HHSRS assessments and proactive management approaches.

Other educational tools are also offered including, the Landlord Focus quarterly news letter, which is produced by the HMO team. The contents of the news letter vary from newly introduced legislation, to details of recent prosecutions to demonstrate that the authority does take action where needed. There is often a misperception that the Local Authority only focuses on the good landlords, however by publicising prosecution work; the Council is able to demonstrate otherwise.

Education, or advisory visits are also undertaken by officers for which the landlord is charged. The Council has seen a recent increase in the demand for these types of visits, which is encouraging. Landlords appear to be taking an approach that they would rather get it right in the first instance by working with the Council, rather than getting it wrong and facing possible legal proceedings at a later juncture.

The Council is also in the early stages of undertaking a more up-to-date Housing Sock Condition Survey in an attempt to better understand the current trends and condition of the private rented sector in Reading. Included within the survey is a health perspective element, which will enable the Council to work more effectively with health and well being boards.

Furthermore the results of this survey will feed in to the evidence base used to consider the need to implement either a Selective, or Additional Licensing scheme (or both) under Part 3 of the Housing Act 2004.

Findings

Whilst undertaking this work it became evident that whilst improvements to the private rented sector are recorded, the method by which this is achieved is not. Attempts are being made locally to improve reporting to highlight whether an informal or enforcement approach was taken; however work is still required.

It is very difficult to provide evidence to support that either approach works best. On one hand the legislation is very descriptive in stating that failure to comply should, or must, result in enforcement action. When one considers the Housing Act 2004 definition of 'enforcement action' advisory methods are not considered as such and should therefore be discounted.

However experience and practical application indicates an informal approach often gives better results; the repair or hazard can often be rectified quicker and at a lower cost to both the Local Authority and to the landlord.

The Local Authority has a suite of tools providing options for enforcement officers; but officers must use their experience and judgement in a consistent way to decide whether enforcement is the most expedient way to achieve the best outcome for tenants, landlords and the Council.

Implications for policy or practice

It is clear that a better method of reporting is going to be required, especially with the return of responsibility for public health back to local government. If Local Authorities are to continue to take the dual approach discussed in this chapter the evidence for both sides of the discussion need to be improved.

To summarise, whilst legislation and guidance dictates that enforcement must be taken in light of non-compliance, there exists a number of enabling methods that can be just as effective in achieving the same goal.

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The Impact of Poor Housing on Children: a Case Study

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Abstract

The relationship between housing conditions and educational attainment are well established but under researched. The lack of basic amenities in housing can be associated with low educational attainment. Such conditions adversely affect a child's health, development and access to friends and social networks which are likely to affect school attendance and performance. One in four homes across the social and private sectors are not of a decent standard. It is reported that 4.8 million homes in England (22%) have Category 1 hazards arising from defects as assessed using the HHSRS.

Introduction

In Barrow-in-Furness a very high proportion of the housing stock in the Private Rented Sector consists of pre-1919 terraced houses, a total of 15,000 properties. Private rented dwellings, as is the case nationally, have the highest proportion of category one hazards. To some extent this reflects the fact that more private rented dwellings are older and are converted flats. Both these factors tend to make a dwelling more like to have a category 1 hazard. As with nondecency, category one hazards follow the national trend with private rented dwellings having fewer category one hazards than the national average, but to a similar degree that owner occupied dwellings are below the national average.

This chapter describes the role of an Environmental Health Practitioner in a case which clearly identifies the link between poor housing and poor educational achievement, the work involved in addressing the disrepair within a house and the necessary partnership working, uniting with the collective goal of achieving the best conclusion for five small children.

The referral was made to an Environmental Health Practitioner in February 2012 by a social worker working with the family who was concerned regarding the conditions within a privately rented house. The property is habited by five children between the ages of five to thirteen; the mother is a temporary lone parent and the father in prison for drug related crime. The house is a 3 storey property, built pre-1920, poorly converted from individual bedsits to a family home and located next to a problematic block of flats owned by the Local Authority.

A formal Notice of Entry was served and an inspection of the property was carried out in February 2012 using the HHSRS. The Category 1 Hazards identified included the lack of an adequate heating system, an unsatisfactory provision of hot water, falling plasterboards to a ceiling in poor condition, unsafe electrical accessories, the absence of a Gas Safety Certificate and no fire detection to the three storey property. The property was filthy with human and animal excrement to bedrooms and urine soaked carpets. There were no external areas available to the children to play in as they were filled with household rubbish.

Background Information/Literature

Housing can contribute to a range of societal outcomes that go beyond providing shelter (Lubell and Brennan, 2007). There is strong evidence that poor housing conditions result in educational under achievement, with children in better quality homes gaining greater numbers of GCSEs, A levels and degrees, and therefore achieving greater earning power. Purely based on differences on GCSE results, it is forecast that £14.8 billion will be lost in potential earnings for the current generation in poor housing (Friedman, 2010).

The connection between poor housing, poor health and poor educational attainment is highlighted in Shelter's Cornish research. The number of lost school days reduced from 9.3 to 2.1 days per 100 along with a significant reduction in respiratory problems when central heating was installed in to damp and unheated bedrooms of children aged 9-11 years. Treating medical conditions associated with poor housing conditions is assessed at £2.5 billion per annum. These figures were based on estimates of costs for GP consultations, associated treatments, hospital in-days and out day referrals where it was assessed that a prime causative factor for the ailment was housing related. The cost of £2.5 billion does not include loss of earnings and any other treatment or therapy.

According to Shelter, 8% of children living in substandard accommodation lose out on a quarter of their schooling. Specifically, this can be linked to overcrowding where, as noted above, space for homework is lacking, and/or living in cold and damp conditions, makes completion of homework less likely, as well as exacerbating health problems. Poor housing is also associated with lower literacy rates and low respect for education. Poor quality housing has been identified as exerting a negative impact on educational performance, whether this is through its association with poor health, such factors as lack of privacy and study space, or because at the neighbourhood level poorer neighbourhoods tend to have poorer housing and schools which do not have successful outcomes for pupils. Gender emerges as a prominent variable in the links between housing and education, with boys particularly affected by parental home ownership status; in this case, four of the five children are boys (Harker, 2006).

Approach and Methods

Almost all legislative powers available to an Environmental Health Practitioner have been used in this case ranging from informal action to prosecution. Following the Council's enforcement procedure, attempts were made to work informally with the landlord and visits were made in person to explain the financial costs of formal action and how far the charges would go towards addressing the disrepair. Subsequently, the relationship broke down between the landlord and tenant, the Environmental Health Practitioner had to then make frequent visits to the property to facilitate Gas Safety checks and undertake other work. The bare minimum of work was undertaken by the landlord, addressing minor works only. Two formal Improvement Notices were served and were neither appealed against nor complied with. Emergency Remedial Action was undertaken to address a front door that did not lock and to repair dangerous electrical accessories. Following the lack of compliance with the Improvement Notices, a significant number of hours were spent by the Environmental Health Practitioner on preparing a 70 page prosecution file, heard in a Magistrates Court in October 2012.

Effective Partnership Working

The case has demonstrated effective partnership working between internal departments and numerous external agencies. Work has involved seeking permission from Environmental Health Management to waive kennel fees to remove the dog to address the faecal matter in the bedrooms. The Environmental Health Practitioner worked with the occupier by both informal and formal action to remove the rubbish and to order large bins to manage their rubbish effectively. Pollution Officers worked with Social Services to give advice on cleaning effectively and the removal of carpets. Neighbourhood Wardens were engaged to monitor the property to ensure the external areas were being kept clean. Requests were sent to the Fire Service to fit smoke alarms as a temporary measure due to the lack of a hard wired detection system. Difficult challenges have been made to Senior Management in Child Protection Services when standards have lapsed, witnessed because of numerous visits by the Environmental Health Practitioner to the property. This, in effect has resulted in the Environmental Health Practitioner being invited to form part of a core team, working with teachers, nurses, paediatricians, social workers, probation officers, the police and fire brigade to ensure the safety of the children is safe guarded. The Environmental Health Practitioner has held regular meetings with the Social Housing Department to ensure they are fully updated and aware of the housing need of the family.

Evidence of Health Protection

The children no longer are sent home from school due to their smell from sleeping in filthy bedrooms. The dog, too big to be exercised by the children, with no access to the external areas was using the children's bedrooms as a toilet. The children no longer have to sleep in rooms which were filthy and the dog has been safely re-homed. The number of days the children are absent from school due to gastro-intestinal illness have been reduced and there has been an improvement in the children's school reports. The children have not had head lice this year and their hair is no longer matted now the shower is working. The bath now discharges to the drainage system. The toilet is now working properly which has led to a reduction in soiling issues at school for the younger children. There has been an improvement of the disruptive behaviour displayed by one of the children.

The family is to be re-housed by the Housing Department in October 2012, free of Category 1 hazards and a home which meets the Decent Homes Standard. The children will not be spending this winter in bedrooms with temperatures of 10°C, and the likelihood of the youngest child being hospitalised with pneumonia in the forthcoming winter of 2012 will be substantially reduced. The children will no longer be socially excluded with the ability to play with friends in their home and in the garden. The children now feel safe in their home and sleep better with an entrance door that locks and not secured by dining chairs. The children will be able to study in their rooms in warmth with weather tight windows, and have the same basic amenities required to succeed in school as their peers.

Implications for Policy or Practice

The need for holistic, joined-up partnership and multi-agency responses to poor housing, social exclusion and child welfare issues is at its most prevalent in a time of reduced resources. This particular case has improved alliances, the dissemination of information and ways of understanding how different agencies react to problems has also developed. It has not been custom, in the past, to attend strategy meetings but this case has improved multi agency collaboration because every professional involved in this case know that the most positive impact on the children's lives will be a warm, safe home.

The landlord was prosecuted in October 2012, £3,000 per Improvement Notice with full costs awarded to the Local Authority, the amount totalling £7k. The family are to be re-housed in Local Authority housing and a Prohibition Order is to be served to remove the property from the Private Rented Sector.

The key message of this paper is the amount of officer time this case has taken resulting in positive changes being made to the children's lives. This is with reduced resources in both the public and private sectors. It is crucial, at a time of expansion in the private rented sector market that Environmental Health Practitioners are there to support and protect the most vulnerable people in society.

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A review of multi-agency enforcement and discretionary property licensing to tackle Newham's private rented sector

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Abstract

This paper reviews the London Borough of Newham's approach to talking criminal landlords through landlord licensing and multi agency enforcement. It considers some of the advantages and disadvantages of such an approach. It considers the local and policy overview; licensing application; multi agency approach and a case study approach is used to uncover some of the legal and technical issues facing practitioners on the front line.

Background information or literature

Newham faces numerous challenges in dealing with its private rented sector and particular reference is made here to the Department for Communities and Local Government paper titled Dealing with Rogue Landlords: a guide for local authorities (DCLG, 2012). This document seeks to provide advice to address rogue landlords who place vulnerable tenants in unsafe or overcrowded accommodation, which can have a detrimental effect on neighbourhoods, including refuse, noise and antisocial behaviour and places pressure on services.

Approach and methods

Newham's private rented sector is estimated to comprise of 38,000 dwellings making it the largest tenure in this east end borough, accounting for 35% of Newham's housing stock. Houses in multiple occupancy (HMO) are increasing in number due to a lack of affordable housing and high levels of immigration, it is estimated they now represent 1 in 4 rented properties. That may account for Newham being the most overcrowded borough in London with 301 people per 100 dwellings (Census 2011). This is 50% more than Kensington and Chelsea, with 199 people per 100 houses. This is compounded by the second highest level of income deprivation (English Deprivation Index 2010), the third highest level of Metropolitan Police recorded anti-social behaviour (MPS 2010).

Much of the above is associated with poorly managed private rented property controlled by a minority of rogue landlords. This has forced Newham to radically reform its approach to tackling landlords who exploit vulnerable tenants by overseeing unsafe and overcrowded housing conditions. Newham has chosen to support vulnerable people by taking rigorous action against criminal landlords and agents who manage illegal and dangerous properties. Where housing crimes are detected Newham EHPs take a hard line, resulting in more than 60 criminal prosecutions in 2011/12. This proactive enforcement focus approach seeks to change the behavior of a small minority of criminal landlords and to provide a deterrent to landlords who are on the boundary of non-compliance. In time creating a better regulated private rented market where tenants are offered a greater choice of safe and healthy homes.

This shift has been led by Newham's Private Housing and Environmental Health team who have developed an enforcement strategy based on a mixture of discretionary rented property licensing and multi-agency enforcement. This new twin track approach was pioneered in a pilot incorporating a Selective Licensing scheme which was the London's first and only 100% landlord licensing area.

By using a multi agency approach officer time can be used far more productively with improved enforcement outcomes. The full use of powers under Housing Act 2004 further increases the impact and helps to drive the worst landlords out of the sector, hopefully to be replaced by landlords who will manage and maintain their portfolios better. This should have an overall improvement in physical conditions in the sector thereby reducing the negative health impacts of poor housing.

This paper reviews current local policy and practise with use of a practical case study.

Licensing and multi-agency partnerships in improving living conditions and health promotion

The pilot covered 580 dwellings, 43% (257 dwellings) in the private rented sector. The two year pilot saw all properties inspected and licensed. More than 30 landlords were prosecuted for offences under the Housing Act and the Town and Country Planning Act, including failure to licence, HMO Management Regulation and breaches of a planning enforcement notices. Reported and observed anti social behaviour significantly dropped over the life of the pilot and helped change the perception of the neighbourhood. However costs related to the pilot were significant due to the number of officers tasked towards this particular pilot.

Property licensing was found to offer two key advantages; firstly it helped identify non compliant landlords. Compliant landlords are first to come forward to be licensed and landlords who are mostly compliant license after a warning letter is received. This leaves a minority (15-20%) of non-compliant landlords, conspicuous by their absence, where enforcement and legal action can be focused. The second key benefit is associated with the additional powers that come with licensing, including failing to license accompanied with fines up to £20,000. This helps ensure landlords take responsibility for their properties and tenants. This approach is justified by findings from the pilot that landlords who failed to license were also found to be non-compliant across the board. These landlords were 4 times more likely to be responsible for serious health and safety failings in the property than a landlord who licensed on time. Anecdotal evidence suggests this non-compliant group also failed to pay income and council tax, comply with planning and building control, encouraged immigration offences and in some cases were responsible for harassing and illegally evicting tenants. Prosecutions for failure to license also open up other powers such as Proceeds of Crime Act and Rent Payment Orders. These draconian interventions can be focused on the most prolific offenders to help drive them out of the sector altogether. They can recoup significant sums of rent and other criminal benefit and shift some of the enforcement costs back on to landlords.

While licensing helps identify criminal landlords and provides additional sanctions and powers, it is unable to deal with the wider criminality associated with the worst run private rented properties where chaos often prevails. It fails to provide the infrastructure necessary to gather the evidence to deliver justice to the worst offenders. To support this area, a multi-agency enforcement team was built up incorporating the Police, Planning Enforcement, UK Border Agency, Fire Brigade and others.

Approach and methods

Taking a multi-agency approach to enforcement is by no means a new concept. This approach has been used by EHPs up and down the country to tackle some of the most prolific offenders of environmental health law. However, Newham have forged strong day to day links with the Police and to help deliver sustainable solutions to problems that give rise to crime and anti-social behaviour. This has been developed to the extent Newham now pay for 30 dedicated Police officers out of its own shrinking general budget.

Police have widely adopted the VOLT model to help drive down community safety problems arising from a combination of four key elements: Victim, Offender, Location & Time (VOLT). This approach has been put to effective use to reduce violence and crime associated with Clubs, Pubs and other licensable premises under the Licensing Act

This model was transplanted in to the Little Ilford Selective Licensing Area and has made a significant difference to the effectiveness of the overall intervention. Intelligence sharing and joint problem solving and the ability to focus different powers on problematic property or persons are key benefits. Operational advantages are a greater presence and security during inspections and control during crime scene investigations. The proactive nature of these interventions often mean tenants have not reported the slum conditions they occupy, mostly because they are too scared or do not care. This results in a semi-hostile environment in which evidence must be gathered during a single inspection, including witness statements from tenants. The downside of this approach is tenants are not consulted on the action taken on their behalf. As much as possible is done by officers to empower tenants by informing them of their legal rights, however the differential in power between landlords and tenant is deeply unbalanced.

The coming together of various powers vested in different agencies creates an intervention which has a greater impact than if agencies worked alone. For example, EHPs have the power to enter residential premises without prior notice in a number of circumstances; however EHPs are unable to force tenants to provide their names or the landlord details. However, with Police in attendance the production of names and identification can be insisted upon. Tackling sheds with beds and illegal conversions is another area that benefits from joint working. Where poorly constructed and unlawful properties result in a number of serious health hazards a mixture of Housing Act and Town and Country Planning Act powers can be used together to achieve sustainable results.

Other benefits of multi agency working are that a significant reduction in bureaucracy can be achieved. Information obtained during visits is available for use by all attending agencies, the landlord business and occupants receive one visit as opposed to sporadic ad hoc approach.

In summary, Newham has moved away from the traditional use of encouragement and legal notices to improve standards in the private rented sector. Hard line enforcement is focused on the criminal landlord community with support from a range of multi agency partners. Landlord licensing is used as a key tool to identify criminal landlords and bring significant criminal sanctions for those who fail to comply. Results from the pilot area are good, although significant resources have been expended on a relatively small area. None the less Newham is convinced that this approach has a future and is proposing to use this strategy to tackle poor housing in the private rented sector on a borough wide basis from January 2013.

Case Study – A Shed with a Bed

A recent investigation into the sheds in beds phenomenon was undertaken by Environmental Health and Planning Enforcement officers. A recent thermal imaging survey had been carried out to try to identify excessive use of outbuildings which may suggest occupation. A particularly poor example was chosen in which the rear outbuilding was known to be used as accommodation and being little more than a garden shed, see photo below.

The occupant of the shed had no written tenancy agreement and was paying a head tenant who collected rent from all occupants and then paid a fixed monthly sum to the managing agents. In this way the managing agent believed that they were letting the property out on one tenancy and could therefore use ignorance of any sub letting as a defence to any Council action.

Joint visits were undertaken to establish details of occupancy, tenancies, rents being paid and relating to outbuildings being used as accommodation. The visit did indeed establish that a garden shed was being occupied as someone's only and main residence with electricity supplied via a gang extension lead from the main house through the back garden. The floor area was 8.6m² with overlap timber walls and a flat roof with approximately 150mm of insulation between the joists to the roof. The floor was an uninsulated suspended timber floor. Washing and cooking amenities were via those facilities in the main house, being used as a HMO. As the property was mid terraced the only access and egress to this rear dwelling was via the main house through the ground floor rear kitchen then hallway to the front door.



An assessment made under HHSRS revealed Category 1 hazards relating to Excess Cold, Fire and Electrical Hazards with Category 2 hazards relating to Domestic Hygiene, Pests and Refuse and Falling on Level Surfaces. The Planning Enforcement officer deemed the dwelling to have been in use without proper planning consent and for a period of approximately 2 years. Following these visits both Officers discussed what remedies were available to each of them and how they may work together. The Planning officer issued a stop notice requiring the unauthorised structure to be taken down and the EHP made a Demolition Order after an initial consultation letter had been sent to all interested parties. By determining the correct timescales, the Planning Notice could be served first removing possible challenge to that notice were Housing Act action to have been taken first. Both enforcement actions effectively required the same result – to have the shed demolished, so if one type of action were to fail or be postponed the other notice would still be present and valid.

The EHP then contacted the council's Housing Options Centre to discuss possible scenarios regarding re-housing so as to prevent the occupant becoming homeless. In this instance the occupant has been offered a room within the main building, which will then allow the Demolition Order to go ahead with minimal disruption to the occupant and without recourse to public subsidy for rehousing.

Implications for policy or practice

These methods of working, using the full range of regulatory tools for the private rented sector in the Housing Act 2004, can be used to target the increasing problem of a poorly regulated sector with an increasing number of wilfully evasive and sometimes criminal landlords. By working with other agencies there are multiple benefits for each service which contributes, not least a reduction in officer time and therefore resources. The impact on those negligent or criminal landlords is also magnified further pressuring them to leave the sector.

As a way of working within the council, multi agency working is still in its relative infancy. However there are already very promising signs that this approach is very effective.

For example on an assessment of person hours spent on complex cases, and in particular in gaining access to those properties, which have numerous defects and legal contraventions, (not solely Housing Act or public health type breaches) these joint visits can reduce wasted officer time by up to a factor of six. That is, for every six visits that may have previously been made now only a single visit is made. The range of information sharing also reduces duplication of similar or the same information, for example a Land Registry search can be obtained once and used by all relevant council departments as well as witness statements by occupants relating to ownership and use of properties.

Other aspects do need noting however, which may pose pitfalls in later legal cases or simple allegations of abuse of power or entrapment. Firstly, when working with other agencies, be they internal colleagues such as Planning Enforcement or external agencies such as UK Border Agency, EHPs need to be mindful of other agencies piggy backing on their powers of entry. For the purposes of enforcing the Housing Act 2004 a s239 notification of entry is solely for the purposes of investigation provisions under that Act so investigations relating to e.g. immigration status will be outside of the scope of a s239. Although s239 allows authorised officers to take other persons with them, that is solely for the purposes of that power being exercised i.e. in investigating premises under Parts 1 – 4 of the Act. Therefore entry to the premises by other officers should receive consent from occupants once the EHP has demonstrated that they have the right to enter (which in certain scenarios does not need prior notification). Finally EHPs should be aware of the ability to use information from council tax and/or housing benefit under s237(2) of the Housing Act 2004 to identify relevant properties.

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Overcrowding and Tuberculosis in London: establishing the context

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Abstract

There are numerous physical and mental health effects of overcrowding on the occupiers of dwellings and overcrowding – or ‘crowding’ – has increased in recent years. One of the consequences of this has been a rise in infectious disease such as Tuberculosis (TB). The incidence of TB in London is closely associated with crowding and local authorities have both duties and powers to address overcrowding. New partnerships in recent years have helped focus around the complex needs of addressing the recent rise in TB through multi-agency working.

Background

It was in the middle of the 19th Century that epidemiological evidence gradually accumulated, mostly through Medical Officers of Health, that death rates were directly correlated with occupancy rates. Although there is now general agreement that both overcrowding and TB levels have risen in recent years, it had been challenging to collate this directly due in part to separate data being collected. However there is a link between poor housing environments including overcrowded conditions and TB. It is useful to refer to the ‘epidemiological triangle’ which helps our understanding of infectious disease such as TB as the product of an interaction between an agent, a host and the environment (Locker, 1997). TB may result where the recipient is susceptible and this may result from general existing level of health, age, nutritional status, previous exposure and immunisation against the disease (Donaldson and Donaldson, 2003). Each of these, and other factors, need to be taken into account in developing and implementing effective strategies to address TB.

Professor Zumla of University College London has recently described London as the tuberculosis capital of Europe. TB cases increased by 50% in London since 1999, 1 in 3 cases are transmitted in the home and 85% of cases are in people who have lived in Britain for over 2 years. Professor Zumla considers that cases of TB discovered in immigrants who have been in the country for more than 2 years are likely to have caught the disease in Britain. The graph shows a dramatic drop for immigrants in this country between years 2 and 3 of TB. It is possible that immigrants in the country between 3 and 10 years may have caught the illness from their relatives at home (Zumla, 2010).

In 2012, the Health Protection Agency reported that there had been 8,963 cases of TB in the UK in 2011 and that notifications and rates had been relatively stable since 2005. Most cases were young adults from urban areas, from countries with high TB rates and social risk factors. Over half had pulmonary TB and those reported as receiving Directly Observed Therapy was low (HPA, 2012).

Approach and methods

Legislation, the London housing situation and partnership applications are now considered.

Legislation for crowding

Local authorities have a statutory duty to inspect, report and prepare proposals in respect of overcrowding in the whole or part of their district. Inspections and investigations into overcrowding require consideration of the number of new dwellings required in relation to those occupying overcrowded housing (or those otherwise in unsatisfactory housing conditions) who are waiting for re-housing. Tower Hamlets, in London, have produced an overcrowding reduction strategy 2009-2012 where they have “proposed a housing initiative to increase housing supply” (Tower Hamlets 2009-12).

Local authorities have powers to require information in writing about the number, ages and sexes of people sleeping in dwellings and there are legal provisions to abate overcrowding. Enforcement is mandatory but leaves an additional dilemma of where those currently in overcrowded conditions will then live.

The current statutory definition of overcrowding has been extant since 1935. There are two measurements of overcrowding; the room standard and the space standard. The room standard is deemed to be exceeded when two people of different sexes over the age of ten not living together as husband and wife have to sleep in the same room. This standard is seldom, if ever, used as if there are two habitable rooms in a dwelling there is no need for a couple of different sex to be sleeping in the same room.

The space standard has two sub categories and the lower number of the sub categories is the permitted number of the dwelling. A habitable room on which the standard is based is defined as a room normally used in the locality for living or sleeping purposes. This can include kitchens which are large enough to take a bed (Wilson, 2011).

The first test is for rooms under 50 square feet (4.465 square metres) are not included in the calculation)

one room = two persons,

two rooms = three persons

three rooms = five persons

four rooms = seven and a half persons

five rooms or more = ten persons plus two for each room in excess of five rooms.

It can be seen that where there are two rooms available the accommodation can be statutorily overcrowded with a ratio in excess of 1.5 persons to a room whereas with one, three, five or more rooms in a dwelling the standard is 33% higher.

The second test is determined by the size of the rooms

A room under 50 square feet is not counted

50-70 square feet (4.465 square metres – 6.503 square metres) ½ person

70-90 square feet (6.503 square metres – 8.361 square metres) 1 person

90-110 square feet (8.361 square metres – 10.219 square metres) 1 ½ persons

>110 square feet (10.219 square metres) 2 persons.

The HHSRS has redefined overcrowding and changed the term to “crowding”. The definition of crowding is, unlike the statutory overcrowding standard, subjective and introduces such terms as a “bedroom” rather than a habitable room. This creates a complication as to what is a “bedroom”. If a room in a dwelling is not used as a bedroom is it in fact a bedroom. Rooms in houses can be used as studies, store rooms, dining rooms or for various other purposes. The HHSRS offers no guidance on this matter and even the objective statement that the number that could be deemed to be overcrowded dependant on the number of people in the dwelling and the number of bedrooms is only a “guide” with the implication that a subjective view has to be taken.

Under sub-section 4 of section 326 Housing Act 1985 there is provision for the secretary of state to introduce regulations as to how a room should be measured. The Housing Act (Overcrowding and Miscellaneous Forms) Regulations 1937 prohibited taking account of areas where the ceiling height was less than 5 feet. Chimney breasts, fitted cupboards and the area within bay windows were to be taken into account (Bassett, 1995). However, this legislation was repealed in the 1990’s and now there is no legislation that deals with how a room is to be measured.

Current London housing situation

London’s population has increased by nearly 20% in the 20 years between 1991 and 2011 (ONS, 2011). One of the largest increases in population as a percentage rate is in the City of London which increased from a population of 5400 in 1991 to 7,375 in 2011. It is unreasonable to consider the City as representative of London as a whole. (Indeed the City of London population fell between 2001 and 2011). The population increase in London from 2001 to 2011 is 11.63% but the stock of dwellings only increased by 6.02% between 2001 and 2009 (ONS, 2011a). As there was not a housing boom in London from 2009 to 2011 clearly the construction industry has not kept pace with the increase in population and overcrowding has been the result.

The four boroughs with the largest population increase are Tower Hamlets, Newham, Hackney and Brent. Tower Hamlets has seen 52% increase in population in 20 years (ONS, 2011b). Some of this increase can be attributed to the increased building around docklands.

| Borough | Tower Hamlets | Newham | Hackney | Brent |
|------------------------|---------------|--------|---------|--------|
| 1991 Census Population | 166300 | 216300 | 185000 | 240800 |
| 2001 | 201100 | 249400 | 207200 | 269600 |
| 2011 | 254096 | 307984 | 246270 | 311215 |

Whilst overcrowding undoubtedly presents a risk to health from mould, accident, infectious disease, depression and lack of educational attainment it is clear that overcrowding in dwellings is a symptom of poverty which will also be prejudicial to health. The problem of associating overcrowding exclusively to deficiencies in health is illustrated by the Operating Guidance to the HHSRS (ODPM, 2006: 92):

“There are difficulties in quantifying the effect of overcrowding on population mortality and morbidity. This results from complications associated with differences in cultural practices, people spending only a proportion of their time at home, and other confounding socio-economic factors. People who live in crowded conditions also tend to suffer multiple deprivation, and separating the effect of poverty from crowding is difficult.”

Although it has been very difficult to ascertain exact numbers of cases of overcrowding but anecdotal evidence suggest that it has risen in recent years. One example is the family in the photograph below occupy two rooms in an East London Borough. The mother has had two sets of twins and her other child sleeps in a bunk bed in the same room. Similar pictures in Romanian orphanages a few years ago generated a wave of compassion in the west however it seems that we are insensitive to such conditions on our doorstep.



Housing conditions and TB

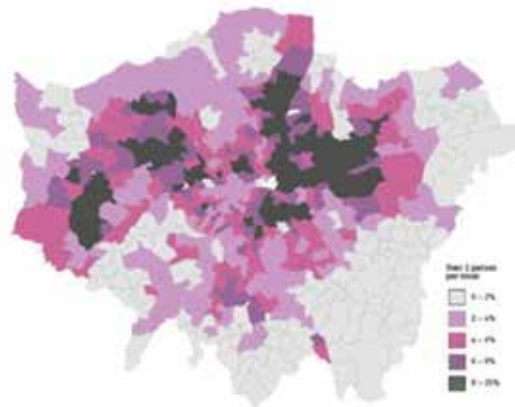
If someone lives in bad housing with regard to disrepair or absence of amenities these can be overcome. However crowding can be particularly challenging to address and we need a more proactive focus as occupiers can live in overcrowded conditions for many years until their family grow up and move away. This leads to depression and a feeling of helplessness by the adults in the family. There is social deprivation as children do not have areas where they can study or play, their opportunities for personal development are severely reduced which leads to inequality. There is isolation as the family have no room to entertain. These are the social effects of overcrowding but there is another public health effect with the increase of the incidence of infectious disease, particularly TB which was described in Victorian times as “the white plague” due to the pallor of the victim’s complexion.

The correlation between TB and overcrowding can be seen from the two maps presented below. The map on the top illustrates the incidence of TB on a borough wide basis whilst the map beneath indicates the incidence of overcrowding in London on a ward by ward basis. It can be seen that there is a close correlation between crowding and TB. The boroughs on the eastern fringe of London have a low incidence of TB and comparatively little overcrowding. Boroughs such as Brent and Newham have a high incidence of TB and high levels of overcrowding.

Figure 1- Incidence of TB per 100,000 population (Red dots indicate location of TB clinics) – Source HPA



Figure 2 - Overcrowding by London ward (Percentages of households with more than one person per room) – Source GLA



The current housing crisis is evidenced by the increased overcrowding that is present and that there is insufficient suitable, available and affordable accommodation as an alternative for many living in overcrowded homes. In addition we need to take a more proactive role in addressing the overcrowding problem that exists. EHPs in local government must insist that their authorities adopt a more imaginative approach to overcrowding and, when they see a situation that a family is overcrowded, they should present the case to their local authority seeking urgent resolution of the situation.

Evidence of health protection and promotion

Those in poor housing are at great risk and as such as decent housing environment combined with appropriate medical and social intervention are essential as part of partnership approach to tackle the complex interrelated aspects of this disease. Dealing with TB can be problematic because of the range of responsibilities of the various agencies involved and there is a need for services to focus primarily around housing so that those with, or at risk of TB, have secure accommodation alongside their medical and social care needs. Populations suffering TB may be 'hard to reach' so mobile services may be required to help ensure that all services operate increasingly effectively together and that courses of medical treatment are completed.

Many partnerships have been able to address the interrelated causes of TB. The London Borough of Newham, for example, had one of the UK's highest TB rates which peaked around 2000. Its partnerships work was led by the local authority and involved environmental health, housing, policy officers, TB nurses, CCDC, social workers and local pharmacists and was then funded by a Public Service Agreement. Screening, advice to register with a GP locally and health checks have proactively addressed TB.

Training helped overcome myths, stigma and ignorance around the disease and leaflets, posters and videos in different languages helped spread the message as part of the health promotion campaign including outreach work in bed and breakfast hostels and hotels but also in mosques, temples and via other faith groups. Statistical and qualitative data obtained has been fed back into the strategy and joint working has proven effective (Stewart, Bushell and Habgood, 2005).

Implications for policy or practice

At the time of writing the Health Protection Agency oversees the TB functions to coordinate and control activities. Their guidance provides a useful summary to this paper for continued coordination of services. TB prevention and control to help ensure best practice in TB detection and treatment in risk areas. Local authorities and their new public health functions should enhance service and control implementation through Health and Wellbeing Boards. Lower incidence areas should recognise and follow good practice in high risk areas. Proactive screening should continue, particularly as TB is a global disease epidemic (HPA, 2012).

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Area Renewal: the historical overview

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Introduction

The improvement of housing conditions was a major objective of the public health movement in Britain from the 1840s onwards. Slum clearance dated from the Torrens Act of 1868 but without provision of alternative housing, adjacent houses were sub-divided to meet unmet demand and recreated the slums that had just been cleared (Gibson and Langstaff, 1982). The gradual and sporadic provision of exchequer subsidies followed the Housing, Town Planning, Etc. Act, 1919. From the 1930s government strategies combined slum clearance with increased Council House provision until the 1970s (English et al, 1976). Housing based area renewal policies were developed in the 1960s to respond to the unintended consequences of these strategies; the collapse of private investment in private sector housing.

The impact of rent controls and slum clearance on housing investment.

The Increase of Rent and Mortgage Interest (War Restrictions) Act (1915) was intended as a temporary measure to protect tenants in privately rented accommodation through rent controls and security of tenure but such protection continued in various forms until the 1970s. Investors decided they could make little money from such properties so private investment in new rented units effectively ceased. (Murie et al, 1976).

Owner occupiers who lived in or adjacent to areas deemed to be slums risked losing their homes and were compensated at the empty site value if their home was judged unfit. The Slum Clearance (Compensation Act), 1956 introduced compensation at market value but it took until 1973 for the Land Compensation Act (1973) to require local authorities to re-house occupants (although this was existing practise in many schemes) and pay Home Loss Payments. These were for owner occupiers and tenants as recognition for the special hardship caused by compulsory dispossession of their home (Gibson and Langstaff, 1982).

Meanwhile Council building was focussed on clearing the slums and ending the housing shortage at the lowest possible unit costs. By the 1970s politicians claimed those goals had been achieved and became concerned the traditional approach was displacing private investment in housing in the inner city areas they sought to improve (Malpass and Rowlands, 1988).

From slum clearance to area renewal

Area action to reverse the flight of private sector investment from inner city housing was first encouraged by the Housing Act 1964. General Improvement Areas and Housing Action Areas were introduced by the Housing Acts of 1969 and 1974 respectively (DoE, 1990). General Improvement Areas offered grant support to enable poorer owner occupiers to improve their properties in ways that they could otherwise not afford. Housing Action Areas supported such eventual improvement with enhanced enforcement powers to immediately arrest decline for areas (for example with high levels of renting or multi-occupation) whose improvement could be to the detriment of residents' interests (Gibson and Landstaff, 1982).

Government concluded in time that; "In the late 60s and early 70s clearance of older housing had been the main focus on many urban authorities housing activities. Emphasis moved to renovation but in recent years this has gone too far with properties being renovated when there was no social reason for maintaining them and it was not cost effective" (DoE, 1990:6). By 1989 the Local Government and Housing Act required local housing authorities to carry out a Neighbourhood Renewal Assessment prior to every housing intervention whether for an individual property or for a whole neighbourhood. Clearance could continue but was rarely as cost effective to renewal at the increased compensation rates now due to the owners. The "net present value" of both these options had to be considered against the third option of doing nothing (DoE, 1990).

Funding for area renewal

The Housing Act 1949 first entitled owners of properties judged suitable for renovation to a means tested grant to assist them in doing the work. If their property was included in group repair schemes or a housing renewal area the level of grant support was enhanced (Gibson and Langstaff, 1982). Private sector renewal funding reached a peak during the 1980s with the introduction of mandatory landlord grants as part of government policy to encourage the expansion of the private rented sector. Individual Housing Authorities were encouraged to bid for ring fenced budgets based on local fitness levels that could cover the entire cost of renewal grants, enablement expenses and associated environmental improvements. Housing Authorities that declared Renewal Areas increased their ability to spend such funding. In regions where demand fell short of available budgets Housing Authorities could successfully bid for renewal funds well in excess of their budget entitlement. At one stage government was threatening to withdraw social housing funding from Councils who bid for too little private renewal funding (Snell, 1994).

New approaches to local governance and housing finance

Single pot housing funding allocations were introduced for Local Authorities based upon a mix of needs indices in the late 1990s. They provided far more freedom to move capital funding between different programmes and tenures. The Labour government elected in 1997 re-allocated housing capital funding through regional structures intending this would promote a more strategic approach to building new homes. The complete transfer of private sector housing investment to the regions took effect from April 2006 with no protection of direct government subsidy to existing renewal area. Many regions stopped funding area renewal schemes directly although the funds that remained such as those to return empty properties into use or reduce fuel poverty could be channelled into area based schemes. Area based market failure to renew private sector housing seemed no longer to be a political priority.

From renewal to area regeneration

The decline of private sector housing renewal contrasted with a growth in area based regeneration initiatives. These sought to address non-housing factors of area based economic decline in part is response to a series of inner city riots. "Action for Cities" was launched in Britain's most deprived inner city areas in March 1988. These led to subsequent City Challenge programmes and both included a funding commitment spread over several years just like Renewal Areas. However they were far more broadly focussed on business support, community development, tenure diversification and educational improvement as well as housing improvement. In time City Challenge was superseded by the Single Regeneration Budget programme. A subsequent chapter on area regeneration considers how to argue the case that housing intervention be included in such programmes.

Market Renewal Pathfinders

Placing community regeneration at the heart of housing policy was a priority for the Labour government elected in 1997. 'Sustainable Communities: Building for the Future' launched in February 2003 sought to create places where people would want to continue to live and work; the essence of regeneration. It had a twofold impact on area renewal. Regions that were given control of renewal budgets often chose to remove funding from Councils' own Renewal Areas. However the strategy provided direct funding to nine market renewal pathfinders in north west England affected by abandonment through the decline of the local economy. The programme was subsequently expanded to include a further three areas, including the Tees Valley (CLG, 2009). The final total programme budget was £2.3 billion with a further £59m spent on preparation and transition costs (Wilson, 2012). Area renewal funding had been introduced to entice private investment into run down inner cities or, in the case of the market pathfinders, to gap fund the redevelopment of redundant housing. The guidance developed to support area renewal (DoE, 1996) continues to provide valuable support in making best use of such funding. However private sector renewal funding has currently ceased.

Summary

The first government attempts to enforce improvements to the housing stock failed as new slums emerged to house the poorest residents displaced by clearance. Publicly funded social housing was built to meet their needs but in time this displaced private investment due to the impact of slum clearance and rent controls on property values. Area renewal funding was introduced to reverse that trend as slum clearance programmes drew to a close. This chapter traced the evolution of the different funding mechanisms and legislative frameworks for area renewal. In time changes in housing finance and regional governance reduced financial support for area renewal. One of the first actions of the Conservative Lib-Dem coalition elected in 2010 was to remove funding from market renewal. Area regeneration targeted on social inequality has replaced area renewal focussed on property improvement. A subsequent chapter considers how to get health and housing initiatives included in area regeneration strategies.

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Strategic Area Regeneration

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Abstract

Area regeneration has grown to replace traditional area renewal as the dominant approach to area action in England. Examples are provided of successful engagement with the partnerships that run such schemes to deliver housing improvement programmes. The development of partnership arrangements is described along with the tools available to make the case for the inclusion of housing improvement programmes in new partnerships such as Health and Wellbeing Boards. Lastly the case for adopting an area based approach to the delivery of ongoing improvement programmes is summarised.

Introduction

Political and financial support for area based renewal grants to private sector housing has gone. With it environmental health has lost the basis for its traditional engagement at the heart of such work – our ability to assess the quality of dwellings and make them fit to live in. Since the 1980s regeneration programmes have increasingly addressed social determinants of deprivation through community engagement and improving access to education and employment. The case for including housing intervention within such programmes has to be advanced through local government partnership structures so a business case has to be made for investment in regeneration. Health and Wellbeing boards are unlikely to have the budgets once promised through Local Strategic Partnerships. With a narrower focus on preventative health they offer real opportunities to make the case for health related housing intervention. Environmental Health Practitioners and partners need to engage with these wider concepts of regeneration to be able to support their goals.

Policy background; Regenerating communities

The inner city task force and City Challenge

Urban Programme and then City Challenge initiatives focussed on inner city locations in economic decline during the 1980s. City Challenge bids were expected to include job creation, business support, education and health initiatives in addition to any housing improvements and be tailored to local needs. The Brookhouse and Bastwell Renewal Area took up a high proportion of the Blackburn City Challenge budget. It comprised a large area of inner city privately owned housing where structural failure was causing abandonment and associated squatting and drug dealing on a scale that could not be dealt with through housing renewal funding alone. City Challenge funding was not limited to private sector renewal and elsewhere it supported social housing improvement and provision. In Dalston, in east London, it financed the conversion of a large redundant hospital site into new social and private sector housing.

The Single Regeneration Budget

City Challenge was the model for a rolling programme of regeneration funding that came into operation in April 1994. The Single Regeneration Budget encouraged an area approach to regeneration and the development of extensive partnerships with the community and business (DoE, 1994). Six bidding rounds generated 1028 schemes and key differences with previous regeneration schemes were;

- An increased focus on education and health
- The removal of formally designated boundaries.

The evaluation of the schemes found that they generated significant improvements relative to national indicators in incomes, employment, satisfaction with housing and the locality, and community involvement and safety. However there was a relative decline in health indicators although the report notes that very few of the SRB schemes they studied had “prioritised expenditure of health related activities” (CLG, 2007).

Newham in east London hosted an SRB project with a particular focus on private sector renewal funding. Although initially it included renewal areas and group repair initiatives it increasingly applied enforcement powers to transfer empty and poorly managed rented properties to RSL partners with support from a local housing company, Passmore Urban Renewal Ltd., established for that purpose.

Approach and methods; Engaging with strategic partnerships

Placing community regeneration at the heart of housing policy was a priority for the Labour government elected in 1997. They were increasingly implemented through programmes run by partnerships of local authorities with providers of health services and the Local Government and Public Involvement in Health Act, 2007, gave them a strategic role set out in Statutory Guidance (CLG, 2008).

Many partnership structures became discretionary following the election of the partnership government in 2010 and its commitment to remove centralised bureaucracy to support the “Big Society” (Cabinet Office, 2010).

These changes have not removed the requirement for Joint Strategic Needs Assessments now carried out by the Director of Public Health, the Director of Adult Social Services and the Director of Children’s Services. The Health and Social Care Act (2012) requires local authorities to establish Health and Wellbeing Boards to develop public health strategies informed by these assessments. A number of health outcomes that must be addressed by such assessments are related to housing conditions.

Evidence of health protection: Making the case for housing intervention

The role of the EHP has changed substantially over the last fifty years and the following areas offer new opportunities for our role in housing and area regeneration.

Local authorities are uniquely capable of cross referencing the condition of residential properties with the needs for their residents as evidenced by their benefit and social care status. By working with local health and police services they can identify links between poor housing, ill health and anti-social behaviour. Local authorities are no longer expected to conduct regular house condition surveys and some are using the house condition models offered by companies such as BRE or Expedia as an alternative. However those Councils that have used their Local Land and Property Gazetteer to co-ordinate all their property based records will be best able to compare these with their own records of benefit status to focus on links between housing and other strategic priorities. This leaves them well placed to argue that dealing with poor housing is a strategic priority or, at least, is one component in addressing other strategic priorities. Once strategic objectives are set it allows managers to decide if an area based approach is appropriate.

BRE has developed with the CIEH a toolkit for modelling the health costs of poor housing which has already been used to calculate the costs for Wales and Northern Ireland. A similar report is currently being produced for London and Local Authorities can individually or in partnership commission more detailed reports to support local strategies. The CIEH has also supported the development of the Regulatory Information and Management Systems (RIAMS) which now incorporates a calculator based on the BRE model which calculates the health cost savings of individual interventions. Both are valuable tools for demonstrating that housing improvements should be included in health and wellbeing strategies.

At the height of renewal activity government guidance (DoE, 1996) supported a range of approaches including some or all of the following;

- Area based, for geographical concentrations of poor quality homes where clearance, renewal and group repair was appropriate
- Based on property type (such as addressing insulation/ventilation needs for a particular type of system built dwellings)
- Based on meeting particular kinds of property condition (for example to deal with empties to bring them back into use)
- Issue based (for example through a comprehensive approach to insulate all lofts and cavities)
- A client based approach (for example as part of a strategy to reduce the health risks and hospital admissions for older people)

Implications for policy and practise: when to adopt an area based approach

There is ongoing funding for private sector housing intervention to support a number of the government's policies often to generate savings elsewhere. An area approach is always appropriate to try out new initiatives when budgets are inadequate to allow a comprehensive approach. There are circumstances where an area approach is appropriate to most funding streams depending on local circumstances as follows:-

Affordable warmth and ECO programmes

Government guidance has encouraged an area approach to such work believing it reaches clients who would not "self refer" and who will be encouraged to install insulation once their neighbours engage with a scheme. This is no longer the case once every home has been visited several times or where a comprehensive database of housing condition, previous energy efficiency works, tenure and household benefit status allows better targeting of initiatives. In particular affordable warmth and insulation programmes targeted to those in greatest need should be focussed using Council household records for benefits and use of adult care services.

Empty property work

A number of factors drive empty property work towards particular types of property. Programmes to create new housing from empty homes tend to focus on those that need least work to return to use while those that seek to remove eyesores focus on the most derelict. There is often a good case to be made for an area approach, for example in a town centre to maximise impact, where the easy wins balance the high costs of bringing the most difficult properties back into use.

Aging well at home

Concern at the growing costs of housing an aging population in care homes and hospitals is an increasing priority for government. Generally support for independent living will best be addressed through a client focussed strategy although a property focus may be needed to remove a particular area of property related hazards. If there is a particular area where large numbers of elderly and disabled residents live (for example developments of bungalows) there could be scope for an area approach to engage with clients that will not "self refer".

Enforcement strategies

With the removal of renewal funding, area regeneration schemes, such as those in Newham, relied increasingly on the application of enforcement powers. Indeed selective licensing powers are intended to be used on an area basis as was initially done by Newham Council in Manor Park. The danger of such an approach is that it simply displaces antisocial behaviour elsewhere. At the time of writing Newham has concluded that the entire Borough fulfils the requirements for selective licensing and is applying it throughout.

Looking ahead

Despite the commitment of successive governments to needs-based intervention, preventative health has so far had a low profile in area regeneration schemes. Regeneration strategies have been dominated by the big budget holders providing social care packages or acute hospital services despite partnership working. The collapse of house building and government reliance on the private rented sector to meet the low income housing need may recreate the housing conditions that led to the slum clearance and housing renewal programmes. Environmental health needs to demonstrate the relevance of our work to current government priorities to ensure the accumulated experience it can provide in addressing public health issues is not lost. Arguing the case for inclusion in area regeneration and in wider partnerships is essential to proving the relevance of our skills

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Stanwell New Start

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Abstract

This is a case study describing the key aspects of an area regeneration scheme which sought to address the disrepair and thermal comfort issues associated with around 150 properties, along with some of the societal problems of an area with many indicators of poor health. The paper discusses some of the major obstacles which the local authority and its partner housing association had to overcome and explains how community engagement and dealing with inequality issues was integral to the scheme's success.

Introduction

Stanwell is an area within Surrey which borders Heathrow airport and is close to the M25 motorway and major reservoirs. The locality is one of the most deprived within Surrey. There are high levels of crime and anti social behaviour and a very high proportion of young people are not in education, employment or training. Health indicators are poor including high teenage pregnancy rates and smoking related deaths. (Spelthorne Borough Council 2010, Surrey County Council et al 2010)

Issues being addressed and scope of scheme

The original area within the development boundary comprised 149 flats and houses, with a relatively high percentage of social rented properties (53%). The latter had been transferred, along with the rest of Spelthorne Borough Council's stock, to a housing association during the nineties. It was felt that creative re-design to incorporate a greater percentage of owner occupied properties, along with improved amenities, would create a more balanced community mix of tenure. The condition of the properties was the other driving factor. The housing blocks, which included a number of leaseholder flats, were in poor condition and the layout of communal areas was believed to be conducive to crime and anti social behaviour. In addition there were several streets of 1940's/50's semi detached owner occupied properties, of steel cladding pre-fabricated construction which had been built with an original life span of ten years. They had poor standards of thermal comfort and insulation and were inadequately heated. There was one large area of open space, still owned by the Council, but underutilised by the community due to its layout and location. The scope of the scheme therefore was to regenerate the area through the provision of a total of 356 dwellings including 161 owner occupied properties and a community centre. Furthermore the open space would be re provided in smaller, better designed plots, with facilities such as play areas for all ages. The scheme became known as Stanwell New Start. Figure 1 depicts typical properties before and after the scheme.

Figure 1 Typical owner occupied properties in Stanwell before and after the scheme



The scheme set ambitious promises at the outset, which facilitated resident acceptance. These included the aim that new properties for outright sale or private development would be available to local people, with priority towards young professionals and young families, particularly those entering the owner occupied market for the first time. In addition the existing 70 leaseholder and free holder residents were assured that they would either be offered a like for like property in the new development, or given market value for their homes. These promises undoubtedly assisted with successful engagement, however the counter side was that the scheme's inception was prior to the economic downturn. As time went on a small minority of owners held out for unrealistically high market values. They were, depending on the location of their properties, to some extent able to hold the scheme to ransom- particularly leaseholders within the blocks of social rented properties. The threat of Compulsory Purchase Orders (CPO) assisted but in one or two instances, in less critical locations, it was deemed more financially viable to leave the properties in situ and re design the scheme around them.

Partnership

Throughout the scheme several partners have been involved including the Police and the Health authority but this paper focuses on the Council and its stock transfer organisation A2Dominion Group (A2D) as the principal partners. The Council assisted from the outset with obtaining political support, providing joint publicity and inputting into the outline scheme model. Maintaining political buy in at regular intervals through formal and informal methods proved crucial. The business case was based around cross funding from private sales to subsidise the affordable rented in conjunction with Homes and Communities Agency (HCA) grant funding. Use of the Council owned area of open space was essential, as it facilitated a far more ambitious scheme with additional homes and enhanced public open space than would otherwise have been possible.

A complex legal arrangement was devised whereby the open space was transferred to A2D, with strict conditions attached. An almost equivalent amount of land will be transferred back to the Council at the end of the scheme, albeit in smaller plots. Effective and ongoing work with the Planning department was integral to the project to ensure the final design met criteria relating to house design, mix of social and private units, aesthetics, thermal efficiency, recycling provision, landscaping, better design of play areas and other open space. The Council obtained committee approval to utilise CPO powers for those owners whose properties were located in key areas, such as leaseholders in blocks due for demolition. Ultimately these powers were not utilised but were a useful tool during some difficult negotiations. In addition the Council was able to facilitate the building of a new community health centre within the area with joint GP practices, a community library and a coffee shop run by the voluntary sector.

The partnership has been a successful one but the importance of the right individuals, able to think both strategically and pragmatically to drive the project forward and find ways to tackle obstacles, cannot be underestimated. It has been essential for all to recognise that the economic climate situation at the scheme's inception in 2006 is very different to that of today and there have inevitably had to be changes to the scheme design as a result. It has been particularly important to closely monitor time and expenditure on legal agreements, land valuations etc and to compromise on difficult points where possible to prevent legal costs from spiralling.

Community Engagement and Involvement

The task within Stanwell was a difficult one, to engender a form of social engineering and create a new community, whilst building on the existing strengths of the area which included a strong sense of place, family and history. Many of the residents are 4th and 5th generation and were, understandably, suspicious at the outset.

There are well documented processes and procedures for community engagement (Chanon et al (2000), Hashagen (2002)). Formal resident and stakeholder working groups and public meetings all have a place however the success and effectiveness of these formal consultation methods relies on the skills of the front line staff who need to work quickly to create a level of trust and acceptance of change and ownership. The A2D staff employed had excellent communication skills, the ability to empathise where appropriate and a passion for the project. They were the single most important factor in the community beginning to accept change, through increased visibility and flexible working patterns. The conversion of a property into a community partnership house for use as a base assisted with this aspect. They were able to encourage involvement of residents whilst managing expectations. Building on previous experience staff knew that in addition to approaching local community groups such as scouts, Women's Institute and arts groups, the most effective way to find and engage with less visible but natural community leaders, was to spread messages by word of mouth. It was not always the obvious leaders, in this case the local publican and a community worker turned out to be key. Whilst this liaison is not necessarily the quickest method, it has been found in the long run to be the most effective way of creating strong community cohesion.

Throughout the project people talked with pride about their sense of local history. Whilst many inter generational projects focus on time capsules, the team wanted a more visible outcome and developed a community inspired mural on the site hoardings (see figure 2). Professional practitioners held workshops to capture what locals deemed key history, to scope the art work and to oversee the painting. It was imperative that local people took ownership and a particular strong point was the engagement by young people including some of the disaffected and disenfranchised youth. Some of their messages were overt, some secret, but their involvement helped guarantee the mural was not later defaced by graffiti. On the rare occasion there was damage, the same young people would seek out and chastise the culprits.

Figure 2 Part of the Stanwell Mural



An entire mural has a limited life span and although sections of the mural have been preserved and placed in key neighbourhood locations a companion book and DVD (Stall (2009) recounting the stories and experiences were created for sale, with proceeds put back into other community projects.

Inclusion is important and addressing inequalities was an integral part of the project. The greatest single issue was that of illiteracy, particularly from women who had originated from the travelling community. The team accommodated this need within their communication methods, for example by making appointments to speak to people in their homes rather than rely on printed matter for communication. Where possible they signposted residents to literacy and numeracy classes in an effort to improve their quality of life. It has also been important for all partner agencies to have an understanding of each other's roles so that referrals can be made where appropriate.

Where householders had disabilities a number of methods were employed, for example designing a home for a wheelchair bound man with cancer to meet his needs and built out of sequence from the plan timetable. This enabled him to move straight from his existing home to the next one, with minimal disruption. Another resident with learning difficulties was proud to be employed to count construction traffic entering and leaving the site. Complete with his own clip board and hi-viz jacket he also helped in some of the media events including the first day of demolition.

Evidence of health protection and improvement

The third of four phases is due for completion in 2013. The fourth and final phase is due to be completed in 2015. The new home owners have been very pleased with their houses and everyone has welcomed the new Health centre. It is perhaps too early to provide meaningful statistics around health improvements. However at the outset acceptance of the new scheme by local residents was 18%. This has now risen to 92% (Wilde 2012). The closed circuit TV linked to Police and Council monitors to improve security is due to be installed shortly and should again help with dealing with both real and perceived crime levels.

Implications for policy or practice

Stanwell New Start is considered a success by all partners and more importantly, residents that have moved into new homes. There have been difficult legal and financial problems along the way and the changing economic situation has undoubtedly added to the obstacles. The key factor to success has been thorough and effective scheme planning and employment of staff with appropriate skills. Everyone must be able to understand one another's view point and able to be both responsive and flexible as required.

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Margate's private rented sector: delivering housing enforcement and family support in a seaside town

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Abstract

Margate is one of England's oldest seaside resorts but has suffered from a loss of tourism and parts of the town are now multiply deprived. It has a demographically skewed and mobile community, high numbers of children in care and economic migrants placing pressure on local services. There is little published around the privately rented housing sector in seaside towns and how conditions might be effectively addressed despite a growing interest in other policy areas. This paper presents some findings from interviews with front line practitioners to capture their perceptions around challenges faced in supporting families living in privately rented housing in Margate.

Introduction

With domestic tourism in decline, many seaside towns have struggled economically and socially, leaving some are multiply deprived with a highly mobile, skewed and needy population and an unbalanced, poor quality housing market (CLG, 2007; CLG, 2011). This paper explores front line practitioners' perceptions of housing and social need facing families in the Margate's private rented sector.

Background information or literature

Existing research tends to focus on seaside economies or heritage and regeneration although Stewart and Meerabeau (2009) consolidated and added to the literature around perceptions of housing and health in seaside towns and an innovative Knowledge Transfer Partnership in Essex is contributing to the evidence base of multiple occupation and mental health (see for example Barratt 2010 and 2011). There is very limited knowledge about housing in seaside towns generally, particularly the 'proliferation' of poor quality HMOs that were previously holiday accommodation enabling in-migration, and little is known by strained local public services about how best to address the problems encountered at local level (see Fothergill, 2008; Stewart and Meerabeau, 2009).

Approach and Methods

11 front line practitioners were recruited in Margate and semi structured interviews between April and July 2011 explored their perceptions of challenges and barriers to their work focusing in particular on the private housing sector and related partnership working around the needs of families. Ethics approval was obtained prior to the project commencing. Interviews were recorded and transcribed verbatim before scrutiny and content theme analysis. Some exploratory findings are recorded below.

Findings

Housing at the seaside: Margate's Renewal Area

A view emerged that people moved to Margate above all due to its relatively low housing costs rather than its attraction as a seaside resort (for example, Interview 1,8,10,11). Its Renewal Area – once the site of its flourishing tourist industry with multiple guest houses and hotels – is particularly affected and now the location for targeted enforcement interventions, including HMO Licencing. This high level of in-migration into accommodation originally designed for seasonal tourism has created major enforcement and other family support issues.

Addressing physical housing stock presents many challenges in itself, but concerns were expressed around the skewed population and anticipated influx of low income households in particular as housing benefit cuts are introduced. Margate has therefore been identified as an area requiring substantial intervention from Kent County Council and local agencies to address its multiple complex problems (for example interview 3). Interview 1 sums up the Renewal Area's built environment as:

"an infrastructure of a lot of private rented accommodation which is the kind of legacy of the old residential provision, the hotels, the guest houses, the B&Bs in that particular area in the heydays of the seaside town, which ... since the 70s, has increasingly been taken up and converted ... into multi-accommodation flats (with) ... particular hot-spots and streets of heavy private rented accommodation ... I think those characteristics ... affect some of the profile of the population we have." (Interview 1).

The Renewal Area itself was frequently described as 'a place apart' in character, both socially and economically, often referred to as being 'up there' and with its own personality, rather than an integral part of Margate's geography. It was also seen to have been falling further into decline in more recent years and comprising the worst housing in Thanet (for example, Interviews 2 and 5), problems with vacant properties (figure 1) and HMOs with the creation of an area that has become very hard to manage and tackle, attracting further in-migration of benefit dependent households and vulnerable communities due to its relatively low cost and the nature of stock:

"I think we need more families there and a more mixture of tenure. Whether 85% (renting privately) is an acceptable figure is a difficult thing to say ... that's complete role reversal of the norm." (Interview 2).



Figure 1 – Margate's empty properties (©Jill Stewart, 2011)

An unusually high number of privately rented properties, absentee landlords and lack of social care packages offered were also reported to add to the sense of alienation:

"... much more reliance on the private rented sector to accommodate people with... mental health problems and there's been a lot of... private individuals trying to cater for that gap because the beds are

no longer there. And this particular property had about 20 rooms and it was the NHS and Social Services that were placing people in there, but there was no care package ... one particular (portfolio landlord) ... lets to often difficult people, difficult families and he doesn't live in Kent and we often get problems with his properties." (Interview 2)

Enforcement challenges

Private sector housing enforcement is frequently complex and in Margate further complicated by new legal procedures (for example the new HMO licencing scheme was not yet implemented at the time of this study) and complicated by trying to track down portfolio and/or absentee landlords, requiring considerable time and persistence and we were told of cases where tenants sublet (for example, Interview 2,3,6,10).

Prosecutions were also an enormous resource commitment although there had been recent successes where landlords had been continually uncooperative:

"And the most recent (prosecution) one was a landlord based in north London and this property that had five storeys ... four self-contained flats, no fire alarms, things falling down, the place full of rubbish, no lighting in the common areas – he just ignored it all together, and we prosecuted them for not complying with two improvement notices we served, and they didn't even bother turning up to court ... but ...they were fined £5,000 in respect of each notice." (Interview 2).

Although some landlords were reported as reluctant to do anything (for example Interview 6), housing officers were able to work more closely and interact well with more responsible landlords through the Landlords Forum and several of those we interviewed reported that they tried to be as creative as possible in administering and applying the law both for occupied and empty homes addressing both physical housing and also tenants' needs, but it proved challenging. For example:

"We may be not as flexible or have informal approaches may be as other authorities nearby may have, but that's roughly as a result of the fact that we experience that it doesn't work with our landlords ... (who) wait until they've been told legally that they've got to do something." (Interview 2)

"...so there's a lot of things that have to be brought together and I don't see how, as our team in private sector housing, can influence families living in certain accommodation, other than using our enforcement panels which isn't always the right thing." (Interview 3)

Overcrowding was frequently seen as problematic (Interviews 2,5,7,10), particularly in immigrant communities who were reported as having different housing expectations, including multiple families at one address and the attraction of a subsequently lower rent and some of these families were reported as being very hard to quantify and trace. The following quote is representative of what we were being told:

"there are very often young children who are in inappropriately small accommodation. I've found a ... Czech family living in a two bedroomed flat, but there was a small internal room that had been created by the current landlord and that room was being used by the two youngest children in the family, and I served a prohibition order on that room prohibiting it for sleeping accommodation, that kind of thing goes on in very, very low income families who can't afford

larger properties ... and they're putting themselves or being put into an inappropriately small place". (Interview 5).

The length of time taken for housing enforcement proved challenging for many in the community: "they do report things that they don't necessarily get done and they're in really sort of difficult conditions for quite a long period of time, so sometimes they give up hope really I guess of moving, or they just move from place to place to place (in temporary accommodation)." (Interview 7).

The Margate Task Force and partnership working

Private sector housing enforcement was seen to provide a pivot for other allied services, but partnership working was reported as challenging in its attempts to balance enforcement on the one hand with family interventions and wider community development to bring some sense of stability on the other in what could be an attractive living environment (see figure 3).



Figure 2 - Georgian terrace in the Renewal Area

The Margate Task Force (MTF) in particular has focused around need and proving more coordinated and streamlined services which were highly valued at practitioner level. It was repeatedly reported that the key focus is now on the family, and getting services mobilised to meet their needs and that the situation is constantly evolving and families' difficult housing experiences seen as needing a lot of support, particularly in areas such as secure tenure, poor conditions, safety and overcrowding. Sometimes help was for practical issues, such as referral/signposting to the right people for example for re-housing following a young mother's eviction from the privately rented sector (Interview 7).

But other complex factors proved more difficult to tackle. The following quote is indicative of what we were being told pivoting around poor housing, deprivation and families in need:

"I've often found children living in a room with no furniture, no toys, usually a mattress on the floor and maybe a sheet that is often very dirty... we're much more conscious nowadays of the need to protect the child healthcare and the child wellbeing, so we have internal mechanisms here where any time we find this sort of thing, we'll be referring it for someone to go and have a look at it." (Interview 2).

Family Intervention Projects were reported as initially successful in working with more complex families presenting multiple difficulties through providing a tailored package of focused interventions and wider support. The children's centres and voluntary sector were proving very successful in encouraging attendance and involvement in the community (Interviews 1,7,10) although the community remains fluid and action around housing therefore an obvious pivot.

However, with 6,000 families on the housing waiting list, acute housing shortage meant that families were sometimes housed in unsatisfactory accommodation (Interviewee 2) and the summer season presented particular difficulties. Support packages included help with tenancy sustainment, floating support, initial monitoring for example around housing benefit payments and support in cases of domestic abuse and to offer assistance around training, education or employment where possible (Interviewee 8).

Implications for policy or practice

Margate shares many characteristics of housing in seaside towns whose economies have suffered from its decline in tourism. This paper has explored some of the issues faced day to day by practitioners and strategies adopted but more research is needed to understand issues presented. Private sector housing stock and social interventions in seaside towns require local evidence based partnership strategies to meet the complex needs of often highly mobile families living in sometimes unsatisfactory accommodation.

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“No Use Empty” - Kent’s Empty Property Initiative

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Abstract

Kent County Council launched its ‘No Use Empty’ campaign in 2005, as part of its Public Sector Service Agreement (PSA2) targets, to examine better ways of delivering services; and particularly at working more effectively with District Councils. The primary aim of the Initiative was to improve the physical urban environment in Kent by bringing empty properties back into use as quality housing accommodation.

Introduction

There is a strong demand for good quality affordable housing across Kent, whilst at the same time there are approximately 9,000 long-term empty properties across the County. The initiative was originally focused on Thanet, Dover, Shepway and Swale, as 19 of the most deprived wards, and the majority of empty properties, were located within these four coastal areas. As a result of the success of the scheme, Kent County Council expanded the initiative to include all twelve local authorities in 2008.

Objectives

The aim of the initiative was to substantially increase the number of long-term empty homes returned to use as good quality housing accommodation. A specific numerical target, to return 372 empty properties back into use over the term of the project (3 years), was agreed, which represented a doubling of previous local authorities output. In addition, there was a requirement to achieve an improvement in business confidence and residents perception of the effect empty properties were having on their local neighbourhood.

Development of the Scheme

Prior to the launch of the Initiative a significant amount of research was undertaken:

- Identification of 1,263 long term empty properties through an empty property condition survey, to establish their condition and likely costs of refurbishment
- A business and local resident perception survey was carried out at the start of the initiative to provide a baseline for comparison and a further survey was carried out after the 3 year pilot;
- Appointment of a PR and media company to raise and promote the profile of the initiative nationally and to publicise local successes;
- Development of the No Use Empty Campaign and branding;
- Appointment through competitive tendering of a specialist private sector consultant to work with the local authorities, providing technical and professional support;
- Research to identify and develop the full range of interventions and methods available (in conjunction with the Empty Homes Agency) to help bring properties back into use; and
- To establish what help and assistance would encourage owners to return their properties back into use.

Using this research the Initiative developed a project plan that focussed on the following elements to achieve its aims and objectives:

- An awareness campaign to highlight the issue of empty homes to be targeted at owners through a cross media approach; including launch events, regular mail shots and empty home surgeries for owners in each local authority area;
- The development of an information resource for owners, residents and anyone else with an interest in empty properties. This led to the creation of the ‘No Use Empty’ web site www.no-use-empty.org, and the production of regular newsletters;
- Financial support to encourage owners to refurbish and bring their properties back into use;
- Training for Empty Property Officers and other local authority personnel involved in this work e.g. Solicitors, Planners, Environmental Health Officers, Building Control on the enforcement options; and
- Practical one-to-one guidance on the ground for Empty Property Officers / local authority staff provided by the Project Consultant, thereby enabling them to utilise the full range of legislation options and wider mechanisms / methods to bring empty homes back into use.

The Initiative developed three strands of financial assistance to use its capital funding (£5 million) to encourage the re-use of empty properties. These are as follows:

Loan Scheme – interest free loans are available to help owners / developers refurbish / convert empty homes or redundant commercial buildings. On completion, properties must be made available for sale or rent. The loan fund is operated as a revolving fund so that as loans are repaid, the money is then reinvested to support new schemes. The maximum loan is £25,000 per unit, up to a maximum £175,000 per applicant. The loan must be secured as 1st or 2nd charge, based on a max 90% loan to value (LTV). The funding is provided up front to provide the owner with working capital.

Partnership Fund – funding is made available to the local authorities to facilitate enforcement action where appropriate e.g. Compulsory Purchase Orders, Works in Default or Direct Purchase. District Councils have extensive powers to deal with poor condition properties, but often lack financial resources, personnel or knowledge to effectively utilise these powers.

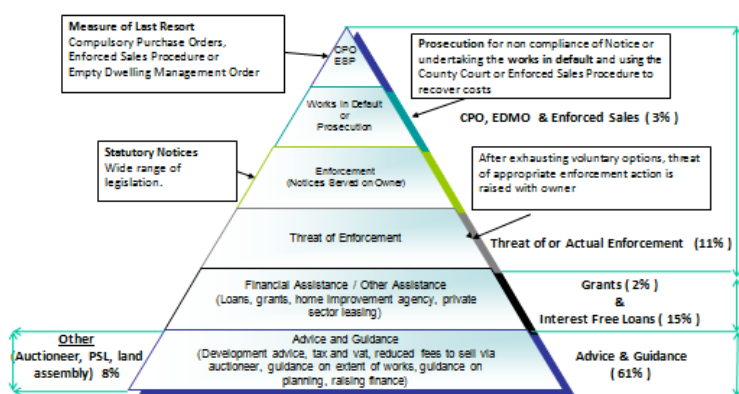
Direct Purchase Scheme – involving the acquisition of empty properties by Kent County Council for redevelopment into accommodation.

Figure 1, provides a breakdown of the different types of intervention that have resulted in empty properties being brought back into use. The predominant method was through advice and guidance (61%) and this correlates to the level of staff resources that local authorities allocate to this work.

Lack of financial resources is one of the main reasons that owners are unable to bring their properties back into use. The provision of interest free loans has been a crucial element, in helping owners renovate their empty properties, at a time when accessing private finance is difficult.

A significant proportion of owners (14%) are reluctant to bring their properties back into use despite a broad range of support and the offer of financial assistance. In such cases the use or threat of enforcement action is necessary to encourage the owner to engage with the local authority. In only 3% of cases are measures of last resort, such as Compulsory Purchase Orders, Enforced Sale or Empty Dwelling Management Orders, used.

Figure 1: Analysis of the type of intervention through the No Use Empty Scheme



NB based on partial analysis of the data

Resources

The Initiative is delivered by the Empty Property team - this is made up of the Kent County Council's Project Manager, Private Sector Consultant and the district Empty Property Officers (predominantly part-time officers). This team operates as a "virtual team" as they are not employed by one body and work from different locations. Support is also provided to the team in terms of its communication strategy by the PR firm engaged specifically for the Initiative.

The local authorities provide 'in-kind' support through the involvement of their Empty Property Officers and other local authority staff.

The main funding for the Initiative, both revenue and capital, has been provided by Kent County Council. The scheme had an initial capital fund of £5 million (Capital & Prudential Borrowing).

In 2012, Kent County Council launched a new loan scheme, specifically for affordable housing, which has a Capital fund of £2 million. The scheme is jointly funded by Kent County Council and the Homes & Community Agency.

Evaluation

The success of the project has been measured by the tangible results achieved through the number of empty homes brought back into use, which amounted to 487 properties in the first three-year period, substantially exceeding the original target of 372. In total, since its inception, the scheme has brought back into use 2,201 properties (up to June 2012).

The scheme has approved over £6 million of interest free loans, which equates to 326 units of accommodation. This has leveraged in excess of £11.4 million of private sector funding (owner's contribution), giving a total investment through the loan scheme of £17.4 million (up to September 2012).

Table 1: No Use Empty Loans approved and private sector leverage achieved by size of development

| Development Size | No. of Units | % of Units | Value NUE Loan £ | Private Leverage £ | Total Investment £ | % of Loan | % of Leverage | % of Total Project |
|------------------------|--------------|-------------|-------------------|--------------------|--------------------|-------------|---------------|--------------------|
| Individuals (<3 units) | 97 | 30% | £2,333,840 | £4,908,575 | £7,242,415 | 39% | 43% | 42% |
| Individuals (>3 units) | 229 | 70% | £3,673,000 | £6,493,991 | £10,166,991 | 61% | 57% | 58% |
| Total | 326 | 100% | £6,006,840 | £11,402,566 | £17,409,406 | 100% | 100% | 100% |

- The average cost of renovating a unit through the loan scheme is £53,403 (often worst properties);
- Kent County Councils average investment per unit £18,425;
- Actual cost to Kent County Council is £2,804 (loss of interest and management costs);
- Repayment of loans to date £1.7 million, a significant proportion repaid before the required date;
- Loan type: 13% 'loans to sell' and 87% 'loans to rent';
- Only 19% of owners who are sent an application proceeded with the loan;
- The loans scheme has created, or supported, 486 new jobs and provided homes to over 489 people;
- For each £1 spent on interest and administration this translates to £20.26 being spent in the local economy (labour & materials); and
- To date only 2 loans have defaulted (non recoverable).

The total investment involved in bringing 2,201 empty homes back into use through the 'No Use Empty Scheme', is estimated to be in the region of £56 million to £63 million.

The business and resident survey demonstrated a greater satisfaction with the local environment as a result of bringing empty properties back into use.

In partnership with Bristol City Council, the 'No Use Empty' Initiative brand was rolled out to the West of England Local Authorities (2010). The 'No Use Empty Initiative won an award from Regeneration & Renewal for their partnership working and was shortlisted for an award by the Chartered Institute of Housing.

The 'No Use Empty' is now widely regarded as one of the most effective initiatives to deal with empty properties in the UK. It has been cited by the Audit Commission and recognised by the Scottish Government, Welsh Government and Empty Homes as a beacon of good practice.

The Empty Property Initiative has been incorporated into Kent County Council's Housing Strategy as a target to support its joint wider regeneration projects within the partner districts and increase housing provision and quality. Specifically, the Initiative has linked with these regeneration projects to identify key properties to target for action. All districts had an empty property strategy in place prior to the commencement of the project. The Initiative has contributed to the aims and objectives of these strategies and increased the numbers of empty properties brought back into use.

Lessons Learnt

The main lessons learnt from establishing the project were firstly, an awareness of the time taken to develop this type of Initiative. Although not overly complex, bringing together the resources, information and personnel required took much longer than originally anticipated and there was a considerable time lag between the launch in December 2006, and the availability of the main financial funding. Good customer care was essential to keep clients informed of progress (or lack at times) in order to keep them on board.

The lack of resources at a local authority level, both in terms of personnel and financial, was a limiting factor. The provision of the capital funding by Kent County Council has, in the main, overcome the issue of financial resources, but manpower remains an issue. Only two local authorities have dedicated Empty Property Officers (and to some extent the numbers returned to use by the individual authorities reflect this situation). For the other authorities, empty property work is just one of a number of tasks undertaken by the person allocated to this role.

Initially, there was a lack of a corporate approach to the issue of empty properties, which resulted in authorities dealing with the problem in a piecemeal fashion. There was lack of understanding of the overall picture and the methods available to deal with empty properties. Creating a change in culture has facilitated a more positive approach to the problem.

The importance of training, both for personnel directly involved in empty property work and for departments that can contribute to this area of work e.g. Legal, Building Control, Environmental Health and Planning, cannot be over stated. For those that provide a 'supporting' role, an increased awareness and knowledge has brought about an increased level of support for empty property work in general.

Shared learning has brought about an improved level of skills and knowledge, which increased the effectiveness of officers in their empty property work. Through the initiative, low cost training has been provided to over 850 officers. One aspect that has proved invaluable has been the services of the Project Consultant, who has provided ground support and practical training on the use of the wide ranging legislation and approaches that can be adopted.

PR and communications, throughout the project has ensured wide coverage both nationally and locally, including television, radio, national and local press. This has not only achieved a strong brand name in the partner authorities, but has also created a ripple effect within the County, and beyond, through publishing our successes. This has resulted in owners becoming more open to constructive dialogue with the authorities, knowing that the local authority are prepared to follow through with their threats.



An effective approach to reducing the number of long term empty homes and maximising income

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Abstract

This chapter considers some of the issues associated with long term empty residential property in the UK, effective strategies for reducing their number and the potential financial benefits of the New Homes Bonus and housing of vulnerable clients. A number of useful web sites and brief case studies are included.

Introduction

There are approximately 930000 empty residential properties in the United Kingdom. (Empty Homes 2011) The majority of empty properties are distributed sporadically, but in some local authorities are concentrated into small areas of deprivation where the housing market has failed or where funding for redevelopment has dried up. Whilst the South East of England averages for example 2.2% of its stock as empty, there are Northern English cities with vacancy rates approaching 7 %.(Empty Homes 2011)

Background Information

There is significant housing demand in many areas of the country with almost 4 million people estimated to be in housing need. (Department of Communities and Local Government 2010) There is growing pressure to build new homes, often in sensitive areas and whilst new homes are more energy efficient than old, the resources and embedded energy required for new build as against renovation and reuse suggests it will be 30-50 years, before the resultant carbon emissions equalise. (Empty Homes {Agency} 2008). Refurbishment of an empty property is however an opportune time to undertake energy efficiency improvements which can further extend the carbon emission benefit of renovation.

Many properties are left empty only for short periods and rarely require intervention but where a property remains empty for more than 6 months, it is designated a 'long term empty' (LTE). Often the owners of these LTEs require help, advice, persuasion or formal action in order to bring their property back into use.

It is estimated that there are approximately 350,000 LTEs in the United Kingdom (Empty Homes 2011). Some Local Authorities undertake full area surveys to identify these properties whilst the majority rely upon Council Tax data; perhaps with data matching techniques and information from Empty Property Officers (EPOs), other departments or agencies to improve accuracy.

Why Properties are left empty and the impact

It rarely makes financial sense to leave a property empty for long periods but LTEs arise for a variety of related and interlinked reasons. (See Table 1)

| Person based | Family | Financial | Commercial | Property |
|--|--|--|--|---|
| Frailty and mental health issues | Death and probate delays | High cost of renovation | Buy to leave – a term often misused as other market factors also implicated | Structural movement investigations |
| The enormity of the task of selling or letting or renovating a property. | A reluctance to allow a family home to be used by others | Insufficient finance to renovate with an unwillingness to sell | Being used for storage often; above a shop | Significant tenant damage e.g. following use of property to grow drugs. |
| Abandonment often following stressful incidents | Family disputes over what to do with a property | Non payment of rent | Significant property portfolio with inadequate systems to limit void periods | Restricted access solely through a commercial premises |
| Significant hoarding preventing work and access | A bad experience with a contractor, estate or letting agent. | Sufficient income to ignore the property | Security issues e.g. above a Bank, Betting Office, Jewellers or Off Licence. | Planning permission issues, appeals and development plans. |

Table 1: Reasons Contributing to LTEs

LTEs can attract unwelcome attention and once antisocial behaviour starts, it often escalates and some of the following issues arise:

1. Building Deterioration:

- Potential nuisance for neighbouring properties;
- Overgrown gardens with potential damage to fences, gutters etc;
- Pest Activity: pigeons; harborage for foxes and rodents;

2. Unauthorised entry

- Property left insecure
- Vandalism and /or arson
- Squatting:
- Theft of metal, heating systems and building materials.:
- Unauthorised refurbishment and letting;
- Dumping of rubbish.

3. Property used as a base for local crime/anti social behaviour.

4. Use of property to falsify credit card and other applications

Significant devaluation of neighbouring property can occur as a consequence of 1-3 above.

Tackling the Problem

Many local authorities with a significant number of LTEs have a programmed and planned approach to minimising their number, appreciating that this is effective. Others do not have dedicated EPOs or systems in place and rely on complaints from neighbours and enquiries from owners to initiate action. This reactive approach is not effective in reducing the number of LTEs as only a small percentage of LTEs result in a direct complaint to a local authority. An effective proactive and corporate approach is ideally supported and directed by an Empty Property Strategy (London Borough of Bromley 2009). Ideally such a strategy should be developed with input from staff from across an Authority and external partners; appropriate consultees include: Legal, Planning, Environmental Health, Housing, Valuation/Estates, Town Centre Management, Council Tax, Finance, a local Letting or Estate Agent, Housing Association and Councillors.

An Empty Property Strategy should consider financial and housing demand issues in the locality, available financial assistance and enforcement options. The inclusion of an action plan with the strategy will also help to focus activity. Without a corporate approach, it is not uncommon for different departments in an Authority to take potentially conflicting action to deal with an LTE where, for example, non payment of Council Tax, an overgrown garden, building defects or a request for loan/grant assistance arise.

It is not necessary to wait until a property becomes an LTE before making contact or offering advice to the owner. The inclusion of advice and information within the revised Council Tax bill, sent in response to an owner's notification that a property has become empty, offers an early opportunity to initiate dialogue. Once property has been left empty for a significant period however, then an element of inertia can occur and regular contact with owners to assist and cajole is effective. As such, it is appropriate to proactively and systematically target LTE owners with a series of advisory but increasingly forceful letters. Such an approach alerts owners to an Authority's serious intention to bring property back into use. The resultant discussions and correspondence also helps to improve intelligence about the reasons for a property being empty, plans to bring it back into use, and identify properties where enforcement action will be necessary. Brighton and Hove Empty Property Officers for example have used such a series of letters to LTE owners for some years and report a response rate of 28 % to their first letter; 42 % following letter 2, then a further 25 % to letter 3, giving a total response rate of 95 % . (Personal communication, October 2012).

Assistance for owners

Political interest in bringing empty property back into use has increased and all major political parties have identified LTEs as a wasted resource. Despite significant public spending cuts, funding opportunities have continued across successive governments for empty property work. Some funding schemes enable Authorities to work together, making more effective use of EPOs. Such a scheme is operated across a number of Kent Authorities. (No Use Empty). Loans and grants administered by Authorities assist owners financially and may be the only source of funding available to them to fund renovation. EPOs can facilitate activity by providing assistance with schedules of repair, sourcing contractors and providing access to leasing arrangements, advice on VAT exemptions, assisting with advice on selling or letting, or through persuasion or enforcement activity.

In declining areas with a large number of empty properties and significant numbers of residents on benefits, some Authorities are offering properties for sale at a minimal purchase price linked to a loan to cover renovation costs and available to working families prepared to remain in the property for a number of years. A scheme in Stoke to sell 35 derelict Council owned properties attracted more than 200 applicants. (BBC 2012). Some housing charities can also assist using funding from the Homes and Communities Agency and typically, make use of volunteers, apprentices and potential future tenants to renovate.

Some LTE owners need minimal financial assistance, but by understanding and empathising with the reasons for the property being empty, it may be possible to find a solution. As an example, an owner of a large LTE, empty for over 10 years, had filled every room to the ceiling, many items of which were too good to be discarded. Having identified the barriers to the property being occupied, the EPO provided a loan of £1000 to cover van hire and several skips to allow the owner to take the valuable items to museums and antique shops and dispose of the rest. Once emptied, the property was sold and renovated and the owner thanked the EPO for making him deal with 'a mill stone around his neck'.

Financial Benefits of Empty Property Work.

Significant levels of additional funding are potentially available to Authorities able to reduce the number of LTEs in their area and whilst there will be factors beyond the control of the Authority; a failure to reduce numbers will be costly. In October 2009 a base line figure for the number of LTE properties in each Authority was established through Council Tax returns.

An annual return (CTB1) is provided to the Department of Communities and Local Government every October and is used to determine if the number of LTEs has changed. Any decrease from the preceding year results in a New Homes Bonus (NHB) payment to the Council the following March, paid monthly for the following 6 years. This is typically worth a total of £7500-£10000 per property. Any increase in LTE numbers also reduces the payment Authorities receive for new build properties, resulting in a double penalty. In the first 2 years of the scheme over 100 Authorities lost money as a result of LTE numbers increasing. In London the difference between the best and worst performing Borough was in excess of £1.5Million. (Homes and Communities Agency 2012).

Where financial assistance is provided to bring LTEs back into use, then the use of the property to house vulnerable clients, nominated by an Authority, can generate additional financial benefits. As an example, an outer London Borough quoted savings of £9.71 per night for housing a family in a 3 bed LTE used to house a homeless family as an alternative to nightly paid temporary accommodation, based on the shortfall of housing benefit payments. An additional housing cost to the Authority in excess of £3400 per year per family (Personal communication August 2012).

An example of higher levels of savings and other benefits was identified and pursued by the London Borough of Bromley. In return for significant grant and loan funding, seven years nomination rights were obtained and a LTE renovated. Energy Savings Trust funding allowed internal and external insulation to be provided along with insulation training for local contractors. The property was subsequently used to house two clients with learning disabilities. Savings in excess of £500 per week, by re housing the clients from their previous supported accommodation were achieved.

Enforcement Considerations

Where LTE property owners do not respond or where properties give rise to serious problems, then the threat of, or actual enforcement action can be appropriate. A number of very different options are available to an Authority and may require corporate consideration. For example, where an owner will not deal with an LTE, it is appropriate to determine the preferred outcome along with the costs and risks. Options can for example include: changed ownership; changed management; works in default of the owner resulting in a debt; or works undertaken by the owner. These can occur as a result of:

- Enforced Sale;
- A Compulsory Purchase Order;
- An Empty Dwelling Management Order;
- Housing Act, Environmental Protection Act or Building Act repair or nuisance notices;
- An Untidy Site Notice (Town and Country Planning Act);
- Bankruptcy Proceedings;
- A Charging Order;
- Pressure on mortgage companies to repossess;

Information about the financial position of the owner, anticipated response, and any debt owed to the Council or other outstanding loans are relevant considerations. Is it likely that the Authority will have to carry out the works and if so the need to consider the risk of recovery of those costs? The likely future use of the property along with a valuation, are also pertinent in determining the best course of action. The range of options and likely inclusion of different departments and budget implications supports the need for a corporate approach. Authorities should be prepared to use the full range of enforcement tools to ensure the best outcome, yet it is evident that not all options are used by Authorities, as an example, few Authorities undertake Empty Dwelling Management Orders with only 58 Interim Orders being registered in the UK (Empty Homes Network 2011). Compulsory Purchase Orders are also used sparingly, yet some Authorities have had significant success with this procedure. (London Borough of Newham 2006)

Implications for policy and practice

The introduction of the NHB payment for reducing the number of empties makes a compelling financial case for Authorities to undertake empty property work and highlights the need to ensure the accuracy of the Council Tax database. The funding generated from a successful empty property programme should be more than sufficient to cover the service costs, with added benefits and savings available if linked to housing of vulnerable clients.

In order to be effective, empty property work needs dedicated staff working proactively and corporately to provide a service able to reduce the number of long term empty properties. Officers should ideally have access to financial assistance for owners and the full range of enforcement tools, along with the full support of Councillors to allow them to take the most appropriate action.





Guidance

Useful practical guidance covering the full range of empty property work is available from several online sources, including:

- The Empty Homes Network which provides a very useful site run for Empty Property Practitioners with an active discussion forum. (Empty Homes Network)
- The Home and Communities Agency Empty Property Toolkit which provides essential information, with links to detailed guidance (Homes and Communities Agency)
- The charity 'Empty Homes', that campaigns for action to deal with empty property and has ready access to statistical information and practical guidance on its own web site.(Empty Homes)

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Demonstrating effective interventions: new opportunities for private sector housing improvement

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Introduction

A Joint Strategic Needs Assessment (JSNA) identifies current and future health and wellbeing needs as well as inequalities to inform future service planning based on evidence of effectiveness. JSNA identifies groups where needs are not being met and that are experiencing poor outcomes and the process is underpinned by partnership working. Housing should be prioritised and 'routine' within JSNA and align closely to wider health and wellbeing strategies and local authorities and their partners need to demonstrate sound local evidence to attract resource; HHSRS has proven particularly useful in this respect.

A range of reports in recent years have added impetus in confirming housing as a social determinant of health alongside the need for effective interventions. The Marmot Review recognised housing and neighbourhood conditions' role in social position and circumstances and the importance of addressing conditions in tackling both health and housing inequality (Marmot et al, 2010). Confident Communities, Brighter Futures (DoH, 2010) demonstrated the influence of housing on mental health and how interventions can help develop individual and community resilience and tackle social exclusion, emphasising the role of evidence in underpinning local plans and commissioning priorities. Building better lives: getting the best from strategic housing for example reiterated the importance good strategic approaches and the need for private sector housing strategies to ensure delivery of financial, social and environmental benefits (Audit Commission, 2009). Local authorities need to therefore be clear about the role of their housing stock, the potential for health gain and the 'value for money' offered.

In the future, many housing improvements could be funded by Health and Wellbeing Boards (HWB) based on JSNA documentation. To achieve this, practitioners will need to collate local evidence of the health impact of poor housing and use it to persuade councillors, Directors of Public Health and others that housing should be a public health priority.

In the last few years, local authorities throughout the country had obtained funding for housing improvements from their Primary Care Trusts (PCTs). Liverpool City Council's Healthy Homes Scheme is the most notable example (detailed elsewhere in this publication). This shows how housing is becoming more widely recognised as a determinant of health. HWB strategies will be based local Joint Strategic Needs Assessment (JSNA) and HWBs will be funded to commission the public health services which are prioritised in the strategy. If local housing authorities continue to prepare good evidence, housing could become a priority for such funding.

Relevant policy and practice

Following the Marmot Review the Public Health Outcomes Framework's vision is to improve and protect the nation's health and wellbeing, with priority on the poorest (DoH, 2012). Its four domains focus on different aspect of health providing new opportunities to see housing as a health determinant, a basis for health protection and improvement and as part of the wider public health agenda to tackle inequalities. Indicators relating to housing include children in poverty, statutory homelessness, tuberculosis treatment completions, hip fracture prevention in the over 65s, dementia and its impacts, excess winter deaths and fuel poverty as well as aspects of the wider living environment (use of green spaces, social connectedness, older people's perception of community safety). These seek to tackle equality and develop benchmarking outcomes as the work of Public Health England develops and consolidates. These also provide an opportunity to re-focus on housing as a health determinant and to reassess evidence based partnership strategies and interventions.

For some time there has been increasing interest in focusing on the effectiveness of strategies and interventions to make better use of declining private sector housing resource in local authorities. Simultaneously a range of publications helped focus on private sector housing as a key public health priority although health has not traditionally been factored into housing regeneration strategies. New protocol for monitoring and evaluation help demonstrate effective interventions as research, stakeholder and management functions in demonstrating use of resource in outputs, outcomes and impacts, where impacts represent overall, sustainable and long-term changes brought about by a project or initiative (see for example Moreno-Leguizamon and Spigner, 2011).

The first step involves gathering evidence of the health impact of poor housing for the JSNA, this has already been achieved by some local authorities. The evidence can easily be obtained by using local data from the house condition survey or a stock modelling exercise and feeding it into the HHSRS Cost Calculator (CIEH Toolkit "Good housing leads to good health" 2008). This will show the savings to the NHS relative to the cost of remedying health hazards in the home (see examples in box below).

Savings to the NHS from dealing with the most common health hazards

Using the HHSRS Cost Calculator, Bristol City Council was able to show how cost effective it was to deal with expected occurrences of Category 1 Excess Cold hazards in the city. They found that the total cost of remedying these hazards would be £2.2m and that this would lead to in an annual saving to the NHS of £7.4m; a payback period of less than four months.

Falls hazards can often be eliminated by simply replacing patches of floorboards or carpet. The CIEH Toolkit says that the average cost of dealing with Category 1 hazards of Falls on the Level and Falls on Stairs is under £400. However, if an elderly person falls and fractures their hip the cost to the health service is many thousands of pounds.

Once the above evidence is available, it can be used to persuade councillors, the Director of Public Health and others on the HWB Board that housing should be a public health priority for inclusion in the JSNA and HWB Strategy. In addition, taking relevant personnel on carefully selected visits is a good way of convincing them of the effects of living in poor homes on the health and wellbeing of the occupiers and case studies with the statistical evidence is useful to illustrate bids for resources.

In some authorities private sector housing practitioners will encounter additional challenges. The first is where the senior manager for the service (usually a Director or Assistant Director), a key person who would link to the HWB Board, is not from an environmental health background. They may be less familiar with the concept of housing as a determinant of health, however they will find that both the Chartered Institutes of Environmental Health and Housing and the National Housing Federation are highlighting housing as a public health priority for HWB Boards.

The second additional challenge is for private sector housing practitioners working in District Councils, where the HWB Board is more remote, at county level. Team leaders in many counties have already established private sector housing groups, which bring the DCs together. These should enable joint working to collate the evidence and persuade those on the County HWB Board that housing should be a public health priority

Summary

Private sector housing improvement needs to be continually championed as a mainstream service by taking advantage of the opportunity presented by the new structure for public health. This could be achieved if an early start is made by gathering evidence for the JSNA and using it to persuade the HWB Boards of the importance of housing as a priority public health issue.

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Further reading and websites

The CIEH Private Sector Housing Evidence Base, currently available via <http://www.cieh.org/>. In particular see the LACORS guidance on health and housing.

Acknowledgement

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Private Sector Housing Interventions and the calculation of NHS savings:

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Abstract

HHSRS harm outcomes can be linked to the expected costs incurred within the NHS and the quantitative health impact calculated. This paper explains the methodology and use of quantitative Health Impact Assessment to help local housing authorities and partners assess the cost and cost benefit to the NHS of effective housing interventions. This information can help provide evidence to inform the JSNA and Health and Wellbeing strategy. The paper also explains how the use of retrospective quantitative HIA can measure the savings to the NHS following mitigation carried out in accordance with both enforcement and proactive strategies.

Introduction

Local Housing Authorities (LHA) are recognising that additional information is required concerning private sector housing to help inform the Joint Strategic Needs Assessment (JSNA). The BRE are able to use the incidence of Category 1 HHSRS hazards in dwellings, either collected by house condition surveys or calculated from private sector housing stock models to estimate the cost to health. This is carried out by subjecting the data to a quantitative health impact assessment. This quantitative HIA considers both the cost and savings to the NHS and the wider society of dwellings with Category 1 hazards and subsequent intervention strategies. Cost benefit scenarios can be developed for different hazards, showing the cost, benefit and breakeven point of carrying out mitigation works for all dwellings with Category 1 hazards. Further scenarios are produced to show the cost and benefit to the NHS and society of carrying out work to dwellings with the least expensive 50% and 20% of required works. The same methodology is demonstrated using retrospective health impact assessment to show savings to the NHS and wider society.

Background information or literature

HHSRS is a means of identifying defects in dwellings and evaluating the potential effect of any defects on the health and safety of occupants, visitors, neighbours and passers-by. The system provides a means of rating the seriousness of any hazard, so that it is possible to differentiate between minor hazards and those where there is an immediate threat of major harm. The emphasis is placed on the potential effect of any defects on the health and safety of occupiers particularly those regarded as 'vulnerable' (the definition of 'vulnerable' is that given in the Operating guidance 2006). The measure used to define poor housing, or dwellings requiring intervention to improve or mitigate hazards, is 'dwellings where a Category 1 hazard is present'. This measure focuses on health outcomes, and its development is informed by a large body of research and statistics on the links between housing and health. "HHSRS is evidence based and supported by extensive reviews of literature by detailed analyses of statistical data on the impact of housing conditions on health" (ODPM, 2003)

The prospective quantitative HIA report draws on this using a methodology developed by the BRE Trust and published in the 'Real Cost of Poor Housing' (Roys, 2008).

Approach and methods

The starting point is for a LHA to supply information showing the number of Category 1 hazards present within the housing stock. This information can be sourced in one of two ways:

- A recent housing stock condition survey database. (The methodology and results are initially evaluated for statistical robustness)
- BRE Housing Stock Model (HSM). Later versions include a model for the presence of Category I fall hazards as well as Category 1 Excess cold and All Category 1 hazards. The HSM can be supplemented with local data concerning tenure and mitigation costs where available, alternatively National costs with a regional multiplier can be applied

The next step is quantifying the cost of improving these poor dwellings. The definition of 'a poor dwelling' is taken from the RCPH publication as a dwelling with a Category 1 hazard. Local costs of mitigation are used where these are available.

Costs of a percentage of works associated with individual hazards can also be calculated e.g. the cheapest 50% and 20% of works etc. This can give more realistic figures as there will always be a small proportion of dwellings where mitigating the hazard is problematic. An example might be where the dwelling is listed and works to fit an alternative stair case cannot be undertaken. Scenarios are built up where the cost of work to a percentage of dwellings is undertaken over a number of years. 3, 5 and 10 year scenarios are usually considered but this can be altered to suit LHAs needs.

These costs are then compared to the expected cost of health care of occupants and visitors to the dwellings, if the mitigation work is not carried out and where it is carried out. This allows a net present value cost benefit analysis to be undertaken.

Health cost development

The health costs are based on the harm outcomes expected for the hazards measured.

Looking at typical health outcomes and first year treatment costs

Table 1 Typical health outcomes and first year treatment cost for selected HHSRS hazards

| Hazard | Class 1 | Class 2 | Class 3 | Class 4 |
|----------------------------|--|-------------------------------------|----------------------------------|-----------------------------------|
| Damp and mould growth | Not applicable - | Type 1 allergy (£1,998) | Severe asthma (£1,120) | Mild asthma (£180) |
| Excess cold | Heart attack, care, death (£19,851) | Heart attack (£22,295)* | Respiratory condition (£519) | Mild pneumonia (£84) |
| Radon (radiation) | Lung cancer, then death (£13,247) | Lung cancer, survival (£13,247)* | Not applicable - | Not applicable - |
| Falls on the level | Quadraplegic (£59,246)* | Femur fracture (£25,424)* | Wrist fracture (£745) | Treated cut or bruise (£67) |
| Falls on stairs and steps | Quadraplegic (£59,246)* | Femur fracture (£25,424)* | Wrist fracture (£745) | Treated cut or bruise (£67) |
| Falls between levels | Quadraplegic (£59,246)* | Head injury (£6,464)* | Serious hand wound (£1,693) | Treated cut or bruise (£67) |
| Fire | Burn ,smoke, care, death (£11,754)* | Burn, smoke, Care (£7,878)* | Serious burn to hand (£2,188) | Burn to hand (£107) |
| Hot surfaces and materials | Not applicable - | Serious burns (£4,652) | Minor burn (£1,234) | Treated very minor burn (£107) |
| Collision and entrapment | Not applicable - | Punctured lung (£3,439) | Loss of finger (£1,536) | Treated cut or bruise (£67) |

which can be attributed to selected HHSRS hazards provides costs. This is an important part of the method and as such a simplified table developed from the Real Cost of Poor Housing publication is reproduced here as Table 1 .

Some of the classes of Harm are marked 'Not applicable'. In these cases the HHSRS class is either very rare or nonexistent. Death, for example, is very unlikely to arise from Damp and mould growth alone so no Class 1 harms are applicable and Radon, if present and causing a health effect, is expected to cause an extreme outcome leading to lung cancer or death hence no class 3 or 4 harms are applicable. Where asterisked the costs are as a result of treatments predicted to be required during the first 12 months. Continuing care costs after one year are likely to occur but these are not modelled.

Consolidating and simplifying these costs gives the following basic figures that can be associated with and used for costing health outcomes:

Class 1 = £50,000

Class 2 = £20,000

Class 3 = £1,500

Class 4 = £100

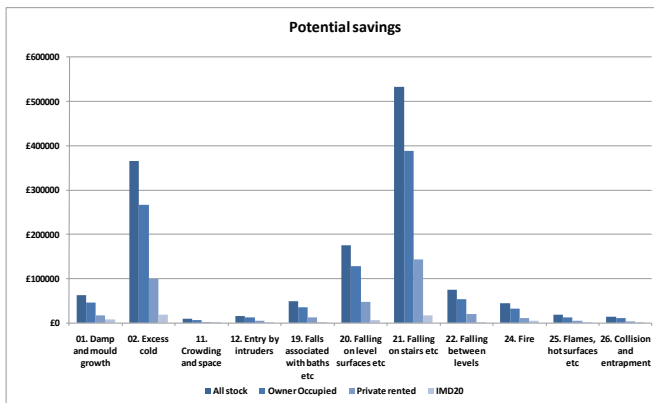
All costs are based on 'simple' sums and although commonly called 'cost benefit' are properly known as 'cost off set'. This means that for the cost to the NHS, other associated costs such as time off work are not included. Similarly for the cost of works the only sum considered is the actual cost of materials and employing a contractor to do the work. Due to the complexity of the issues the model only includes those costs that have direct health costs, however, costs to society are provided as an additional 150 %.

Results and policy conclusions

A prospective quantitative HIA initially calculates the potential savings to the NHS and to society of mitigating the most common Category 1 hazards. This can be split by tenure and linked to the index of multiple deprivation (IMD) An example of an authorities potential savings is shown in

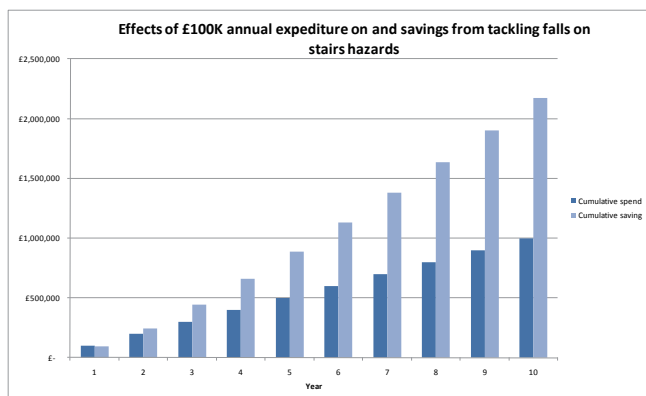
Figure 1

Potential savings to the NHS in LA Example by tenure where Category 1 hazards are mitigated



As well as quantifying total savings, calculations can be made to estimate the savings of investing a set amount of money every year as shown in Figure 2. 100k is spent every year for 10 years on mitigating stair falls and the savings add up to over £2 million. The model works by tackling the 'easiest to fix' repairs first. Some caution must be expressed as it is an idealistic model but does show the possible savings.

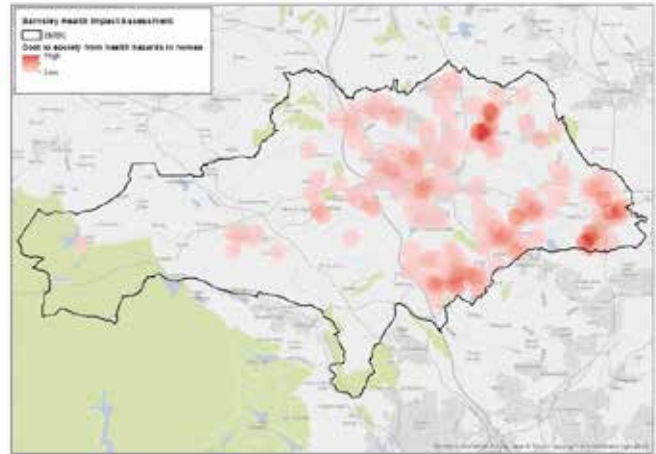
Figure 2



The estimated savings where an authority spend 100K on mitigating Falling on stair hazards

The quantitative data can be linked through GIS mapping to show 'hot spots' where interventions can best be targeted. Figure 3 shows such an example as applied to Barnsley. Barnsley MBC supplied a database of the results of their recent private sector house condition survey. The Category 1 hazards recorded during this survey have been mapped. Thanks to Barnsley MBC for permission to use this map. This HIA is still in progress and a workshop of health practitioners will meet to add additional information before the report is finalised.

Figure 3 Health cost hot spots in Barnsley

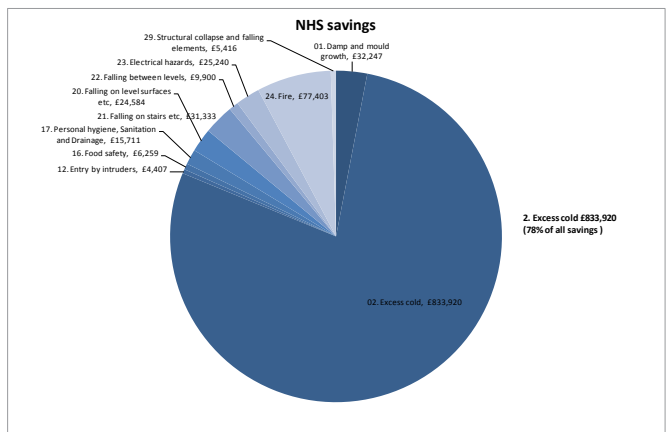


Retrospective HIA

This can be used where both Category 1 or 2 hazards have been mitigated. The same methodology applies.

The health benefits and savings to the NHS and the wider society can be shown following both renewal intervention and enforcement strategies. Figure 4 shows the estimated annual savings following mitigation of 2016 hazards during 2008 to 2012. HHSRS data was collected from a number of authorities. They were all authorities where measurements of the health impact of the works carried out to mitigate HHSRS hazards had been measured. With their permission, a collation of all the results has been carried out. The total estimated savings to the NHS is over £1 million per annum. The saving through mitigating Excess cold hazards alone is estimated as £833,920 with a further £77,403 on preventing harm outcomes associated with Fire. No account of inflation is included. This methodology only measures the monetary impact, the health impact of feelings and benefits to individuals and households is assessed by other qualitative means. An adult who for the first time in their life is asthma free as a result of removing Dampness from their home was reported as one such case resulting from this project. The costs associated with harm outcomes cannot be fully quantified in such a case.

Figure 4 Estimated Annual Savings to NHS following mitigation work



All together it is estimated that 242 incidents have been prevented as a result of mitigating 2016 housing related hazards. This means that 242 people will have been saved from requiring medical intervention but it is not possible to estimate the saving in work and school days lost or the long term affect to both the household's and the national economy. The Housing Health Cost Calculator HHCC www.housinghealthcosts.org is now live and can assess the health savings to both NHS and society of mitigating hazards. This can be used where Category 1 or 2 hazards have been mitigated. The same methodology applies. EHPs enter the data of the hazard both before and after mitigation and the hazard score is automatically calculated. The health savings benefit is calculated following this.

It is recommended that ALL assessments even where hazards are mitigated informally should be recorded. The conclusions in the recent report (Stephen Battersby, 2011) suggests that LHAs could make better use of their powers and this calculator and recorder should help deliver that aim. The number of dwellings made free of Category 1 hazards during the year is a new reporting requirement in accordance with ELASH. The calculator will record the savings to the NHS and society where ever an assessment is recorded. There is a default set to automatically enter the 'average' HHSRS score following mitigation. Where Excess cold is mitigated a higher than average likelihood figure should be entered which better represents the type of mitigation measures being commonly applied. A nominal cost of work should be available even where landlords have carried out the action. This will provide the basis of a cost benefit calculation.

Implications for policy or practice

This quantitative HIA gives costed evidence of the benefit of private sector housing intervention both through proactive strategy and enforcement.

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Linking Housing Conditions and Health

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Abstract

This paper reports on a study that examined the potential savings to the NHS of housing renovation work in a number of local authorities as part of their Decent Homes programmes for private sector housing. The study used a methodology developed by the Building Research Establishment (BRE) to compare the costs of remedial improvement and works with the estimated cost benefit to the NHS. While low-cost interventions can give a particularly good value for money in terms of health and well being, this does not mean that such interventions should be given priority over dealing with other hazards.

Introduction

There is a growing body of evidence demonstrating the link between housing conditions, particularly housing deficiencies, and the health of occupiers. For various reasons and because these are people's homes, it is often difficult to show a clear and measurable cause/effect relationship.

Work by the BRE has included the development of a methodology that provides the means to compare the cost of housing interventions with the potential savings to the health services. Using this approach the BRE has been able to show that poor housing in England is costing the NHS in excess of £600 million a year (Roys et al., (2010) and in Wales £67 million per year (Davidson et al., 2011). This model has been possible because of the adoption of the HHSRS.

This chapter reports on a pilot study using an adapted BRE model, and data from six local authorities on housing interventions in as part of their Decent Homes programme for the private sector. This has been used to calculate the resulting financial savings to the health sector.

To meet the Decent Homes standard a dwelling has in the first place to be free from any Category 1 hazards. A Category 1 hazard would be one with a hazard score of 1,000 or more using the HHSRS as set out in the Housing Health and Safety Rating System (England) Regulations 2005 (SI 2005 No 3208) (Wales has its own but identical Regulations). While the Decent Homes standard is a non-statutory standard, under the Housing Act 2004 Part 1 local housing authorities have a duty to take one of the courses of action within the Act where a dwelling contains one or more Category 1 hazards.

Background information

The work, a joint project between Warwick Law School and the BRE funded by the 4North West (North West Regional Leaders Board) and was undertaken in 2009. The HHSRS was developed using actual health data related to the housing stock. It was possible to identify at the likelihood of occurrences that caused harm justifying medical attention from hazards within the housing stock. It was also possible to identify the proportion of different harm outcomes as the result of those occurrences in homes.

On that basis it has been possible to develop a cost model as treatment costs are well developed. Further information can be found on the Warwick University, Institute of Health, Safe and Healthy Housing Unit website and the address is given below, and includes reports on the development of the HHSRS. The costs to the NHS are possible to assess because these are 'real costs' with information available. For example, at its simplest it is said by the North West NHS that an average GP appointment costs the NHS £25 and a visit to A&E can cost the NHS between £59 and £117 (website below) but more detailed treatment costs are known for different health outcomes.

The BRE model limits the potential cost savings to those attributable to the health service, which may be no more than 40% of the total costs to society from housing conditions, including loss of earnings, under-achievement at school social exclusion and other problems.

Approach and methods

Local authority 1 (LA 1), a metropolitan borough, was used as the first case study and as a pilot. Data were provided from activities to deliver the private sector Decent Homes Programme in the form of 388 cases within a spreadsheet and 369 individual reports on dwellings. The data included results of assessments determining non-decency and the cost of the works carried out to deal with the non-decency. Of particular interest was whether there were any Category 1 HHSRS Hazards, and the cost of dealing with those Hazards. Adapting the BRE's work (Roys et al., 2010) (the CIEH HHSRS Cost Calculator was a bi-product of the development of this) the cost of dealing with Category 1 Hazards could be related to the cost saving to the health service. Ideally, three sets of data were required:

1. the HHSRS Hazard likelihoods and outcomes before any remedial works
2. the HHSRS Hazard likelihoods and outcomes on completion of the remedial works
3. the cost of the remedial works relating to each HHSRS Hazard

Members of the team from BRE selected 30 cases at random and imported data from these into a spreadsheet devised as part of previous work (Roys et al., 2010). This spreadsheet used differences between pre- and post- remedial works likelihoods and outcomes to calculate the value of benefits in savings to the health service of undertaking the works. Comparing these to the costs of works also allowed calculation of "payback" periods.

In some cases, there was no information on the HHSRS assessment post remedial works (either because the assessment had not been done, or had not been recorded). For these, the assumption made was that the works had reduced the HHSRS Hazard(s) to the national average for that Hazard as given in the HHSRS Operating Guidance (ODPM, 2006).

The information included in the data supplied by LA 1 along with BRE's work, demonstrated that it was possible to quantify the potential savings to the NHS. If the other authorities could supply the specified data, then the same exercise could be carried out.

Five participating local authorities were then asked to provide the three sets of data listed above, for each dwelling where they had intervened as part of their Decent Homes Programme. This information was used to identify Hazards where the mitigation works produced the shortest payback time giving some indication of value for money. For example, dealing with the Hazards of Falling on Level Surfaces and Entry by Intruders gave "payback" periods of one and two years respectively. This analysis also indicated those Hazards and remedial action with the longest payback periods.

Findings and results

Four examples of the findings are reported here. In LA 1 the total estimated annual benefit to the health service of works undertaken to reduce the Hazards in the 30 dwellings in the sample was £34,900 against a total one off cost of £310,000. If this represents around 40% of the total cost to society, the total annual cost benefit could be around £87,250. This means that the payback period (the period when the cost to society of these housing interventions will be recovered) was nine years.

For LA 2 (a non-metropolitan unitary authority) the average cost for the mitigation work for 212 hazards in 156 dwellings was £1,020 (a one-off outlay) and the average annual cost benefit was assessed as £278. The payback period for these works would be around 3.6 years. The longest payback periods were for the Hazards of Fire, Damp and Mould Growth, and Food Safety – 33, 17, and 16 years respectively.

In LA 3 (a non-metropolitan unitary authority) the single highest cost was £3,015.40 to address Excess Cold. Although the likelihood of an outcome causing harm in this case was 1 in 56 before mitigation work and reduced to 1 in 1000 afterwards, this still only yielded a benefit of £312 per year to the NHS. This illustrated the point that, while for Excess Cold the likelihood of an occurrence causing harm could be reduced, the spread of possible outcomes would not change, with Class I (the most serious and expensive to treat outcome) remaining the same after the mitigation works. This would not be true for all hazards, but would depend on the presence of deficiencies that affected the spread of possible health outcomes. It should be remembered that the cost benefit analysis related only to the savings to the NHS, and did not include other savings to society including stress and impacts on general well being.

In LA 4 (a metropolitan LA) the average cost for all works was £929 (a one-off outlay) and the average annual cost benefit was £475. The single highest cost was £3,600, again to address Excess Cold. This only yielded a benefit of £288 per year to the Health Service, and the explanation for this is given above.

Implications for policy or practice

At this time it is not possible to compare cost benefit between authorities, or to cumulate the findings from these authorities. This is because, while there might be consistency of HHSRS assessments within each authority, it is not clear that there would be consistency between authorities. Unlike for the English Housing Survey there is no “standardisation” of assessments. Indeed it is likely that relatively few local authorities undertake any such internal “re-calibration” exercises to ensure quality control.

While the individual HHSRS assessments may give a similar Hazard Scores, the deficiencies leading to that assessment may be very different. The Hazard Score for the same Hazard in two properties may be similar, but the deficiencies leading to that Hazard could be very different meaning different mitigation works and different remedial costs, but similar health treatment savings. Construction forms (design and materials) may also vary with some being more expensive to deal with than others. It is only by using data from sources such as the English Housing Survey that national cost benefit analyses can be carried out.

The use of average figures for all hazards dealt with hides some useful information and the figures for some of the individual local authorities hide some further complexities. Details of the low cost interventions and the high cost interventions show that there can be considerable differences in the cost benefits to the health sector. Within authorities, it may be best to look at each Hazard if the data are plentiful, or to look at individual cases as examples.

The cost benefit for those Hazards such as Entry by Intruders and Falling on Level Surfaces, that show the shortest payback periods can appear attractive. The annual savings to the NHS would equal the one off cost of the remedial works in a relatively short period. Such minor works might be suited to be undertaken through the Handyperson Schemes or similar. However this does not necessarily mean they should be given preference over other Hazards.

Some, such as the majority of Excess Cold Hazards and Fire Hazards can be more expensive to address. It is also difficult to quantify the wider benefits. Dealing with Excess Cold can contribute to carbon reduction, better educational attainment and sense of wellbeing from more complete use of the home (Green and Gilberston, 2008). The mental stress from losing one’s home as the result of a fire has not been fully assessed. The BRE method takes no account of the cost of the fire and rescue service or insurance costs either. A more nuanced approach is therefore required when making policy.

Further work by the BRE has shown that were the definition of poor housing extended to include all homes with a SAP >41, and heating and insulation improvements were targeted on those properties, the potential benefit to the NHS will be an additional £700 million+ over the £600 million quoted above (Nicol et al., 2010).

What is suggested (and was not possible in this study) is that local authorities should review the deficiencies contributing to the apparently expensive Hazards to see if alternative and cheaper works could produce similar results, while recognising the other benefits obtained. As the HHSRS Worked Examples demonstrate it is possible to re-rate hazards on the basis of potential and different remedial works (see website listed below).

This study has shown HHSRS data can be used to both demonstrate potential health gains following housing interventions and to put a financial value on those gains. It is axiomatic that the greater the consistency in Hazards assessments and the more accurate the recording of data, the more reliable will be the results. To make the most of this approach, local authorities should systematically record for each dwelling survey –

- the individual Hazard(s) being assessed
- the likelihood and outcomes before intervention
- the works specified to reduce the individual Hazard
- the cost of the works associated with the individual Hazard
- the likelihood and outcomes for the hazard after intervention

This should be for all significant Hazards that can be reduced, and not just Category 1 Hazards. As has been shown however many local authorities have been slow to record data in a way that allows such an analysis to be undertaken (Battersby, 2011).

If local authorities record the Hazard data then a new interactive tool, the Health Cost Calculator available from RH Environmental and the BRE (see website below) will enable the health cost saving of Hazard mitigation to be calculated. This is an important way for local authorities to demonstrate the potential value of interventions in housing to improve public health. It will also allow them to develop more effective intervention strategies for housing and health.

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Further reading and websites

Warwick University http://www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/healthyhousing/hhsrs/

NHS NorthWest

[http://www.northwest.nhs.uk/document_uploads/Choose % 20Well/ A4_feeling_unwell_posters.pdf](http://www.northwest.nhs.uk/document_uploads/Choose%20Well/A4_feeling_unwell_posters.pdf)

Worked Examples at

<http://www.communities.gov.uk/documents/housing/pdf/138571.pdf>

RHE/BRE Housing Health Cost Calculator

<https://www.housinghealthcosts.org/>



Accident Reduction in Home Environments

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Abstract

This chapter reviews effective interventions aimed at reducing the incidence of home accidents from falls and fire, in a variety of settings and is particularly focused on the two primary risk groups identified in the Housing Health and Safety Rating System (ODPM 2006) i.e. those over 60 and those under 5 (ibid).

The approach taken in developing this is to use some of our own practice and experience adopted in a number of local authorities and, through an examination of international evidenced best practice.

In any intervention process the emphasis should be placed upon directing resources at areas with the most hazards and the greatest risk and there is evidence to support a more targeted environmental health response for the risk groups. Effective interventions may include a combined focus on education, in which environmental health could be an agent of change due to their access to a variety of at risk groups; reducing environmental hazards and effective enforcement of safety standards both of which environmental health have a direct involvement with.

Some of the interventions identified are common practice whilst some will be a call to arms for EHPs to potentially extend their practice remit to lessen the risks of unintentional injuries sustained within the home.

Introduction

Sengoele et al (2010) and Keall et al (2011) highlight the difficulty in determining the exact accident rate statistics arising from the home and it has been argued that this lack of clear evidence may reduce motivation to develop interventions (WHO 2012). It is generally only at the point of medical intervention that any potential data will be recorded, and thus many accidents are never acknowledged. The International Classification of Diseases (ICD) version 10 provides a series of codes to record home accidents however, it will remain important to reflect on cross national comparison due to differences in reporting, and detail of causation (Smith et al undated and Jansson 2005) who suggest that this leads to an underestimation of figures.

In the United Kingdom, as a result of the dissolution of the Home Accident Surveillance system, there are few, if any clearly aggregated primary national statistics. Reference to the Office of National Statistics (2010) suggest that 2667 deaths occurred in the home environment, but also lists 2234 death where the location is not noted. ROSPA (2012), using ONS statistics, suggest approximately 5000 home accident deaths in 2009 pointing to continuing increase from approximately 3500 at the turn of the millennia. This is in line with the WHO (2005, cited in CIEH 2005) which suggested 4100 people die in homes and 270000 are injured. Both ROSPA (2012) and Keall et al 2011 point to home/leisure fatal accident rates being twice that of road accidents. There are efforts to coordinate this data through the South Eastern Western Public Health Observatory; Injury Observatory for Britain and Ireland; and the Miskin Group, a team of prominent injury researchers.

In order to develop a targeted approach to reducing home accidents Environmental health Practitioners (EHPs) can obtain injury statistics from the injury observatory for Britain and Ireland. For England the injury profiles for local authorities, provides an interactive tool (http://www.apho.org.uk/default.aspx?QN=INJURY_DEFAULT) which enables interrogation of Local Authority accident rates and hospital admissions with comparison to national averages. Further data sets

are available for Wales, Scotland, Northern Ireland and Ireland. This can be utilised to provide objective evidence as to the level of injuries within a district and will enable determination of where actions may need to be applied. The HHSRS cost calculator available from www.cieh.org/library/Knowledge/Housing/HHSRS_cost_calculator.xls provides a further tool to estimate the costs of home accidents and can be used to support cases for targeted action.

Maconochie (2003) highlights that effective intervention in injury reduction requires intervention in three areas, education; reduction in environmental hazard and enforcement of safety legislation. The authors would contend that a further parameter be added which focuses on "at risk groups". Literature points to two groups as being most at risk: those under 14 and those over 60. Many reports have identified home accidents as the major causative factor in child mortality and loss of productive life in Western countries (Keall et al 2011, Sengoele et al, 2010, Towner and Mytton 2009, Sethi 2005). The Health Protection Agency (2007) estimate 882,500 accidents led to under 14s attending Accident and Emergency departments as a result of home accidents, with the majority the result of falls and being struck by a static object. It should be noted that this is a considerable difference in scale to figures within other data sets but matches Towner and Mytton (2009) view of 1 million hospital visits per annum. Likewise the impact of falls within the home setting for those over 65 is considerable. Kannus et al (2005) estimate that between 30-60% of this population fall each year, depending on residential setting. They go on to highlight that 20% of these injuries require medical intervention and are the major cause of functional impairment, disability and death (Ibid and Todd and Skelton 2004).

There are a number of other hazards involved in home accidents. Keall et al 2011 states that domestic fires led to 374 deaths in the UK accounting for 82% of all fire related death in the UK. Holborn et al (2003) identify smoking, alcohol, old age, disability/illness, living alone and social deprivation as risk factors. Ahrens (2011) adds cooking, portable space heaters, candles, lighters and matches, and electrical failures in upholstery related fires. These papers support the contention that removal of hazard in addition to effective enforcement and interventions which are focused on risk groups are all important factors in effective practice.

What is of concern to the EHP is that the distribution of accidents is not uniform within the at risk groups. It is clear that there is a differential in the numbers of childhood accidents and socio-demographic determinants:

Table 1: Socio-demographic risk factors contributing to higher rates of childhood accidents in the home

| Risk Factors | Location | Reference |
|--|----------|----------------------------|
| Younger maternal age, financial problems, maternal mental distress, older siblings, male children. | Norway | Myhre et al (2012) |
| Educational level of parents and income, with single parents or size of dwelling showing no effect. | Denmark | Laursen and Neilson (2008) |
| Male children, socio-economic group, unemployment, unsafe home, play environment, young mother, number of siblings. | UK/EU | Towner and Mytton (2009) |
| Male children, income level, area deprivation, single parenthood, low maternal education and age, poor housing, large family size and substance abuse. | EU | WHO (2008) |
| Homes of families reported to childcare services may pose a greater threat to child safety than other homes | US | Metchikian et al (1999) |

Disadvantaged groups are more likely to live in poorer housing and their knowledge and health behaviours may then compound their exposure to hazards in the home. Furthermore, their health status and biological sensitivity may make these disadvantaged groups more vulnerable to adverse health effects of exposure and the result of this response may be worsened due to reduced access to health care (WHO 2012). Effective intervention should, therefore, be targeted at the identified disadvantaged groups.

Approach and methods

This study was conducted by way of a literature review of peer reviewed materials including European systematic reviews and grey literature, including government reports, WHO literature, and materials from action groups involved in accident reduction written in English. Searches were made of the following databases: google scholar, science direct, pubmed and opengrey using the search terms: accident reduction, effective accident reduction in the home, home accident statistics, children and home accidents, older persons and home accidents, over 60 and home accidents. The reference lists contained within these initial articles were explored to further locate additional articles on accident reduction and effective intervention in home accidents. Specific review was undertaken of European wide reviews. A timeline was applied to all material to exclude articles produced before 1980.

Summary of findings and application

Effective intervention should focus on the three areas of education; reducing environmental hazards and effective enforcement of safety standards, coupled with a focus on at risk groups (Maconochie 2003, WHO 2008, Towner and Mytton 2009). Environmental health practitioners play a key role though advice, financial assistance, advocacy, and enforcement (Burrige and Ormandy 2007).

Education and training

There are a number of educational programmes aimed at children, for example Learning About Safety by Experiencing Risk (Laser), and a few that focus at seriously at risk families e.g SafeCare® run by the NSPPC. There is evidence, however, to suggest that educational programmes for parents/carers, coupled with home inspections have some success (Kendrick et al 2012, Laflamme et al 2009). King et al (2001) further showed that intervention visits to assist in risk reduction significantly reduced both the numbers and seriousness of accidents. For older people, Todd and Skelton (2004) point to education on hazard removal and home modification, plus home based exercise programmes to improve balance, and medication review.

Is there a place for education and can EHPs be involved? Some authorities are already involved for example the London Borough of Hounslow operated a home safety programme, in which targeted home safety advice was provided to older persons. This included both physical checks of equipment, including safety blankets, electrics, fridge operating temperature etc, but also advice on security (Alan Page pers comm.), likewise Liverpool City Council are operating a "Healthy Homes" scheme in which advice is given on home safety, alongside normal environmental health interventions. For the future a co-ordinated approach with partners such as Health Visitors, National Childbirth Trust, SureStart, (NICE 2010), Age Concern, Occupational Therapists and Adult Social Services to target "at risk" groups could provide a mechanism to reduce incidents of home accidents.

Removal of the environmental Hazard

Keall et al (2011) evidence the role of installation of smoke detection; temperature limiting devices on hot water systems; guards/catches on window at and above the second floor windows. WHO (2005) suggested a further focus on cupboard door restrictors, handrails, socket protectors, CO detectors, safe thresholds and safe kitchen design and Keall et al (2008) adds poor lighting and slippery surfaces. The HHSRS does focus on a number of these risks, (Housing Act 2004), but arguably still operates as a property focused intervention, rather than as a tool to focus on "at risk" individuals, families and communities. There are other tools which may be more applicable to assessment of these at risk groups including the home safety inventory, which can be further targeted (Lach 2012), home accident prevention inventory (Tertinger et al 1984), Safehome questionnaire (www.safehome.org.uk).

Assessments for modifications to older peoples home are now common place in the UK, although funding for adaptations may be more restricted. NICE (2010) has suggested a more co-ordinated approach to assessment and intervention for the under 15s, with suggestions including installation of home safety equipment, although they do recognise that some residents do not have the right to install equipment in their home environment.

Effective enforcement

Evidence points to effective enforcement being a key part of any strategy to reduce home accidents. "Effective" suggests a valuable, successful and efficient outcome. EHPs traditionally see this as an improved dwelling, case completed, or that a notice/letter has been complied with. It is suggested that as an alternative EHPs should make more use of the HHSRS methodology to record the reduction in risk to vulnerable clients, number of lives saved, number of people assisted by the intervention, and the cost saving to the NHS, the latter through use of the HHSRS cost calculator mentioned above. EHPs should also work with other agencies to identify individuals, families and communities most at risk and implement joint initiatives to provide a more effective response.

Area and risk based interventions

The evidence demonstrates a link between social deprivation and accident rates. Towner and Mytton (2009) point to the effectiveness of community based "falls" programmes, whilst the CIEH (2008) evidence the effectiveness of community based initiative focused on the most disadvantaged groups. Such interventions involve removal of hazards, effective enforcement, and educational initiatives to develop a culture of safety. Armed with the data from injury profiles for local authorities environmental health practitioners can target resources toward accident reduction programmes on an area and risk group basis.

Implications for policy or practice

Whilst the HHSRS provides a risk based methodology (ODPM 2006) it remains, in many ways, a property based intervention tool. There is clear evidence within the literature that there are other factors beyond age that increase the risk of home accidents. EHPs should use available data to determine the local prevalence of accidents and combine their resource with other agencies to target the most at risk through education, advice giving, removal of hazards and effective enforcement.

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Housing Health and Safety Rating System and Noise: an effective toolkit for reducing Hazards to Mental health and improving Wellbeing?

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Abstract

Since 2006, all Councils in England and Wales have a duty under the Housing Act 2004-Housing HHSRS, to assess potential risks to the physical and mental health of occupants from exposure to noise inside a dwelling or within its curtilage. Hazard identification, includes exposure to Noise caused by poor sound insulation. Yet inspections to identify Hazards from Noise and Council enforcement action remain low. This chapter considers how a different and more robust approach by Councils could help minimise impacts to Mental health and encourage Wellbeing.

Introduction

There is a deep synergy between good health, Mental health and Wellbeing. The constitution of the World Health Organization (WHO, 1948) unequivocally states:

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (p. 1).

In 2001, the WHO annual world report was dedicated to the improvement of Mental health including a call for all sectors to be more involved in improving the mental capital and Wellbeing of communities.

More recently, successive UK governments have sought to encourage the prevention of mental illness by adopting early intervention strategies (DOH, 2010). The fiscal and societal costs of poor mental health have encouraged a greater focus on measures to intensify prevention strategies for mental illness and positively promote wellbeing (DOH, 2011).

Background

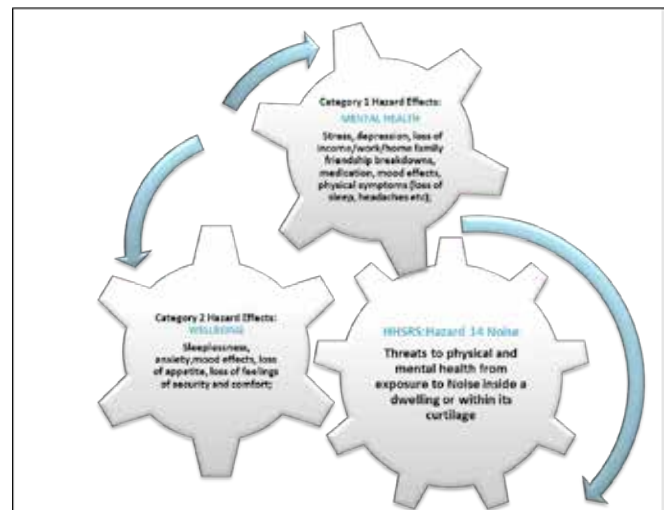
It has long been recognised that where people live affects their health and chances of leading flourishing lives (CSDH, 2008; Marmot, 2010). The Government Office for Science (2008) Foresight project includes a plethora of evidence; a review of over a thousand papers to illustrate that poorer housing quality can lead to poorer mental health. The report notes that Noise is generally viewed as a negative ambient factor in physical environments and can adversely impact on quality of life, learning and mental capital. The Built Environment task force, part of the Marmot Review noted environmental noise problems are worse in areas of deprivation, areas of high density housing and rented accommodation, also commonly occupied by those less well-off (Power et al 2009).

Noise affecting homes can originate from a variety of sources; such as music, household appliances, machinery, people, road traffic, aviation, or transport. Whatever the origin, Noise is much more than an annoyance and can intrude on well-being, even if individuals have not yet evidenced actual symptoms of a disorder (Stewart et al., 2011). Protecting and safeguarding individuals from the adverse effects of Noise, whether from unreasonable behaviour or from environmental conditions, is a non-negotiable duty for all Councils in England and Wales (Kayani, 2009).

HHSRS is a risk assessment tool for assessing potential risks to the health and safety of occupants in residential properties. Since 2006, all Councils have a duty to assess possible risks to the physical and Mental health of occupants from exposure to Noise inside a dwelling or within its curtilage; Hazard 14.

HHSRS enables Hazard identification, including harm from exposure to environmental noise caused by poor sound insulation. Where Hazards from Noise are identified, Councils can invoke a range of enforcement options to reduce or eliminate Hazards. A Hazard assessed with a score of more than 1000, is deemed a Category 1 Hazard; and Councils have a duty to take one of the courses of action in Part 1 of the 2004 Act. Hazards scoring 999 or less are classified as Category 2 Hazards and allow Councils to exercise discretion in decisions to take action (ODPM, 2006). Figure 1, illustrates the interconnection between Mental health, Wellbeing and Category 1 and 2 Hazards from Noise.

Figure 1: Mental health and Wellbeing effects of category 1 and 2 Hazards from Noise (Adapted from CSDH, 2008; Kayani, 2008; Marmot, 2010; ODPM, 2006; Power et al, 2009; Stewart et al., 2011; WHO, 2000, 2001, 2011).



Approach

As early as 2008, a study by the Chartered Institute of Environmental Health (CIEH) questioned whether HHSRS was being used effectively by Councils in respect of public health and reducing health inequalities. The Battersby Report (2011) noted that less than 10% of dwellings with Category 1 Hazards were dealt with in any year, with some Councils averse to effective regulation. Post Battersby, a further survey of enforcement activity of Councils found a disparity in HHSRS data systems used by Councils and collection of enforcement data (CIEH, 2011). It is therefore unsurprising that there is a paucity of data for Hazards from Noise.

A 2010 independent study based on Freedom of Information requests to 98 Councils in London and the South East, which gathered data on numbers of inspections for Hazards from Noise and resultant enforcement activity, does provide some insight into the issue of Hazards from Noise.

Findings

The study received responses from 89 Councils and found that 81 % of Councils did not conduct any inspections for Hazards from Noise (Figure 2). One Council responded that no inspections were conducted, as there are no Hazards from Noise within in its area (Noisedirect 2012). Overall 95 % of Councils did not take any enforcement action (Figure 3); and only 4 Notices (including 1 Hazard Awareness Notice) were served by Councils.

Figure 2: Number of Councils conducting inspections for Hazards from Noise

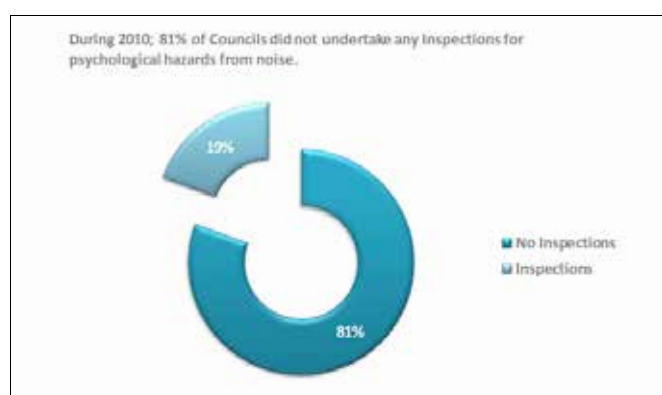
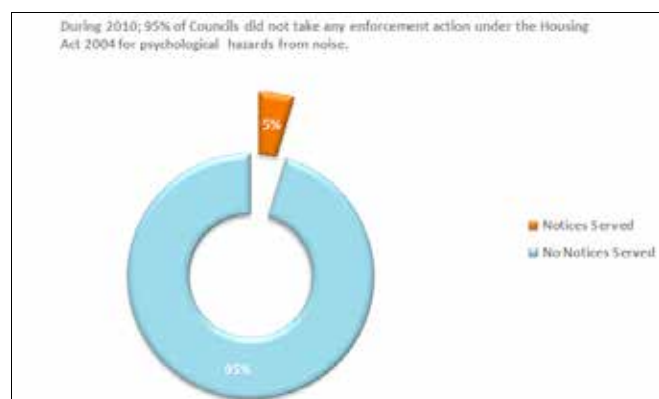


Figure 3: Number of Councils taking enforcement action for Hazards from Noise



Source: Noisedirect (2012)

Good practice

The creation of local health and wellbeing boards to tackle wider economic, social, and environmental determinants and the consequences of mental health problems (DOH, 2011) has resulted in an imperative for local partnerships to be forged and different sectors to work effectively together. Joint Strategic Needs Assessments (JSNA) including quantitative and qualitative data, are pivotal to the process.

Dispiriting as the findings of the above surveys are, there is evidence of pockets of good practice and the emergence of proactive and diverse approaches for dealing with issues of Housing and Noise.

One example is the Selective Licensing scheme recently launched by the London Borough of Newham (2012). The scheme will charge

all private sector landlords a fee of £500 for the borough's 35,000 private rented properties, generating fees in excess of £17.5 million for the Council; to improve its housing evidence database and tackle issues of anti-social behaviour.

The Bristol City Council Model in Table 1 is another excellent example of good practice. It uses available resources including harnessing the expertise of staff and making use of available data, with thoughtful and considered policy and practice. Since 2003, Bristol has maintained a database of all Category 1 Hazards, allowing ready access to data for Hazards for Noise.

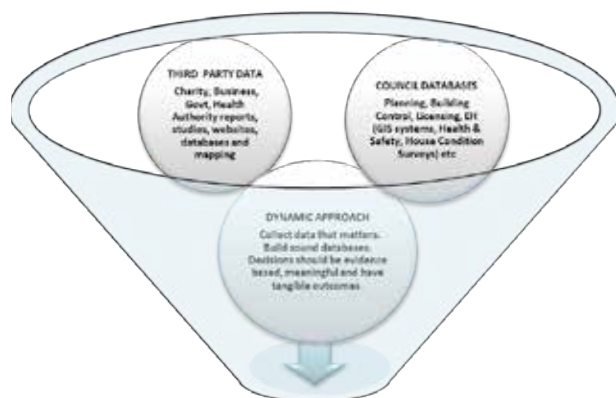
Table 1: Bristol Good Practice Model for Hazards from Noise. (Adapted from Bristol City Council 2006, 2007, 2008, 2011, 2011, I Cole. Bristol 2012, pers. comm., 21 Sept, LACORS 2010)

| Data | Documents | Training | Practice |
|--|---|---|--|
| <ul style="list-style-type: none"> Hazard database recording 10 Category 1 Noise hazards since 2003; Quality of Life surveys data; 2007 Stock Condition Survey; 76 Category 1 Noise Hazards estimated; 2011 House Condition Survey identified 0 % Category 1 Noise hazards for private rented sector and 1.6 % for owner-occupiers and; Identified 4.4 % of converted flats representing 10.7 % of all private sector dwellings; Use of Bristol Noise Maps | <ul style="list-style-type: none"> Enforcement Policy; Protocol to differentiate between nuisance noise and HHSRS Noise Hazards; HHSRS worked examples for common noise Hazards. | <ul style="list-style-type: none"> HHSRS Noise Hazard Training for nuisance investigation teams; Training by Acoustic expert; Worked examples of impact and airborne Noise Hazards; Training in Building Regulation requirements and WHO Guidelines (2001). | <ul style="list-style-type: none"> Service of Hazard Awareness Notices in accordance with Enforcement Policy; Improvements achieved through informal action i.e. secondary / double glazing, provision of acoustic matting for impact noise etc; Partnership working and training with West of England local authorities; Heel tap tests, subjective Noise assessments and SLM to assess basic Noise levels. |

Implications for policy or practice

Effective action to promote Wellbeing and reduce Hazards from Noise need not be resource intensive. Figure 4 illustrates how practitioners can utilise available information to create meaningful evidence databases to assist Hazard assessments.

Figure 4: Evidence databases for Hazards from Noise using existing resources.



HHSRS assessments for Hazards from Noise should be evidenced based, meaningful and have tangible outcomes for Mental health and Wellbeing.

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Further reading and websites

Heathrow noise action website: <http://www.heathrowairport.com/noise/> flight tracking and sound insulation schemes to mitigate environmental noise impacts.

Flightradar24: <http://www.flightradar24.com/> live flight tracker; allows environmental noise effects to be assessed.

DEFRA Noise Mapping England website: <http://services.defra.gov.uk/wps/portal/noise> Noise maps for 23 urban areas allowing determination of exposure to environmental noise.

Affordable Warmth Projects

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Abstract

This paper delves into the issues surrounding fuel poverty; trends since the mid 1990's, causes and consequences. However, most importantly, a case study example of best practice is discussed in the form of an 'Affordable Warmth Network', that is, a referral network of preventative organisations set up to assist to continue the reduction of fuel poverty county-wide. This utilises a multi-pronged, targeted approach in reaching the most vulnerable of residents at a variety of levels to bring about the success so far achieved.

Introduction to fuel poverty

Two terms used in this paper are 'fuel poverty' and 'affordable warmth'. The definition of the former has been the subject of a report published in March 2012 by Professor John Hills of the London School of Economics. This new way to measure fuel poverty moves away from the traditional "if householders are paying more than 10% of their net income (before housing costs) on achieving affordable warmth, they are classed as fuel poor" definition, and instead moves to a more accurate definition in the hope of targeting assistance to greater effect. The new definition reflects the wording of the Warm Homes and Energy Conservation Act of 2000, which states:

"A person is to be regarded as living 'in fuel poverty' if he is a member of a household living on a lower income in a home which cannot be kept warm at reasonable cost".

The definition of affordable warmth used here is the financial ability of householders to heat their home adequately; that being 21°C in the main living area, 18°C in other occupied rooms.

Using the original definition of fuel poverty, fuel poverty appeared to fall dramatically, by four-fifths, between 1996 and 2003/04. In terms of number of households in England suffering fuel poverty, figures dropped from 5.1 million to 1.2 million in those 8 years. Since 2004, there has been a steady rise in numbers of households in fuel poverty to 4 million households by 2009. Latest figures (for 2010) show a reduction in numbers once again.

Causes

Through GIS mapping, as would be expected, close correlation is seen between areas of high fuel poverty households, and properties classed both as 'hard to heat' (those houses off the mains-gas network, so using oil, LPG or electricity for heating) and 'hard to treat' (those costly to insulate, having solid walls for example). Of course, there are many other causes of fuel poverty such as low income (which has become an increasing factor with increase in redundancies, and wages not keeping pace with the increasing cost-of-living), cold weather (the particularly harsh winter of 2010 created a greater need for warmth, as the number of heating-days was greater than that compared to winter 2011, for example), under occupancy of houses, inefficient heating systems, unfair energy pricing (hitting the most vulnerable the hardest, for example because they cannot use the internet, or are in fuel-debt and forced to use a prepayment meter so not necessarily able to gain online, direct-debit or dual-fuel discounts).

Residents vulnerable or 'at risk' of being in fuel poverty in particular are therefore the elderly with over 65's making up over 50% of fuel poverty households across the UK, disabled or long-term sick, unemployed or people on low incomes, and families with young children (particularly single-parent families). Often it is a number of factors in combination which lead to an inability to achieve affordable warmth.

Impacts

The health impacts of living in a cold home are well documented (for example in the Marmot Review Team's "The Health Impacts of Cold Homes and Fuel Poverty"). Direct health implications include an increase in the risk of heart attacks, respiratory illnesses, conditions exacerbated by excess cold, and trips/falls leading to injury. There are also a number of indirect health implications to the detriment of those householders and society, such as increased isolation, emotional distress, depressions, anxiety, lack of energy, loss of working or schooling days.

Case Study of Success

United Sustainable Energy Agency has taken a leading role in several 'Affordable Warmth Networks' across counties in the Thames Valley, South East England. These networks are county-wide referral webs between key organisations that provide services to, or have regular contact with vulnerable residents. Funding has been attracted from a range of sources depending upon the region, but has included the Primary Care Trust, county council, district councils/local authority, LAA reward monies, and Department of Health funding. The networks are able to provide advice on a wide range of topics, and refer onto suitable organisations directly for assistance. Specifically from the affordable warmth team, assistance includes fuel debt advice, energy efficiency, switching suppliers, available grants for insulation or heating repairs/upgrades, benefit checks, home improvement agencies or equivalent, support organisations and Green Deal/ECO advice and referrals. Of course many other services offered by partners are appropriate and compliment the affordable warmth aspects, so partners get far greater 'buy in' to services offered.

The aim of the network is to enable residents to keep warm and well in winter (and cool in the summer) by providing advice which enables long-term sustainability to each household's individual situation. There is often a combination of assistance required to achieve this, for instance; insulation to ensure heat is kept where needed, and the property is cheaper to achieve adequate warm, a benefits check to ensure that correct entitlement is being claimed, and education as to behavioural changes that can be made (at no cost) to ensure maximum efficiency of resources. The ultimate message it to ensure that people can continue to afford utility bills despite the upward trend in prices, and save carbon emissions where possible.

One of the keys to success has been wide partnership working, as this has both increased the spread of advice and services accessed, and enables more vulnerable residents to go to a local organisation that they trust, or are already in contact with, opening a door to a much wider remit of help and advice. The other key to success has been the 'on-the-ground' outreach activity that has been made available in the form of talks to local groups (including carers, Women's Institutes, lunch clubs, over 60's social groups, and Children's Centres), events, and front-line staff training (for example to district nurses, local authority contact centre staff, housing associations).

In the few months preceding Christmas, the outreach team feeds into existing campaigns such as the seasonal flu vaccination clinics, and electric blanket testing days, providing good targeting to residents in need. By using GIS data mapping of key indicators shown to have close correlation with areas at risk of fuel poverty, further targeting of effort to the most vulnerable of areas prone to being in fuel poverty has enabled maximum benefit under this network. Useful data sets include off-gas network regions (so have to utilise more expansive fuels for heating, such as electricity, LPG and oil), property type (for example those likely to have solid walls, so are harder and more costly to insulate), energy consumption data, and index of multiple deprivation, combined with local data sets.

Community groups have become interested and increasingly involved in promoting the project through the projects that they are undertaking, such as thermal imaging work. This effort is again fantastic, as the community groups are very enthused, are able to get the message out in person, and know to a greater accuracy than GIS mapping is likely to show which are the areas in their communities more likely to be struggling to afford gas (where appropriate) and electricity bills.

Although the drive from central government for local authorities to take action on energy and fuel poverty issues was largely removed in 2010 with the repeal of the National Performance Indicator framework, for many it still remains a priority area, despite funding cuts. Indeed, there are cost efficiencies to be gained by having a county-wide initiative, as well as the obvious benefits for the range of involved partners and associated reach to vulnerable residents.

There are obvious reasons why such work is important; not least because it would be morally wrong not to try to assist those residents most in need, or most at risk (typically around 90% of excess winter deaths attributed to excess cold are in the age group of 65 and over). For the National Health Service, such work is likely to represent a cost-saving, with less people being admitted to hospital as a result of health impacts from cold homes. And finally, fossil fuels are being depleted, the effects of climate change are already apparent and will become more so in time: all of us alive today must do what we can to ensure that the world inherited by our children is not damaged beyond what we can avoid. We must live in a more sustainable and energy-efficient way, reducing our reliance on unsustainable energy sources in order to avoid truly catastrophic consequences.

By following a simple energy hierarchy whereby unnecessary wastage is cut out (for example by insulating buildings and behavioural change), the remaining energy demand is used as efficiently as possible (through more efficient technologies) and lastly, as much of the final energy demand is sourced from renewable sources of energy. Government incentives have helped, such as Feed-in-Tariffs for electricity generating renewable technologies that have driven the photovoltaic (in particular) industry forward in the UK. The Green Deal, described by Greg Barker, Minister of State, as “the biggest home improvement programme since the Second World War” provides a whole new mechanism of gaining home energy efficiency improvements. This brings an end to grant funding such as the Carbon Efficiency Reduction Target (CERT), and instead allows full up-front costs in the form of low interest loans, attached to the electricity meter point of a house. Payback of the loan will come from savings that the household make, and must be fully paid off within a certain given number of years, depending on the technology installed. For people currently struggling to afford adequate warmth, a pot of funding called the Energy Company Obligation (ECO) will be made available to assist those most in need.

Implications for policy and practice

It remains to be seen how effective Green Deal will be, especially for residents struggling to afford adequate heating. It is clear that greater partnership working, preventative networking to try to prevent issues before they occur, getting the message out as to available assistance and a strong presence at a community level are all key elements to success.

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Tackling Energy Efficiency in Hard to Heat Areas

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Abstract

The future for Private Sector Housing departments will be about being able to demonstrate the positive public health outcomes of the work they do. Having an understanding of the type/condition of housing in their districts will help Local Authorities achieve this by identifying those areas where poor housing is affecting health. This paper discusses a targeted insulation promotion to identified hard to heat areas of the district. It demonstrates what can be done by Private Sector Housing departments working proactively with limited resources/time while working with partner organisations.

Introduction

The government's own Hills Review (2011) recently estimated that more people die because of cold homes than die on the nation's roads. However, in today's Private Sector Housing/Environmental Health resource limited world, it is all too easy to take a step back from Energy Efficiency and focus on the 'bread and butter' i.e. dealing with disrepair complaints or DFG cases. After all, where is the money/resource going to come from to finance an energy efficiency promotion? The problem is further exacerbated in predominantly rural local authorities where there is an absence of areas with high housing density to benefit from big money schemes such as CESP. However, rural communities have their own problems in the form of hard to heat/off gas homes due to the limited reach of gas supply in rural areas. Homes are potentially 'hard to heat' if they are of solid wall or non-traditional construction (i.e. non-cavity wall), or have no access to mains gas. Off-gas homes are likely to be more common in rural areas and in these homes, more expensive heating fuels may have to be used.

Older homes, primarily those built before the 1940s, are more likely to have solid walls, and tenants will normally face significantly higher heating bills in these properties because heat loss is greater than through cavity walls. For example, a solid wall home with minimal loft insulation, double glazing and electric storage radiators would have a SAP rating of 24.

Given that it is generally recognised that the best way to protect people against fuel poverty is with energy efficiency improvements, it is important to try to maximise the take up of these improvements for those households who are at the greatest risk of fuel poverty.

Background information

There have been many successful schemes run across the UK to promote energy efficiency grants. An example of a very effective scheme is the Kirklees Warm Zone Scheme which, between 2007 and 2010 installed insulation measures in 51,155 homes (Web 2). However, this scheme benefited from over 20 million pounds of funding from Kirklees Council, Warm Front and CERT, which many smaller more rural authorities with dispersed populations cannot hope to attract (In Central Bedfordshire, we have one Lower Super Output Area which is predominantly social housing).

The aim of this initiative is to show what a Private Sector Housing department can achieve without any additional funding by using its own local knowledge while working in partnership with other Council departments and various organisations. The catalyst for this initiative was the increase in CERT funding from large utility companies in January 2012. This is due to the deadline for the Government CERT targets placed on utility companies expiring in December 2012.

Many of the larger utility companies are not on track to meet their targets and are allocating additional funds to increase the uptake of carbon saving insulation measures. In particular, CERT funding for External Wall Insulation (EWI) has been increased to 100 % grants for vulnerable super priority groups living in off gas solid wall properties.

As a Council, we saw this as an opportunity to fight fuel poverty that was too good to miss.

Approach and methods

In order to take full advantage of this 100 % funding for external wall insulation (EWI), it was important for us to understand the make up of our private housing stock in terms of where the off gas/solid wall properties are located. Our research into the Council's private housing stock reports revealed that there was not much detailed information about where precisely these hard to heat properties were located. We knew the broad areas of our community that were off gas, but we didn't have the information broken down into ward boundaries that would enable a targeted promotional mail shot to be undertaken.

After some online research, it was apparent that this detailed information was freely available on the internet. The Rural Fuel Poverty website (Web1) provides detailed housing stock information produced by the Centre for Sustainable Energy on numbers and percentages of off gas and solid wall properties for all Council areas of England. Of particular use to us was that this data is broken down into wards. This information coupled with previous stock condition data and local officer knowledge helped target the hard to heat areas of our district.

Information from the electoral register provided a list of over 25000 properties located in wards with the highest percentage of off gas and solid wall. Access to Council Tax benefit information allowed us to identify 4500 properties where occupiers were receiving means tested benefits and therefore potentially eligible for 100 % grant for EWI.

A significant number of these 4500 properties were RSL properties, therefore it was important to confirm (prior to the mail out) that the RSL were happy for their residents to apply for these grant measures. Working in partnership, we advised the RSL about what we were doing and how the whole process would work. The RSL advised Aran Services that they would in principle agree to the installation of these insulation measures.

Although the Council was not procuring a service in the traditional sense, we were advised that we had to interview a number of insulation companies and undertake a quality assessment or mini procurement exercise to ensure that we selected the best offer for residents. Four companies were interviewed to ascertain the quality of service that they would provide and the best financial deal for residents. We selected Aran Services Ltd as they were the only company at the time who were providing a true 100 % funded grant for EWI.

Findings: evidence of health protection, improvement and promotion

The letters were sent to the targeted properties in April 2012. The take up of the insulation measures was slow but steady. The Figure 1 confirms total figure as of 31 August 2012.

Figure 1 – Completed installation as of 14 September 2012

| Measure resulted after survey | Complete |
|--------------------------------------|------------|
| Cavity Wall Insulation | 43 |
| Loft Insulation: Under 60mm Existing | 42 |
| Loft Insulation: Over 60mm Existing | 29 |
| External Wall Insulation | 0* |
| Grand Total | 114 |

* There are 5 applications submitted for Building Regulations

As much of the focus of this initiative was on tackling fuel poverty, it is interesting to note that 23 of the 42 loft insulation installations of virgin lofts (i.e. <60mm insulation thickness present) occurred in solid wall properties where the occupiers were receiving means tested benefits. It can therefore be reasonably deduced that 23 cases of fuel poverty have been alleviated. Furthermore, it can also be argued that 42 properties have had Category One hazards remedied for Excess Cold under the HHSRS.

Implications for policy or practice

This simple initiative demonstrates that it is important for a Local Authority to understand the condition of its private sector housing stock and where the most vulnerable are living, to inform a targeted promotional area based approach. The methodology of this type of proactive exercise will be important for Council's to get the most out of the ECO carbon saving and affordable warmth elements of the Green Deal where ECO funding is available for the most vulnerable and those living in hard to heat homes. Having the ability to access specific detailed housing stock information means that a Council can be a proactive partner, working alongside a Green Deal Provider, to gain control of where ECO funding can be used to help drive up energy efficiency standards.

Furthermore, demonstrating the links between poor housing and health will become more and more important from 2013 when Councils gain control of the Public Health budgets (via Local Health and Wellbeing Boards). Fuel Poverty, Excess Winter Deaths and Falls in the Over 65's are all Public Health Outcome Indicators as identified in the Department of Health's Outcomes Framework (DOH 2012). Local Health and Wellbeing Boards will have the power to direct Public Health funding streams to departments which can show they can make a positive impact on Public Health

In this case, the results show that fuel poverty and excess cold health hazards have been remedied. This information can be used to justify additional funding from public health budgets to spend on tackling the health inequalities linked to housing. It can also be uploaded on to systems such as the BRE HHCC Housing Health Cost Calculator to enhance the evidence of health improvement of this initiative by providing savings to NHS and society.

A council's understanding of the make up of their housing stock helps identify areas of poor housing; this energy efficiency initiative shows what a Private Sector Housing department can achieve without any additional funding by using local knowledge while working in partnership with other Council departments and various organisations.

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The new public health system in England; opportunities for joint working

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Introduction to subject

The Health and Social Care Act (HSCA) was passed in March 2012, following a troubled passage through the legislative system (Calpin 2011; Owen 2012; West 2012). Much of the news coverage around the provisions of the HSCA referred to controversial changes to the healthcare system, and there was relatively little media attention given to the public health provisions, which were generally welcomed (or at least not opposed) by both local government and NHS representatives (Local Government Association 2011; NHS Confederation 2011).

The HSCA requires that Health and Wellbeing Boards (HWBs) are in place in England by April 2013 and also that public health professionals currently located in the NHS are transferred to upper-tier local authorities. Some commentators (Killian 2012) have contrasted the new system with that prior to the NHS reorganisation of 1974, (when the majority of public health functions were transferred from local government) noting that different skill sets will now be needed.

HWBs are essentially committees of upper-tier local authorities; however, they are unusual in that statutory board members, including council officers (Directors of Adults and Children's Services and Director of Public Health), elected members, public representatives, and GPs as representatives of Clinical Commissioning Groups (CCGs) are all voting members. This is rare in a local government setting, where traditionally, officers advise and elected members make decisions at a strategic level.

Readers will note that neither environmental health (EH) nor housing services have a statutory place on HWBs; also that the EH profession sits at the lower-tier in two-tier systems, whereas HWBs are located in the upper-tier of local government. This potentially has implications for their visibility and how they will work and engage with others under the new regime.

Most upper-tier authorities have set up HWBs which have been operating in 'shadow' form from late 2011/ early 2012, these are known as 'early implementers' (Department of Health 2011). Shadow HWBs are not obliged to meet in public, but many do; from April 2013 when HWBs go live, this will be required.

HWBs will be charged with promoting joined-up working and tackling health inequalities; they will also be required to produce Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) for their areas (Department of Health 2012). Commissioning decisions made by local authorities and CCGs should be in line with the JHWS; in theory ensuring that health and wellbeing commissioning is undertaken to jointly agreed local priorities. Many shadow HWBs have their JHWS out for consultation at the time of writing (September 2012).

Relevant literature, policy and research

This area of health policy is very fast-moving and consequently much of the published material is opinion or based on short surveys, rather than on detailed empirical research.

There is a great emphasis in the government advice and guidance on the new arrangements as an opportunity for closer joint working between the health service and local authorities; however much of the rhetoric to date has been around integrating social services and NHS healthcare (Wistow 2011) rather than on the wider opportunities offered for joint working.

The majority of the literature and commentary on the role of environmental health in the new system has been produced by the Chartered Institute of Environmental Health (CIEH) in consultation with its membership and in response to various government documents (Chartered Institute of Environmental Health 2011; Williams 2012 1). The CIEH has lobbied for a statutory place on HWBs for the lower-tier districts and boroughs in two-tier systems (Milton 2011), and for a Chief EHO to be appointed, however this has not been successful to date (Wall 2011; Williams 2012 2).

Outside the CIEH publications, there has been very little discussion on the role of EH in the new system; however an ongoing research project (Dhesi forthcoming) has found that EH functions, including private sector housing are being discussed at some meetings and/or included in documentation such as JSNAs and JHWS published by some shadow HWBs. For a discussion of the early findings of this project in relation to how some HWBs are viewing EH and private sector housing, refer to the relevant chapter.

There has been a long history of initiatives intended to promote partnership working between local government and the health service which have faced challenges and/or not lived up to expectations in improving health outcomes (Smith, Bambara et al. 2009); these include Joint Consultative Committees (Humphries 2011), Health Action Zones (Glendinning 2002), Local Area Agreements and healthy settings (Dooris 2004). Challenges identified in these earlier initiatives include 'deep-rooted political, organizational and cultural barriers' (Evans and Killoran 2000). The new system faces additional issues around the transition of public health professionals; a background of public service funding cuts; and providing for the needs of our ageing population. Whilst there is optimism, there is some concern that HWBs could develop into 'talking shops' and fail to deliver their potential (Humphries, Galea et al. 2012).

Summary

Many people view the new public health arrangements as a fresh opportunity for greater joint working, particularly between professional groups which previously may not have come into contact. The roles of EH and private sector housing are not statutorily included as part of the system and will require professionals to make the most of opportunities locally to ensure their voices are heard. There is a need for all parties to commit to work in different ways if the new system is to deliver on its promise.

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I would like to acknowledge the contribution of Dr Anna Coleman, who commented very helpfully on drafts of this chapter.

Health and Wellbeing Boards and Private Sector Housing

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Abstract

This chapter outlines early findings of a qualitative research project exploring how health and wellbeing boards (HWBs) are tackling health inequalities, focussing on environmental health (Dhese forthcoming). The findings relate to an analysis of the pre-shadow and shadow periods of four HWBs and interviews with environmental health practitioners (EHPs) and managers. Early findings show that reference to private sector housing by HWB members and in documentation is patchy. Housing is established in the literature as a determinant of health and practitioners can and are making a case for their work to be recognised and supported by HWBs as contributing to tackling health inequalities.

Introduction / statement of the problem, issue being addressed or research question

The Health and Social Care Act (HSCA) (2012), has introduced significant changes to the healthcare and public health systems in England. One of these changes is the creation of HWBs in upper-tier and unitary English local authorities. HWBs will be expected to promote joined-up working and take action to tackle health inequalities, by producing Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) (Department of Health 2012), which will inform local commissioning decisions.

This chapter describes some early findings, in relation to private sector housing, of an ongoing research project exploring how HWBs are tackling health inequalities, with a focus on the role of environmental health (EH). The project is looking in detail at the development of four HWBs during the pre-shadow phase (to April 2012); shadow phase (April 2012- April 2013); and for a brief period when HWBs go live (April 2013 onwards). At the time of writing, HWBs are at the half-way-point of the shadow phase.

The legislation and guidance produced by the government so far has given little detail on the expected structure and functions of HWBs and early indications are that they vary greatly across the country (Humphries, Galea et al. 2012).

Background information or literature

Health inequalities have been acknowledged in the UK for many years, but as Mackenbach (2010) notes, the strategies tried so far to address them have been largely ineffective. This is generally a consensus view, summed up by the White Paper 'Healthy Lives, Healthy People: Our strategy for Public Health in England' which states that 'Health inequalities between rich and poor have been getting progressively worse. We still live in a country where the wealthy can expect to live longer than the poor' (Department of Health 2010).

There are many different theories on the causes of health inequalities and what should be done about them, however the current government subscribes to the 'lifecourse' approach advocated by Michael Marmot (Marmot 2010) in the 'Fair Society, Healthy Lives' review, to which the White Paper was a response. This approach suggests that 'health in later adult life may be a result of complex combinations of circumstances taking place over time' (Bartley 2004 :103) i.e. that there are a number of factors experienced throughout life, which can affect health. The lifecourse approach is reflected in many of the JSNAs and JHWS analysed as part of the research project.

Housing which is in poor condition or overcrowded, and circumstances of fuel poverty are well documented as determinants of health (Townsend, Davidson et al. 1988; Marmot Review Team 2011; World Health Organization Expert Group 2011) and fit with many of the theories relating to health inequalities, including the lifecourse approach.

Approach and methods

Qualitative methods are being used, comprising semi-structured interviews with HWB members and other relevant individuals; analysis of documents produced by or associated with HWBs; and observations of HWB meetings. The study design is in the form of longitudinal case studies, with additional interviews being carried out with environmental health practitioners and managers in England, to give some extra context.

Of the four HWBs being studied in detail, two are based at the upper tier authorities in two-tier systems and two in unitary authorities. These are located in the Midlands and North of England. The context interviews with EHPs and managers have been carried out in the majority of English regions. At the time of writing (September 2012), 39 interviews and 12 observations have taken place.

Analysis of interview and observation data has included coding thematically. Themes have been identified both inductively and deductively, i.e. being identified prior to data collection during the literature review and also arising from the data. Documents analysed include minutes of meetings, terms of reference, workplans, JSNA and JHWS documents, including drafts for consultation. Data collection and analysis is ongoing.

Results: recognising housing, health and wellbeing in HWB

The table below summarises the level EH and PSH involvement and recognition in four HWBs during the shadow and pre-shadow phases.

| Site 1- Unitary | Site 2- 2-tier | Site 3- 2-tier | Site 4- Unitary |
|---|---|---|--|
| Housing and EH head of service (and other non-statutory members) removed from HWB following local election and change of ruling party. Committee report, which included PSH as part of regulatory services offer was well-received. EH-supportive Director of Public Health (DPH) has moved on; relationships to be developed with new DPH. | EH representation by elected members and a chief executive. Focus is on healthcare and integrated care. Brief discussion of EH at one board meeting, and some functions have been included in the draft JHWS (including a section on housing). Some board members keen to discuss what EH can offer in research interviews. DPH very supportive -set up sub-for health protection, including EH reps. | EH representation on the HWB by elected members and directly on a sub-group. High level of support offered to HWB elected members. The Wellbeing agenda is supported, but the focus is on sports services at district level. Consultant in public health spends a day a week in lower-tier authorities. | No direct representation on board and no overt discussion of EH functions in meetings. DPH is supportive and has been working with EH outside the HWB structures. This is the only HWB in the project which is not yet meeting in public. |

Table 1. Shows a summary of Environmental Health and Private Sector Housing involvement and recognition in four HWBs

Below, several emerging themes are discussed, with examples from the data collected to date.

HWB members' awareness of housing as a health determinant

When asked about what they perceived health inequalities to be and what they thought should be done about them, some board members mentioned housing, whereas others did not. The following quote from a HWB member (site 2) shows an understanding of the role of housing in health and this is reflected in the draft JHWBs produced on behalf of the board, which includes references to both social and private sector housing conditions

'...housing is kept in a first world situation, not a third world situation and certainly some of our housing, as you've identified, is pretty damn poor; well people aren't going to get a good life out of that are they?'

Some HWB members showed a more detailed understanding of the work of EH in PSH; when asked whether they thought EH had a role in tackling health inequalities, a HWB member (site 3) responded

'I do, particularly district level, because of housing and because of the impact that they can have on, you know, looking at older housing and the work that they can do in getting it updated with heating, insulation, you know, all of those sorts of things.'

Responses so far have been mixed, with some HWB members showing a much more nuanced understanding of housing as a health determinant than their colleagues.

HWB members' awareness of EH role in PSH

There are also varied levels of awareness on the functions of environmental health practitioners in general and their role in PSH in particular. Some board members recognised housing as a determinant of health, but did not connect this function with the EH profession, which could be a reflection of local arrangements. The following quote from a HWB (site 2) member illustrates this point

'I've always thought the housing element was done by the housing officers...'

In particular, this appears to be the case with the administration of disabled facilities grants (DFGs), which perhaps links with the dominance of the 'integrated care' agenda discussed in the introductory chapter to this section. Another member of a HWB (site 2) was not familiar with DFGs in connection with EH

'DFG's are definitely going through heads of Housing.'

It seems that in some areas, PSH is not understood by HWB members to be connected with EH.

PSH and social housing

As with other emerging themes, there are mixed levels of understanding of the differences between social and PSH and several HWB documents refer to an ambition of achieving decent homes across tenures. Some HWB members have displayed a nuanced understanding of the issues; during an observation at site 1, a member said that whilst the authority have made huge strides in improving the quality of some council housing, they felt that this had led to the ignoring of the private rented sector and owner occupied properties in the area.

Gaining recognition

As HWBs are in their shadow stage, which is a time of development and change; members have been asked in interviews what changes they would like to see over the next year as HWBs go live. A HWB member (site 2) responded

'I think, it's really damaging not to have Environmental Health and not to have Housing represented around the table. That, I think, is a real disadvantage for us.'

This is one example of recognition amongst HWB members of the role EH and housing professionals can play in the new system; even where they are not represented on the HWBs or in sub-structures, there are people willing to be persuaded of the case for involvement.

This, however, should be contrasted with site 1, where following a change in administration at local elections, the Housing and EH director was removed from the shadow HWB along with other non-statutory members. Prior to this reorganisation, a committee report was taken to one HWB meeting (site 1) outlining the regulatory services offer, giving practical examples of initiatives undertaken by the directorate; including a project dealing with 'rogue landlords'. The report was well-received by members, with a key HWB member expressing their 'wholehearted support'.

Where EH and PSH professionals do not have a place on the board or sub-structures, some have achieved recognition for their services by contributing to the draft JHWBs, as one HWB member (site 2) describes

'To be fair, I don't know about the Environmental Health bits, but, certainly, the Housing aspects, we really nudged colleagues to get involved and to do something and, to be fair, they jumped at the chance'

(See also the Liverpool chapter in this section for a detailed account of a successful case for funding for PSH interventions in tackling health inequalities.)

Implications for policy or practice

Readers will see that the results of the project so far show a mixed picture in the understanding of EH and PSH roles, and their different levels of involvement in the new system. HWB members and support officers, especially those based in upper-tier authorities, may not be fully aware of the health and social issues associated with PSH and their access to professionals who can help tackle them. Several examples do show, however, that practitioners working in PSH have a new opportunity to showcase their work to HWBs to achieve recognition in the wider public health community for their role in tackling the wider determinants of health.

The initial findings of the research indicate that HWB members are often willing to listen to and act on arguments that are effectively made; that demonstrate the impact investing in PSH work can have on the health of the local population; and that offer constructive solutions to local challenges, in-line with the JHWS priorities. PSH practitioners can and are being heard by HWBs, but they need to proactively and effectively set out what they can offer. Thought also needs to be given to whether the case can be better made in conjunction with environmental health colleagues where housing services are separate, and also with trading standards colleagues, as a 'regulatory services' offer.

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Further reading and websites

For a clear and helpful introduction to the literature on health inequalities see Bartley, M. (2004). *Health Inequality: An Introduction to Theories, Concepts and Methods*. Cambridge, Polity Press.

Wirral Healthy Homes

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Abstract

The Joint Strategic Needs Assessment provided an effective partnership based starting point for integrating and evidencing housing's contribution to the health agenda, together with establishing the right contacts and having access to relevant and up to date intelligence, which Wirral was able to produce through the Housing Strategy Team and Public Health Intelligence Teams. Wirral's Private Sector Housing Team have established regular engagement with the Director of Public Health as well as GP Consortia Commissioners and the GP Forum through updates and stakeholder events to raise the profile of the scheme. This is even more vital to demonstrate how the scheme links in with the new Public Health Framework and how, through the partnerships which Healthy Homes have created we should be able to help assist the local authority to meet it's duty to improve the health and wellbeing of Wirral residents, by linking with the Fuel Poverty, Excess Winter Deaths and Statutory Homeless indicators.

Introduction

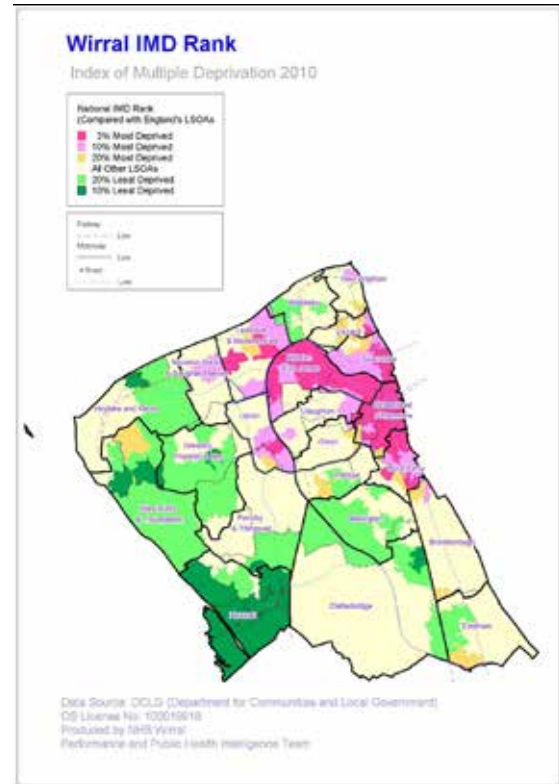
Reducing health inequalities required effectively partnership working and a consideration of the wider determinants of health. This, combined with the need to be cost-effective and focus on prevention, means that new approaches to delivering public services must be considered and adopted (Marmot 2010). The core theme is the need to ensure we respond to the different needs and aspirations of individuals and communities, enabling residents to thrive and achieve their full potential by working to narrow the inequalities gap and supporting a more diverse population in the future.

The catalyst for initiating Wirral's Healthy Homes project was a forum on improving the health and wellbeing of the residents of Wirral the chair of the group was the newly appointed Director of Public Health. A brief summary of what Healthy Homes was trying to achieve was sent to the Director of Public Health and in January 2010 Private Sector Housing Officers gave a presentation to the Director of Public Health demonstrating how a Healthy Homes initiative could help improve the health and wellbeing of the vulnerable residents of Wirral. A Building Research Establishment (BRE) toolkit was used to demonstrate the financial impact of hazards on the home on NHS primary and secondary care budgets.

Wirral Context – Evidence Base for Healthy Homes

The main causes of health inequalities are income inequality and poverty, education, living environment, employment and lifestyle behaviours such as smoking, obesity and excessive drinking. The Healthy Homes programme aims to improve people's health outcomes by tackling the root causes of health inequalities and uses evidence based on the Health Evidence Network (HEN) (WHO, 2005), Centre for Sustainable Energy report on Fuel Poverty and Ill Health (Barker, 2001), HHSRS (ODPm, 2006) and BRE cost benefit analysis modeling too (Davidson et al, 2010). While the Council has a statutory duty to respond to complaints regarding poor living conditions, recent evidence from complaints received compared to residents helped via healthy homes has shown that many of the most vulnerable residents are unlikely to report poor housing conditions.

Map 1. IMD Ranking 2010



Map 1 shows the areas in dark pink as ranking the worst in terms of Indices of Multiple Deprivation (IMD) 2010 which combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score. These areas are closely mirrored by the IMD Health Ranking

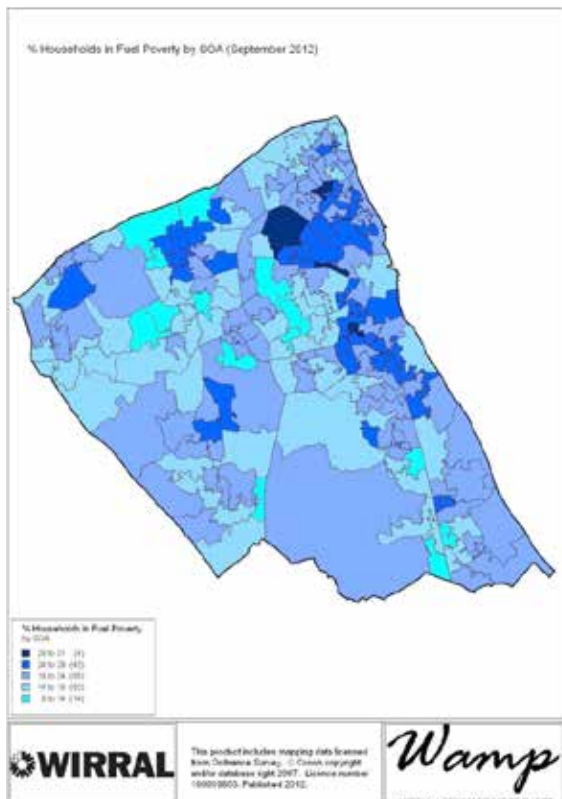
There is also a strong correlation between poorer quality accommodation and concentrations of excess winter deaths. This is because in the target area, over 57 % of category 1 hazards relate to excess cold and lack of thermal comfort, with a further 33 % relating to falls. These two issues account for over 90 % of hazards and will inevitably contribute to increased pressure on frontline health services.

The highest rate of non-decency is for households where those aged between 75 to 84 years at 65.0 %, the next highest being for households aged 85 years or over (57.1 %).

The target area has, on average, a 16 % higher death rate in the four Winter months (December to March) than in the rest of the year. While fuel poverty (map 2) (spending more than 10 % of household income on fuel) is much more prevalent in the most deprived areas-darker blue, excess winter deaths are not especially more prevalent. (JSNA)

Poor housing is associated with ill health. Around 39 % of private housing stock in the Wirral area is estimated to be non-decent, with the main hazards being excess cold, falls on stairs or electrical hazards (based on the Private Sector House Condition and Home Energy Survey, Wirral Council, 2008). The costs of illnesses from cold and damp housing conditions to the NHS are estimated at over £0.6 billion per year (Davidson et al, 2010) .

Map 2. Fuel Poverty Index by SOAs 2012



People’s health and wellbeing is influenced by many factors, such as income, employment, education, housing and transport. Despite improvements in life expectancy nationally, there are wide differences in people’s health outcomes. This is particularly apparent in Wirral where life expectancy in parts of west Wirral is 9 years more than someone living in Birkenhead in the east⁷

Approach and methods

On the 20th September 2010 a stakeholder event was held to outline the new Healthy Homes initiative. The Council with Wirral NHS, Merseyside Fire & Rescue Service, Merseyside Police and a number of Community and Voluntary Sector agencies launched the pilot scheme in New Brighton which aimed to reduce all hazards in the home that could affect the health, safety and wellbeing of residents.

The first target area, Victoria Parade, had around 1000 homes. Households were offered a free home safety check and advice given where necessary to point out any hazards that need to be removed to make the homes safe. During the pilot a steering group was set up to oversee the scheme. Initially the project sought to engage vulnerable residents through a door-knocking exercise and single assessment survey to signpost residents to a number of partner agencies on a street by street basis.

This was successful but due to recommendations gathered from the Health Impact Assessment, Wirral are now working with the more vulnerable groups utilising the knowledge and existing relationships with frontline staff from e.g. Drug and Alcohol Team, Children’s Centres, Social workers, POPIN (Promoting older peoples independent network), Occupation Therapists, District Nurses, Health visitors and other health professionals. Wirral have also started working with the Fostering Team where we have been undertaking Healthy Homes surveys for new and existing foster carers to ensure that the home is safe for children and young people to live in.

Healthy Homes looks at a more holistic response to the full range of home based hazards and has developed a referral network of individuals experienced in working with vulnerable people. The scheme relies on effective inter-agency working and the development of a simple single assessment form which refers in services such as fire safety checks, home improvement agency support, energy efficiency grants, adaptations, the handyman scheme and health services as well as full housing inspections where serious hazards are identified. Using these interventions will go some way to addressing the underlying causes that contribute to health inequalities and low life expectancy; it will also improve the health and wellbeing of those involved. Healthy Homes aims to:

- Remove the main building-related hazards in the home for the most vulnerable households (e.g. young children and older people)
- Improve living conditions and health and wellbeing
- Prevent deaths, hospital admissions and GP consultations linked to poor housing
- Reduce health inequalities

The referrals that are made as a result of the healthy homes visit could result in:

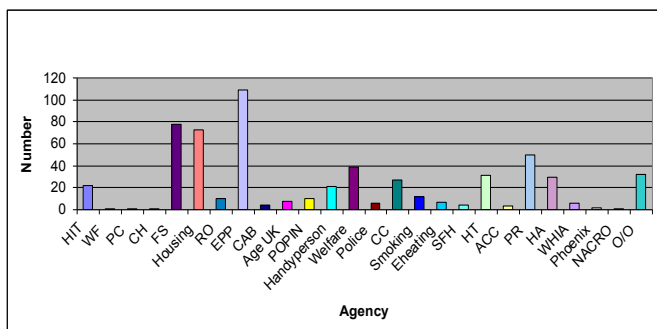
- Housing Health & Safety Rating System visits which can reduce 29 hazards in the home which will reduce GP contacts & hospital admissions
- Fire Safety visits in vulnerable properties can reduce accidental house fires and related injuries
- Employment and training initiatives can improve mental health and wellbeing
- Benefits advice can enhance income, another key health determinant
- Police Home Safety Advice will improve perceptions of security in the home and community safety
- Energy Efficiency improvements will reduce Fuel Poverty and are often free for vulnerable groups- Excess winter deaths
- Specialist support for vulnerable groups through POPIN, Handyman Scheme, Disabled Facility Grants and adaptations.
- Referrals to Smoke Free Homes / smoking cessation will impact on many key target areas
- Referrals to Health Trainers to improve fitness and healthy eating

Evidence of health protection, improvement and promotion

Since Healthy Homes started back in 2010 Wirral have completed 836 surveys and made 966 referrals to partners. 184 referrals were made to Energy Projects Plus for assistance with loft and cavity wall insulation, energy efficiency advice along with assistance to reduce help fuel bills and thus reduce fuel poverty. 130 referrals were made to the Fire service aimed at reducing accidental house fires and related injuries.

A total of 138 referrals were received for assistance to remove hazards in the home that could cause an accident or contribute to ill health and improve property standards, this was comprised of 58 owner-occupiers and 80 private rented tenants. Referrals from health professionals including GPs ensure that our resources are focussed on assisting those most vulnerable.

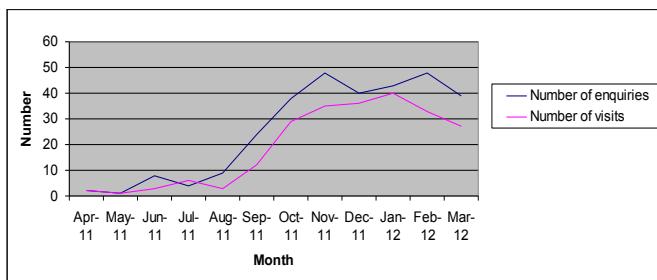
Graph 1, The referrals made to partners following a healthy homes survey April 2011-March 2012



Wirral have been working hard to establish good working partnerships to receive referrals for assistance through Healthy Homes from key front line staff including health professionals. A number of training presentations have been provided throughout the life of Healthy Homes. Healthy Homes have provided presentations to Private Sector Housing, Environmental Health, M.F.R.S (Merseyside Fire & Rescue Service), Energy Projects Plus, Reachout, Wirral Handyperson Scheme, Age UK Wirral, District Nursing Team, Health Visitors, P.O.P.I.N (Promoting Older People's Independence Network), DASS (Department of Adult Social Services) –Home-start Wirral, Besom in Wirral, Support workers from Wirral Drug and Alcohol Teams, Housing Associations within Wirral, Health Trainers, the Occupational therapists team, the GP forum, tenancy support teams providing support to those with drug, alcohol or mental health issues, Social workers and support worker from Children Centres and Wirral's fostering team.

The highest number of referrals was from Health Visitors with 73 last year, the Fire Service, support workers from the Drug and Alcohol Team and Children Centres. Targeting front line staff dealing with particularly vulnerable clients has enabled Wirral to provide help to those who need it. It has been noticed that once a presentation has been carried out the number of referrals has increased by 50%. We have also received a number of referrals from those agencies who are providing support to residents who have been taken into hospital due to ill health or injury and they require assistance from Healthy Homes to enable the residents to return home.

Chart 2, The ages of the residents who benefited from a healthy homes survey April 2011-March 2012



Graph 2. The number of referrals received and the number of visits carried out March 2011-March 2012

The referrals have increase 10 fold from the same period last year and now average 40 a month.

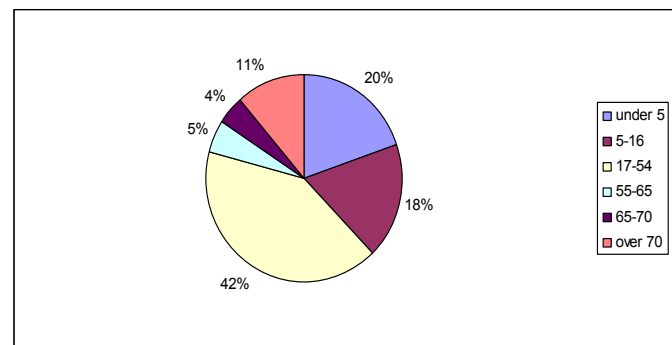
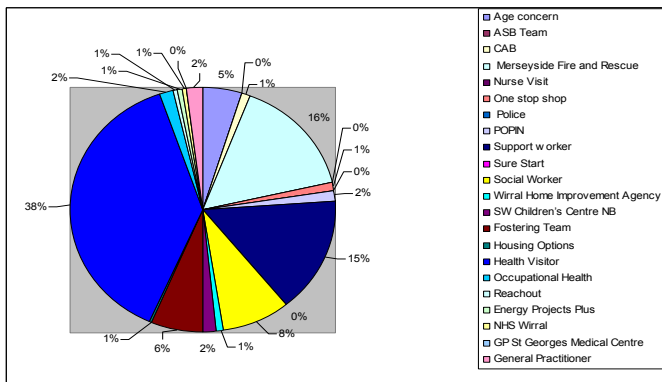


Chart 1 The number of referrals which have been made April 2011-March 2012.



Wirral carried out a total of 226 Healthy Homes visits in 2011/12 and helped a total of 393 residents in Wirral. The biggest age group was 17-54 year olds second was the under 5's and 15% were over 65 years old. The profiles of those residents that we are currently helping and those that we intend to help will change with the start of the Safe and Warm in Winter Campaign which will target those who are more vulnerable to cold weather. It will link in with the cold weather plan, the new Public Health Frameworks and the Department of Health funding for Warm Homes Healthy People.

The tenure break down for the surveys carried out is Owner occupied- 36.9%, Private rented- 38.1% and Housing Association- 25%. We have been working closely with Wirral partnership Homes and Riverside so that they are aware of Healthy Homes and what benefits it can bring to their tenants.

Campaigns, partnerships and future projects: a summary

- Wirral's Stay Safe and Warm Campaign linking in with the Cold weather plan – established in 2011 and delivered via more referrals to Healthy Homes to ensure a more coordinated approach, including community networks such as the Wirral Foodbanks to engage with “hard-to-reach” and at-risk households to Warm Front and other grant regimes.
- Community Resilience - a new initiative to respond to Cold Weather alerts using a new network of 500 Wirral Emergency Volunteers to target the most vulnerable groups and offering pathway clearing, service delivery, shopping and help with medical appointments
- Immediate safety in the home - emergency heating can be provided by the Fire Support network to homes along with a CO detector if gas appliances are present, a winter warmth pack, a fire safety check and smoke detectors and a check for loft insulation (some at no cost to the scheme) and support through Health Through Warmth for more permanent heating solution referrals.
- Winter Preparedness - working with Age UK Wirral and their home from hospital service (currently assisting 75 residents), providing support for a month to those over 60 returning from hospital to carry out daily chores), Wirral Foodbank, POPIN (Promoting Older People's Independence Network) and the Wirral Healthy Homes Team, the fund will pay for Winter Warmth Packs which will be distributed through their networks of befrienders, volunteers and centres.
- Improving Awareness - Local fuel poverty charity Energy Projects Plus will deliver an affordable warmth training package to housing association front-line staff and provide home visits with advice on energy efficiency, fuel tariffs and benefit entitlement checks alongside affordable warmth training to Age UK volunteers as well as home visits to identify any energy efficiency improvements needed and refer the client onwards to appropriate grants and loans.
- Wirral's Fostering Team – to support the team in Healthy Homes visits for foster carers to support Wirral's child poverty agenda and ensure vulnerable children are protected in their temporary homes, with 71 Healthy Homes reports have been between April 2011 and March 2012.

Implications for policy and practice

The Public Health Framework 2012-2016 provides for further ways of aligning health and housing and against a background financial austerity and reductions in the voluntary sector, this successful, sustainable project grew out of a Health Impact Assessment, led by Wirral Council staff, with assistance from IMPACT, University of Liverpool, health commissioners and providers, local primary care organisations, the voluntary sector, Police and Fire and Rescue Service enabling better evidence-based decision making.

As a result of the systematic health impact assessment approach, talks are being held with clinical commissioning groups. This project is an exemplar of community asset-based ways of working in line with both the localism agenda (a UK coalition government policy) and health policy agenda. This has been achieved by aligning and re-focussing existing resources with minimum additional funding £25,000 p.a for a Healthy Homes referral co-ordinator, whilst providing significant savings to frontline health services.

The scheme has been described as an outstanding example of targeted partnership working providing access to a wide variety of services including health services to the most vulnerable residents, with minimal funding during a period of significant public sector cuts. (International Health Impact Assessment Consortium, University of Liverpool).

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Wirral Joint Strategic Needs Assessment (JSNA), Health and Wellbeing in Wirral

Useful Websites and other Sources

Health Evidence Network (HEN) is a network of organizations or institutions promoting the use of evidence in health policy or health technology assessment.

<http://www.euro.who.int/en/what-we-do/data-and-evidence/health-evidence-network-hen>

Centre for Sustainable Energy <http://www.cse.org.uk>

Cornwall and Isles of Scilly, Strategy to reduce Health Inequalities 2011-2016, Good Health and Wellbeing for everyone

Department of Health, 2010, Our health and wellbeing today, supporting evidence, London

Luton's Partnership- Strategy to reduce health inequalities: 2010-2026

Wirral Council, Housing Strategy 2011-2026

Home Improvement Agencies – helping vulnerable, disabled and older people to live independently

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Abstract

Since the early 1980s home improvement agencies (HIAs) have played a major role in assisting older and disabled people to live independently, safely and in comfort. Currently there are about 200 HIAs in England; in Wales, Care and Repair Cymru provides a network of 22 agencies, one for each of the Welsh county authorities. Every year HIAs in England deal with around 200,000 enquiries and process at least £60 million of disabled facilities grants and a further £128 million of repairs which are funded through owners' contributions, low interest loans, grants and charitable contributions. HIAs are the largest providers of handyperson services which undertake up to 125,000 jobs per year. Some HIAs are run as independent charities, others are provided by national charities such as Age UK, or registered housing associations and increasingly locally by the district council or London Borough as part of the councils' private sector housing teams. HIAs are being forced to diversify and scale down their services as the government withdraws virtually all central funding.

Background and history

Home improvement agencies are now an integral part of local services to assist vulnerable people stay living independently in a comfortable healthy home. They are unique as they provide comprehensive housing services while being run on a voluntary basis. Late in 1978 a pilot scheme was established in Ferndale in the Rhondda. It was sponsored by Shelter and HACT (Housing Associations Charitable Trust) and supported by the Labour Government's Manpower Services Scheme (MSC). Ferndale 'Patch and Mend' provided a small repairs service to poor older owner occupiers where the labour was provided free but the client paid the cost price for materials. At the same time Anchor Housing Trust had set up a series of pilot schemes to use the house renovation grant system to assist older people to carry out essential repairs and adaptations. By 1985 there were more than 200 small housing agencies and Shelter, HACT and Anchor Housing Trust decided to set up a national organisation to promote and coordinate the newly formed projects. Care and Repair Ltd. was registered as an Industrial Provident Society (IPS) in 1985. At that time thousands of older people were living in homes which were damp, unhealthy and dangerous; many lacked basic amenities such as hot water and an indoor toilet. The majority of these poor quality or 'unfit' homes were owner occupied and renovation initiatives had failed to reach this particular age group.

In 1985 the Inquiry into British Housing, chaired by the Duke of Edinburgh (See Joseph Rowntree Foundation, 2002), published its report. One of the key issues noted was the need for support for low income home owners living in poor housing, given that the vast majority of unfit housing was located in the private sector.

By 1986 Government was taking an interest in the HIA initiative. There was growing recognition of the implications of the ageing of the population and in particular the increase in the proportion of 'older old' people living in their own homes. The Government of the day was keen to promote the benefits of owner occupation, but successive local and national surveys of the condition of the housing stock revealed the continuing over-representation of older people in poor standard owner occupied housing. A government policy response to this situation was called for and later in the same year the Department of the Environment allocated to Care and Repair Ltd. one million pounds to fund the development of 25 new schemes over two years on a pound for pound basis.

So began one of the major housing success stories of the 1990s. HIAs spread rapidly and Care & Repair Limited built a coherent movement leading to the awarding of a 4 year contract by DoE to act as the national co-ordinating body for HIAs in England and again for 1996-2000. By the year 2000 over half of England and all of Wales had a local HIA.

The policy impact years of 2003 to 2009 resulted in Care and Repair, England having a high profile with successive housing ministers. This resulted in joint work on the production in 2008 of the first ever national housing strategy for an ageing society, Lifetime Homes, Lifetime Neighbourhoods (DCLG, 2008), the content of which reflected much of the work of Care & Repair England over the previous 20 years. It created the stimulus and funding for handyperson services, support for provision of housing options advice and information and more money for home adaptations as well as a high profile for home improvement agencies in general.

Despite all of this positive development, there continued to be slow progress in improving private sector housing conditions for older people compared with the strides forward and large scale investment in making homes decent in the public sector. This resource shift was underpinned by a change in the policy position of the government of the day which did not support state assistance to help low income older home owners living in non-decent homes. The view that older home owners have an asset that they should use to meet their financial needs, primarily through equity release, was and continues to be pervasive.

The global financial crash in 2009 and the election in 2010 subsequently transformed the operating environment. Since the conception of HIAs in the 1980s, they have received much of their funding support from local housing authority (LHA) private sector housing renewal funds (PSR). This budget, first created in 1949, was available annually until 2010. In the financial years 2007/08; 2008/09; 2009/10 the government allocated to English LHAs £1.07 billion for private sector renewal. Under CSR/10 between 2010 and 2015 the budget for private sector housing renewal is zero. There is unlikely to be a further comprehensive spending review until 2015 and no one is optimistic that this 60-year old budget will be restored. It is in this financial climate that HIAs must now work for the foreseeable future.

The Modern Home Improvement Agency

As described earlier there are many different models of home improvement agency. The earliest HIAs established in the mid-1980s tended to be independent IPS' with their own management committees. Some were set up under the auspices of housing associations; the biggest being Anchor Staying Put which operated under a regional structure. At one time there were more than 90 such Staying Put HIAs.

Until 2003 individual HIAs had been part funded by the government through the national co-ordinating body which until 2000 was Care and Repair, England and between 2000 and 2003 was Foundations, an offshoot of CEL Ltd. based in Glossop in Derbyshire. In 2003 the government set up the 'Supporting People Programme' (SP) which provides housing support to vulnerable people. The finance from central government comes via the Welfare Authority (now Adult Services). The money has been protected by a 'ringfence' but this is being removed in 2013. In 2010/11 the baseline SP figure was £1.636 billion, but 2014/15 this will have reduced to £1.59 billion (DCLG, 2012), with no increase for inflation. It should be noted that only a very small part of the budget goes to support HIAs. The Supporting People finance is allocated through contracts which can be for anything between one and four years.

HIAs augment their budgets in many ways. For more than 25 years local housing authorities have used some of their housing capital to support local HIAs. Traditionally HIAs have been able to charge fees for work with this money being taken from part of any home improvement or disabled facilities grants. From April 2010 this housing capital allowance has ceased making it very difficult for LHAs to support local agencies. This has resulted in many HIAs closing or being forced to merge with neighbouring services and scaling down operations.

HIA Services

Figure 1 describes the structure and services of Bristol Care and Repair. This independent award winning HIA was established and registered in 1986 and is generally accepted as one of the top five HIAs in England. Earlier in 2012 the four unitary authorities, Bristol City Council, South Gloucestershire, Bath and North East Somerset, and North Somerset decided to go out to tender to select one HIA to cover the Bristol and Bath conurbation. West of England Care and Repair (WEC&R) (formerly Bristol Care and Repair) were successful in winning this four year contract. This is the longest contract yet commissioned in any part of the country. The services provided by a generic HIA are as follows.

- Visiting clients at home or providing detailed telephone advice;
- Setting out housing options to help clients decide what type of housing is best suited to their changing needs;
- Checking entitlement to any financial help, including grants, loans and charitable funding;
- Project management, drawing up plans, getting estimates and liaising with others involved in any building work needed, such as EHPs, grants officers and occupational therapists;
- Provision of handyperson services, to carry out small jobs around the home, help with gardening, or coming home from hospital. This includes identifying potential hazards around the home to prevent falls and maximise home safety;
- Helping to make homes more energy-efficient.

Handyperson services

Evidence consistently shows that older people place great value on services that offer them 'that little bit of help' and enable them to remain living independently in their own homes. Handyperson services are perhaps one of the best examples of 'that little bit of help', assisting older, disabled and vulnerable people with small building repairs, minor adaptations such as the installation of grab rails and temporary ramps, 'odd' jobs (such as putting up shelves, moving furniture), falls and accident prevention checks, and home safety and energy efficiency checks.

Handyperson services were first set up in the UK by the charitable sector in the early 1980s with the aim of improving the quality of older people's lives by improving their housing conditions. There is a range of funding sources for handyperson service including Supporting People, adult social care and health services.

In 2009 the Department for Communities and Local Government (DCLG) introduced additional funding for handyperson services to enable local authorities to develop new services or expand existing services. However, as part of the cuts in CSR10 the finance available for 'handyperson services' has been cut by almost 50% between 2010 and 2015 from £20 million in 2010/11 to £10.5 million in 2014/15.

A typical handyperson service will provide:

- Small building repairs;
- Minor adaptations (such as installation of grab rails or temporary ramps);
- "Odd" jobs (for example, putting up curtain rails and shelves, moving furniture);
- General home safety checks with remedial action (for example safety checking or repairing/replacing appliances);
- Falls/accident prevention checks with remedial action (for example, securing loose carpets or putting up grab rails);
- Security checks with remedial action (for example, checking and replacing window and door locks);
- Energy efficiency (for example installing low energy light bulbs, draft proofing);
- Signposting clients to other services.

Implications for policy and practice

HIAs are making a major impact in reducing the number of privately owned or privately rented homes that are cold and in a non-decent condition. Each year thousands of older, disabled or poor people have their homes improved to a warm, safe and healthy standard by their local HIA. They provide excellent value for money and all HIAs are non-profit making. Many EHPs continue to play key roles on the management committees of the 200 HIAs operating in England. Currently the Director of Care and Repair Cymru is an EHP as is the Chair of Care and Repair, England.

There is no doubt that the future of HIAs nationally is threatened by huge cuts in the housing and supporting people budgets. The demise of private sector renewal funding has resulted in a large number of well established home improvement agencies. There are no indications that funding will improve in the foreseeable future.

Figure 1

Bristol Care & Repair Home Improvement Agency (now WE C&R)

Established in 1986, Bristol Care & Repair is a charitable organisation that helps the elderly, vulnerable & disabled to live independently in their own homes in warmth, safety and comfort. A small selection of the current range of services is shown below:-

1) Handyperson Service

Our Handyperson service provides you with the practical help you need to undertake smaller repair and renovation jobs around the home. Our team of Handypeople are all experienced and multi-skilled tradespeople.

You can ask for essential repairs, such as fixing a toilet that won't flush or repairing a lock. We also do some of the 'nice to haves' such as fitting a shelf or hanging pictures. Some of the work is free and for some there is a charge. Contact us for more information.

In 2011/12 The HIA completed 7,822 handyperson jobs.

2) Larger Repairs

As well as our Handyperson service we also take on larger repair jobs - work that can take more than half a day to complete. If you have a problem with your home our repairs team can help you find the best way to fix it. Larger repairs could include:

- re-roofing
- re-wiring electrics
- central heating work
- dealing with rising damp and penetrating damp
- replacing doors and windows
- repairing uneven paths and steps.

In 2011/12 the caseworkers gave practical advice to 3,370 people, this resulted in 576 completed major jobs these included major repairs and adaptations at a total value of one million pounds.

3) Housing Options

We specialise in helping older people, and disabled people of any age, choose the most suitable place to live. We work with homeowners and private tenants across Bristol. Housing choices can be complicated and we provide the advice and practical support you need. For example, we can:

- arrange to visit you at home to talk things through
- give advice on all of your options, including: staying where you are buying or renting moving to retirement, sheltered or residential accommodation
- help with forms and paperwork
- provide ongoing support through the moving process until you are settled into your new home.

Sources: extracted from a variety of documents that can be viewed at www.wecareandrepair.org.uk

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- DCLG (2008) Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society (Feb 2008) Online available www.communities.gov.uk/publications/housing/lifetimehomesneighbourhoods
- DCLG (2012) Local Government and the Spending Review, 20th October 2010, London: DCLG
- Joseph Rowntree Foundation (2002) Inquiry into British Housing 1984-1991, York: JRF (The first report of the 'Inquiry into British Housing', chaired by the Duke of Edinburgh published in 1985 is no longer available but a later version is available online from the Joseph Rowntree Foundation at <http://www.jrf.org.uk/sites/files/jrf/HousingInquiry.pdf>)

Linking Housing & Health - Well at Home Project, Westminster.

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Abstract

The link between housing and health is now well-established, and evidence illustrating this direct connection is increasingly available. However, joint work between housing and health services based is still uncommon, despite the potential benefits for occupiers of residential accommodation. Westminster Council and NHS Westminster (PCT) worked together to target vulnerable householders in older, poorer housing to improve their health. This collaboration was NHS funded through a project entitled 'Well at Home' (WAH). Through this work, 108 additional households benefited from property improvements following 413 healthy home surveys. The cost savings of completed interventions was calculated at some £39,210 per annum, but projected savings including ongoing cases was estimated at £70,000 p.a.

Introduction

In March 2009, NHS Westminster agreed to invest £320k of non-recurrent funding over 2 years to employ 3 additional Environmental Health Officers (EHOs) and a health promotion nurse (HPN) to enable collaborative working on housing and health issues, through the WAH project.

The aim of WAH was to co-ordinate service delivery between Environmental Health (EH), housing and health services in known local areas of deprivation as part of a holistic approach to tackling health inequalities through tackling one of the wider determinants of health – housing.

Vulnerable householders are at particular risk from potential health hazards caused by poor housing conditions. They also have the greatest exposure to many common home hazards due to the longer periods they spend indoors. For example, very elderly householders are more susceptible to any Excess Cold hazard at home, due to poorer blood circulation.

Westminster has predominantly older housing stock, over half (53 %) of which is privately rented; much higher than the national average (15 %). At the same time, the Borough has both very wealthy householders, and some of the very poorest, with some markedly deprived areas up in the north-west, north-east and very south of the City.

The WAH project was based in 3 of these geographical areas, and aimed to work collaboratively with existing Local Area Renewal Partnerships (LARPS in each of these locations. The LARPS were funded by regeneration funding from central government via the Westminster City Partnership comprising Westminster City Council, NHS Westminster (PCT) and other key partners. Prior to the WAH project, LARPS had already been established for several years at a neighbourhood level, undertaking community regeneration initiatives. The 3 areas targeted by the project were Church Street, South Westminster and Westbourne.

In the Church Street area, there was a high proportion of rented accommodation (80 %), mostly social housing (71 %) provided by the Council or housing associations. Half of the resident population were of an ethnic minority origin. 40 % of the working age population were economically inactive, with 19 % registered as having limiting long-term illnesses. Life expectancy for males and females was some 8 years below the average for the Borough.

South Westminster was an area of contrast with extreme wealth and poverty sitting side by side. Over half of the housing there was social stock, the highest densities of which were on 2 local Council estates.

The area has the lowest life expectancy rates for women in the Borough, and high levels of income deprivation affecting children.

In Westbourne, again over half of residents occupied social housing, with the highest number of children of any Ward in the Borough, with many of those living in workless households. Take up of lone-parent benefits was also the highest in the City. Self-reported health was the worst in Westminster with 15 % of residents indicating that their health was "bad" or "very bad". Self-reported health was captured as part of the Westminster City Survey of all residents carried out in 2007.

In each of these areas, the aim was to adopt a proactive approach in engaging both residents and service providers, in order to facilitate home visits where a holistic assessment of the occupier's health could be undertaken; this comprised both an assessment of the home environment, and of the personal health & well-being of residents. The latter was carried out through confidential health interviews, and simple health checks e.g. blood pressure.

Background

The WAH project was expected to build on the work of several previous health and housing related projects all funded by Westminster NHS, to help tackle health inequality in the Borough. 3 previous projects involving Residential Environmental Health had been funded by NHS Westminster on the theme of housing & health; the One Point of Access to Health project, the Public Health project and the Healthy Futures project. These earlier projects had piloted collaborative working between a range of local partners to facilitate the referral to the Council of vulnerable households in poorer residential accommodation, in specific geographical areas.

Such households were offered a healthy home survey by an EHO to identify any potential health hazards that might be impacting occupier's health arising from property deficiencies. The underlying principle being that any residential premises should provide a safe and healthy environment for any potential occupier or visitor. Where hazards were identified they were assessed for risk using HHSRS methodology for the evaluation of health hazards at home.

Partnerships were managed through Development Groups for each project phase; these groups formed an important vehicle for information exchange, training, innovation, project development and monitoring of delivery. They inherently included the local LARP partnership and a range of other service providers, including representative 3rd sector organisations and various NHS staff.

A key part of all of these projects was educating and informing other front line health and housing services of the link between housing and health, and of the services available from Environmental Health to mitigate health risks at home. Generally, there was widespread ignorance as to the range, or scope, of services provided by the local authority.

Approach and methods

The WAH project work undertook 4 main activities:

- Healthy home surveys for residents, delivered by EHOs.
- Health & Well-being checks for residents delivered by the HPN.
- Promotion and education amongst partners and other services.
- Development of referral mechanisms between community, health and housing services.

Proactive outreach to residents within their homes was originally attempted as a way of identifying vulnerable householders in a tight geographical area chosen by analysing multiple deprivation data at Enumeration District (ED) (neighbourhood) level from the Office for National Statistics (ONS). This included delivering promotional leaflets, door-knocking and the use of simple questionnaires. However, the number of home surveys generated from this approach was minimal, given the resource intensity needed. Instead, outreach work was changed to promote partnerships with existing services having contact with residents in their homes, for example, health visitors and district nurses. Referrals routes for residents in apparent need with poor housing were promoted and established, and over time a steady stream of referrals (260 in total) came in to the Council for investigation and follow-up.

From the outset of the project, it was decided to record and evaluate the improvement in the residential accommodation where positive interventions had mitigated or removed health hazards. This was done using HHSRS assessments of the condition of those dwellings involved, both before and after remedial works had been undertaken, and applying the theoretical savings in NHS costs allied to that reduction in health risk, as modelled by the Building Research Establishment (Davidson et al, 2010).

Findings and opportunities for health based interventions

Due to the age, nature and character of Westminster's housing stock it was anticipated that certain hazards would be more commonly found than others. 4 specific hazards were more common as shown in Figure 1 below:

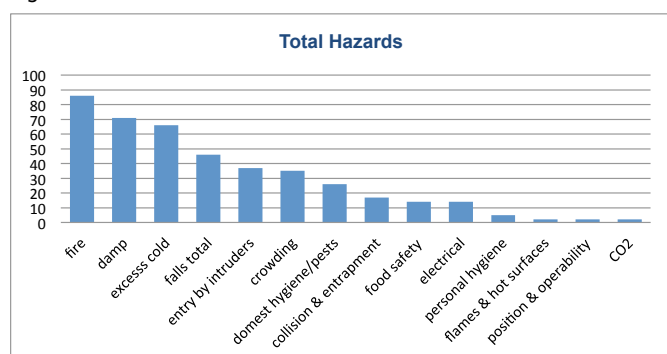


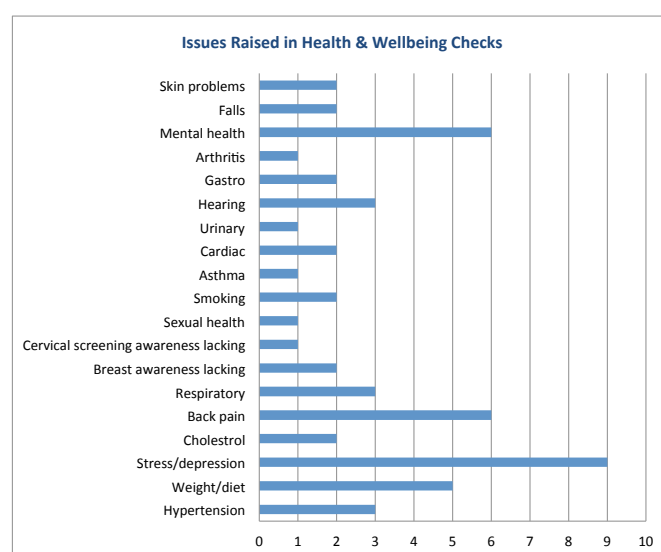
Fig. 1 Total Hazards Identified by Type

Following identification of hazards, interventions were applied to mitigate or remove hazards. In total 413 healthy home surveys were completed; of these 79% of resident households were 'vulnerable' and of those, 64% were low income families. Works were completed on 108 properties by the end of the project, with 60 other property cases still ongoing. Projected NHS cost savings relating to all of these properties amounted to £70,000 per annum.

The nurse specialist delivered health & well-being checks on a similar basis to that of healthy home checks; proactive outreach to residents, and following receipt of referrals, with a number of joint visits being carried out with EHOs where necessary, particularly where there were complex needs. 32 such checks were carried out altogether. The nurse specialist joined the project team late in the project cycle, which accounts for the relative low number of health & well-being assessments.

A number of personal health issues were raised by residents during these checks as illustrated in Figure 2 below:

Fig. 2



Mental health issues, including stress and depression were numerically the most common health issues raised, out of a wide range altogether. This was not entirely unexpected considering the target client group and the condition of accommodation they were likely to be occupying.

The project team were careful to refer residents to a range of other support services where applicable dependent upon their specific assessed needs; 350 referrals were made in total – a significant number - to a range of 33 other services, above and beyond the housing interventions indicated earlier.

Implications for policy or practice

Making a difference by delivering real improvements and 'getting things done' for residents was an important part of the project from the start, and this was broadly delivered based on set of target outputs/outcomes. The use of the HHSRS system as a basis for healthy home checks and associated interventions proved effective, and was a useful illustrator of the intrinsic link between poor housing and health for associated project partners, who were initially unfamiliar with it and/or sceptical about the approach.

The joint work carried out in the latter part of the project between the nurse and the EHOs was particularly effective in undertaking holistic assessments of residents and their homes through joint visits. In this way, significant physical and psychosocial issues could be identified and worked through for particularly vulnerable residents. This usually involved a number of repeat visits, to check follow up and progress of issues.

Feedback from visits, promotional events, briefings and training sessions was generally positive and successfully established a significant increase in case referrals from a range of service providers.

The geographic neighbourhood approach with local partners allowed the project team to tailor their outreach work taking advantages of already established community connections and relationships to successfully promote the project work in a relatively short period of time.

Joint partnership work of the type illustrated by the WAH project shows the potential synergy and benefits of collaborative working between housing and health services, particularly for vulnerable clients with multiple or complex needs. It allowed greater access by these residents to environmental health and other services; access that might well not have happened without the proactive intervention of project work of this nature.

The successful outcomes from this project, has supported the continuation of further funding from NHS Westminster for continued health and housing collaboration, with a wider range of partners in successive financial years.

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Tackling Health Inequalities – Liverpool Healthy Homes Programme

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Abstract

Liverpool Healthy Homes Programme is tackling health inequalities through reaching out into priority communities, engaging with residents and improving housing conditions and access to health and wellbeing related organisations. Understanding the causes of health inequality and building on housing market renewal experiences, the Council's Public Protection Department have been commissioned by the Primary Care Trust to visit 25,000 properties in priority neighbourhoods, secure improvements to the worst 4,400 homes, make thousands of referrals to partner organisations, and run health promotion campaigns. The programme ambitiously aims to prevent up to 100 premature deaths, and reduce medical interventions by 1000 when fully implemented.

Introduction

Whilst good progress is being made to reduce death rates in Liverpool residents (Liverpool NHS Primary Care Trust and Liverpool City Council, 2012), Liverpool still has among the highest mortality rates, lowest life expectancies and greatest health inequalities nationally. The difference in estimated life expectancy between the most and least deprived areas of the city is 11 years for men and 8.1 years for women. With persistently high levels of deprivation in the city, Liverpool remains ranked as the most deprived local authority area in England on the ID 2010, with its position unchanged from the 2004 and 2007 Indices (Liverpool City Council, 2011).

The private sector housing stock in Liverpool consists of 148,000 dwellings. An estimated 13 % contain deficiencies that give rise to serious housing hazards (category 1 hazards), the greatest concentration being found in the private rented sector (David Adamson & Partners Ltd, 2011).

The Council ran a pilot project under the Housing Market Renewal Programme in 2008, which required the inspection of 230 properties in a specific neighbourhood. Serious housing hazards were identified and improvements secured with recourse to the Housing Act where necessary. It was also observed that there were large numbers of vulnerable people who were not accessing mainstream services.

Given the success of this pilot, the Council applied to the Primary Care Trust for funding for a much larger project that would improve housing standards and health and wellbeing across the most needed areas of Liverpool. The application was successful, with the PCT awarding the Council £6million, launching the Healthy Homes Programme in April 2009.

Background information or literature

Health Poverty Index (2005)

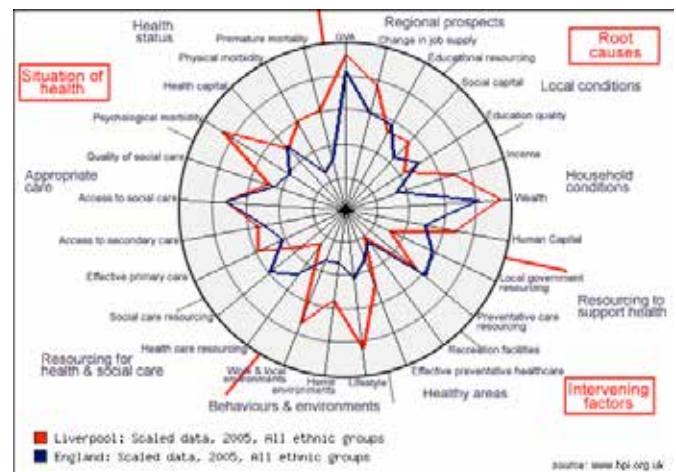


Figure 1

The Health Poverty Index (HPI) tool allows groups, differentiated by geography and cultural identity, to be contrasted in terms of their 'health poverty' (Dibben, et al, 2008). A group's health poverty is a combination of both its present state of health and its future health potential or lack of it.

Figure 1 compares Liverpool's health poverty with the English average. One of the largest 'gaps' is found for the home environment indicator. The constituent elements of this indicator can be broken down further which shows that poor quality housing is a major contributor. There is also a considerable disparity in health poverty for lifestyle, which includes smoking prevalence, alcohol abuse, drug misuse, diet and lack of exercise.

Housing conditions

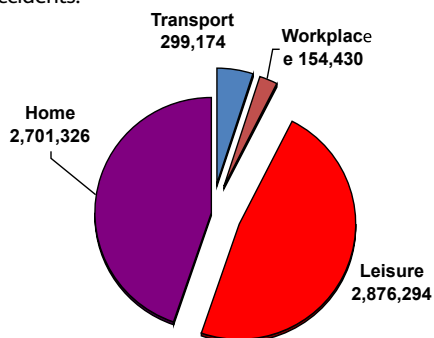
According to the last housing condition survey (David Adamson & Partners Ltd, 2011), the private sector housing stock in the City of Liverpool consists of 148,000 dwellings with a population of 332,000. Whilst acknowledging that housing conditions in the city show significant improvement both with regards to standards of fitness and performance against the decent homes standard, the survey reported the following statistics;

- Private rented accounts for 42,500 dwellings (29 % of private housing stock).
- House in Multiple Occupations (HMO) – 5,000 dwellings contain 17,000 households
- Fuel poverty – 44,100 private sector households (28 %)
- 19,400 dwellings contain category 1 hazard (13 %).
- Highest risks relate to Excess Cold, Falls, Electrical, Fire.
- Highest rates of Cat 1 hazards are in the private-rented sector (18.7 %)

Accidents

After leisure activities, the home is by far the most common location for accidents to occur. Figure 2 shows the breakdown of injuries by location. 45% of accidents occur in the home (Roys et al, 2010). Accident prevention is therefore also an important element as it addresses the behavioural issues in addition to the physical issues that can cause accidents.

Figure 2



In 2008, accidents were the 6th highest cause of death in Liverpool with 154 deaths (Tavriger and Gardiner, 2010). It is estimated that almost half of these accidents occur in the home accounting for 77 deaths per year with approximately 4,000 hospital admissions.

Accident related hospital admissions are also high locally; there were 8,033 in 2007/08 making Liverpool the 2nd highest local authority area in terms of accident related hospital admissions.

In 2008, 50% of accidental deaths were caused by falls – 90% of which were in people over 65 years of age.

Figure 3 is an accident pyramid showing the ratio between different types of accidental injuries in Liverpool according to outcome/severity. For every death, there are 63 hospital admissions for accidents.



Excess winter deaths

Of further concern is the fact that on average, there are 276 excess winter deaths in Liverpool each year (Department of Health, 2012). It has also estimated that for each winter death, there are 8 emergency hospital admissions (South East Regional Public Health, 2009).

Housing and health

Liverpool's Joint Strategic Needs Assessments have identified housing quality as a contributor to health inequality (Liverpool NHS Primary Care Trust and Liverpool City Council, 2008), with the latest stating that poor quality housing affects physical, social and emotional wellbeing and causes illness and death through excess cold, increased infection, asthma and other respiratory illnesses (Liverpool NHS Primary Care Trust and Liverpool City Council, 2011).

On the basis of national estimates from the ODPM, poor housing conditions are implicated in up to 500 deaths and 5000 illnesses requiring medical attention in Liverpool each year.

Delivering the programme

Identifying the Areas for Intervention

Intervention at a neighbourhood level is the primary activity of the Healthy Homes Programme and the key to engaging with the most vulnerable groups suffering the greatest health inequalities within the most deprived households across the city.

To make most effective use of resources, a 'Healthy Homes Index' has been created from 14 data sets – see Figure 4, and when set against the Office of National Statistics Lower Super Output Areas (LSOAs) the index is able to show which of Liverpool's 291 LSOAs are the highest priority areas.

Figure 4

The 14 data sets which inform the Healthy Homes Programme Priority Areas

From IMD (Index of Multiple Deprivation) 2010:

1. Income Deprivation;
2. Health Deprivation and Disability;
3. Barriers to Housing, and Services; and
4. Living Environment;

Tenure & condition

5. Private rented percentages by LSOA taken from the census (2001).
6. Density of RSL property as a percentage (April 2011) – N.B. when ranked, lowest density is ranked no.1, highest density ranked 291.
7. Category 1 hazards by electoral ward - % category 1 risks present (2010 private stock condition survey)
8. Decent Homes Repair by ward - % non-compliant (2010 private stock condition survey)

Health

9. The rates of years of potential life lost as taken from the 2010 IMD years
10. Ratio (per 1000 population) of emergency hospital admission episodes between 2008 and 2010.
11. Residence for hospital admissions for falls

Poverty and crime

12. Residential burglary 2008 rate
13. Housing Benefit rate 2011
14. Fuel Poverty Indicator is a statistical model of fuel poverty based on the 2003 English House Condition Survey (EHCS) and 2001 Census

The programme also aligns with other programmes in the city ensuring that opportunities for positive intervention are maximised.

Pre-survey Reconnaissance

In advance of any other activity, planned survey areas are visited to review the type of housing stock within the area e.g. terraced, flats, high rise apartments detached houses etc. and consideration given to environmental factors such as fly-tipping, empty housing, overgrown properties etc. Any such issues are reported to the relevant council service to respond to. This is an important aspect of the programme and resolution to these sometimes long standing problems has added benefits as it is recognised that many people suffer distress and anxiety from such issues.

Community Engagement

Community Engagement has proved to be an essential operation prior to going into a survey area. This activity has two essential aspects, firstly it enables the programme to advise relevant people, community groups and organisations that the area is about to be surveyed and raise awareness within the community, and secondly it enables people and organisation to advise the programme of known issues that will inform the service.

Prior to entering an area for surveying, various groups and organisations are contacted including:

- Councillors
- City Council Neighbourhood Management Team
- Community Groups
- Resident Groups
- Local Activity Groups
- GP Surgeries and Dentists
- Children's Sure Start Centres
- Libraries
- Schools
- Police
- Social Landlords

The team use various media to engage the various organisations, community groups and services to support the activities including distributing of leaflets, booklets, posters and attending meetings and discussion groups, local radio and other media if this is thought to help and ensure the message gets out to residents.

Pre-survey Notification

Prior to the advocate team visiting the targeted area, a pre-survey letter and leaflet is distributed to each household containing basic information for the resident on the purpose of the surveys. These letters are hand-delivered a few days in advance, helping to also develop local knowledge of the area and any access issues that the team may encounter during the surveys e.g. locked security doors on maisonette blocks, vacant properties, sheltered housing etc.

This letter also provides residents with the option of an appointment where they can use a free telephone number or email address.

Advocate Intervention

The Healthy Homes Advocates are the fundamental part of the outreach programme as they are the people who actually make contact with the residents to undertake the surveys.

Advocates call at each property to speak face to face with residents using a bespoke survey form to ascertain specific needs linked to their health and wellbeing. This looks at many aspects including:

- Housing conditions
- Access to medical practitioners (GP and Dentists)
- Benefits
- Employment advice
- Support mechanisms for residents with young children
- Support mechanisms for the elderly
- Energy efficiency measures
- Fuel poverty
- Access to health and drug support agencies
- Exercise and fitness regimes
- Healthy eating and nutrition programmes
- Other individual needs as they are identified

Direct referrals on health issues can be made to a wide range of partner agencies including the in-house Environmental Health Team who inspect properties in poor condition and use powers under the Housing Act, to ensure landlords carry out necessary improvements and repairs.

Advocates will follow up any referrals that result from the surveys they have completed with the appropriate partner agencies. It is partners who then deliver the services required.

Progress and Findings

By the end of August 2012, over 24,000 assessments had been made leading to over 19,000 referrals to partner organisations – see Figure 6.

Housing Improvement

Over 3,800 HHSRS inspections have been undertaken as a result of referrals from Healthy Homes Advocates and Inbound Referrals from health professionals. This has resulted in over 2,700 category 1 hazards being identified and removed and over £4m in investment by private sector landlords generated as a result of enforcement action being necessary by Healthy homes Environmental Health Officers.

Figure 5 – Distribution of category 1 hazards identified

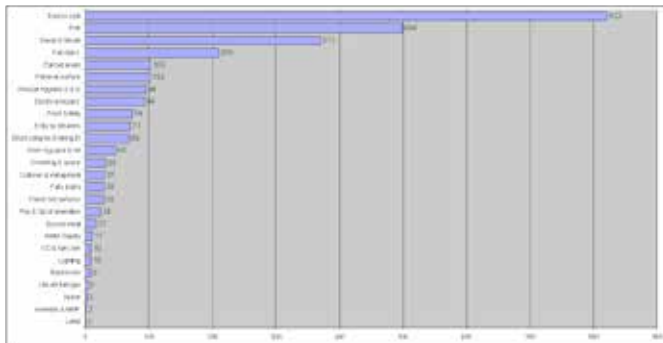


Figure 6 – Referrals to partner agencies



Healthy Homes on Prescription

The project has recently secured £75k from Scottish Power to deliver the Healthy Homes on Prescription project. This is extending the reach of the Healthy Homes Programme, and assisting health professionals to meet the housing, fuel poverty and energy efficiency needs of their patients. Of the 95 GP practices across the city, so far 82 have had searches set up to identify patients considered particularly vulnerable to sub-standard housing and fuel poverty, 55 agreeing to an "alert" being added to their patient record system covering 28,718 patients. In these cases, the GP is prompted to ask the patient during their consultation about their housing conditions. As a consequence, we are now receiving approximately 25 referrals per month from those practices where the system has been fully introduced. We also routinely hold "Healthy Housing surgeries" in approximately 25 practices where Advocates discuss with patients in the practice waiting room the services that are offered.

NHS Savings

The Building Research Establishment has estimated the extent of financial savings to both the NHS and wider society from making homes safer. Housing improvement carried out during the first year of the programme is estimated to save the NHS in the region of £439,405 per year, from this point onwards. As these savings are based on physical housing improvements that are sustained, these savings are cumulative. Over a 10-year period these could be extrapolated to an approximate saving of £4.4m. The wider benefits to society including NHS savings are estimated at £11 million over 10 years.

As the current phase of the Programme will deliver five times the number of inspections undertaken in year one, it is estimated that the Healthy Homes Programme could make savings of up to £55 million over a 10 year period.

These figures are based purely on the impact of housing improvement activity and not the many other health improvement activities including the thousands of referrals generated into health and social care services.

Other Economic Impact

This work has a consequential effect on the local economy. On the basis that there are approximately 3 employees for every £100,000 spent on construction (L.E.K. Consulting, 2012) it is estimated that the improvement work is supporting at least 30 construction jobs in the City.

Evaluation

Evaluation is ongoing and is measured by a variety of methods including:

- re-contacting all residents 28 days after making a referral on their behalf to ensure they have been contacted by the referral partner;
- Tagging referrals to partner organisations;
- customer satisfaction surveys (10 % of all households engaged with); and
- EQ5D – measuring self-reported health and wellbeing.

Given the large number of other projects contributing to the same cause, it is difficult to isolate the health improvements solely from the programme. However, city-wide, there has been a reduction in health deprivation since 2007 (fewer SOAs in most deprived 10 %) and a reduction in excess winter deaths – see figure 7.

Figure 7

| Year | Excess Winter Death |
|-------|---------------------|
| 10/11 | 226 |
| 09/10 | 301 |
| 08/09 | 320 |

Other successes include the contribution the programme has made to increasing dental rates '...the highest NHS dental access rate Liverpool PCT has had for over two years.... innovative ways of improving dentistry access through the 'Healthy Homes Dental Scheme' NHS Operational Plan 2011/12. Furthermore, as part of the accident prevention campaign, schools were visited by a drama group to deliver home safety messages.

The pupils were encouraged to produce a rap to encapsulate their learning, with the best raps entered into a radio competition. The level of interest was so great that the radio station reported that this was the “most successful microsite in the history of the station”.

Implications for policy or practice

The home is central to health, safety and wellbeing, investing in housing is an investment in health.

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- Chartered Institute of Housing’s Inside Housing: <http://www.insidehousing.co.uk/story.aspx?storycode=6508221> discusses cost benefits of housing improvements, citing Liverpool Healthy Homes as an example of partnership working)
- Audit Commission publication ‘Building Better Lives’: <http://www.audit-commission.gov.uk/nationalstudies/localgov/buildingbetterlives/Pages/casestudies.aspx> It provides a good outline of what the Healthy Homes Programme aims to deliver and how it came about

Promoting the role of housing within health and social care, a partnership approach across Derbyshire

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Abstract

This paper seeks to share some of the steps that have been taken to raise the profile of housing functions within the preventative agenda in Derbyshire to influence health and social care professionals and commissioners to recognise housing as being of the wider determinants of health. This work has been led by the PCT with support from Councils across the county. Amber Valley Borough Council has been proactive in supporting this approach in developing and building on local partnerships with Health and Adult Care to increase the understanding of housing's impact.

Introduction

This paper sets out some of the approaches taken in making the links between housing and health in Derbyshire. There is nothing complex about this approach, but has been a case of proactively seeking opportunities to influence and get the voice of housing heard within larger organisations and continually building on previous progress. The approach has required input locally and countywide. In April 2009 the Derbyshire Health and Housing Group (DHHG) was widened from Southern Derbyshire Health and Housing Forum which had been in existence for over a decade. The new DHHG provides a link between health and housing related services across Derbyshire. This mature group is in a positive position to support and deliver tasks identified within the sphere of health and wellbeing and with Adult Care input is well placed to deliver.

Background information and literature

When the DHHG was originally established it was recognised that a post of Health and Housing Strategy Manager was required to develop partnerships that could deliver the health and housing agenda. This post is currently funded through Derbyshire County PCT, and will transfer to Derbyshire County Council in 2013 under the transfer of Public Health functions to first tier Local authorities to provide an essential strategic bridge between the health, social care and housing sectors.

Over the years the Group has received funding from the PCT to provide funding to "kick-start" a number of initiatives many of which have developed and attracted mainstream funding.

Amber Valley Borough Council is in mid-Derbyshire with a mix of urban and rural housing issues. There are particular issues revolving around housing conditions associated with levels of owner occupation by asset rich, cash poor older people.

Approach and methods

Tackling fuel poverty has been a key focus as the ability to heat a home is a major issue for residents in Derbyshire based on the type and age of properties. There has been a concerted effort to concentrate on fuel poverty and the link to excess winter deaths to encourage professionals to take a wider view beyond a narrow clinical focus. With all Councils running insulation schemes there has been efforts to develop simple referral pathways. Cold and the health effects of cold is a widespread understood concept and one that can be easily related to without the need for extensive training and has therefore been used as a means of encouraging professionals to think about the living conditions of their clients when in their home. This is an action identified within the NHS Cold Weather Plan (DoH, 2012). It should be said that there has been limited success, but significant increases in referrals are taking place.

Here lies the challenge for those working in the fields of housing and health policy. Housing policy remains a district council function and whilst there continue to be some excellent examples of close working between districts and the PCT there is so much more that could be achieved for the benefits of Derbyshire's residents by investing in prevention activities that keep older people in particular out of doctors' surgeries, hospitals and residential care homes for as long as possible.

From Amber Valley Borough Council's perspective the main approach has been to document and promote evidence that would make other professionals sit up and take notice of the case for making the housing connection. Since 2007 a concerted effort has been made to provide senior managers and elected members with case studies of actual interventions, an approach which has proved far more powerful than raw statistics to influence decision makers.

An example of a case study was the following; The Council received a telephone call from a Mental Health Nurse regarding one of his patients who suffers from severe depressions and had other illnesses. She is 79 and the nurse stated that her house felt cold when he visited and that some of her other conditions would be exacerbated by the cold and the nurse asked if there was any help we could offer. The Council's Energy Officer arranged to meet him on his next visit to the lady to check the house for insulation.

At the visit some of the rooms of the bungalow had low temperatures even though the central heating was full on. The property could not have cavity wall insulation, but the loft was not up to standard so the Council was able to arrange for the loft insulation to be topped up to 270mm (at no cost to the lady as she was over 70). The radiators were barely warm, so with the permission of the owner the radiators were bled and they became instantly warm. We arranged for the loft to be insulated and this was carried out two days later.

Anticipating the structural changes in health, a strategic decision was taken to promote the case studies to increase the integration with health and social care. This led to the production of a paper 'Housing and Health' using many of the case studies that had been used internally to show the value of the service (Arkle, 2011).

This document has been widely circulated and used for the basis of raising awareness through a range of forums. With the new arrangements for public health developing it was proposed through the Derbyshire Health and Housing Group to produce a more substantial challenge document setting out in more detail the value of housing to health. Following an invitation by the CIH to talk about the success of work across Derbyshire a decision was taken to actively use the five stages of life to emphasise the impact different housing functions on the person. Housing was broken down to distinct disciplines and statements written to set out the potential impacts. This appears to have the greatest impact on non-housing professionals, emphasising the value of personalising health.

An initial draft of the challenge document that had input from public health was reviewed and submitted to the Adult Care Board (Arkle, 2012). The paper was presented in September 2012 and the impact of housing on the individual had the greatest impact. This process has achieved what it set out to do as Clinical Commissioning Group representatives have taken on board the content and are now appear to be using this evidence which is outside their normal range of clinical interventions to particularly look at how health can engage on fuel poverty.

Officers from Amber Valley Borough Council has been given a positive opportunity to improve local interaction between health, social care and housing through a Total Place project. Based on the challenges and demands from the rising number of elderly people Derbyshire County Council commissioned analysis completed by Deloitte to look at spend on services across the Borough on elderly people (not published). This identified that AVBC spend was at the preventative end of the spectrum whereas DCC and NHS spend was reactive. This suggested that most of the expenditure is after they have developed a serious condition. Total Place would offer an ideal opportunity to close out the triangle between health, social care and housing. At this time it was decided that a cautious approach would be best as to push too hard would have met likely resistance.

It was determined that a positive start would be achieved through looking at how services connect locally and making sure that services were better joined up, rather trying to make more fundamental changes. Taking this approach meant that those spending money on reactive services would be more open to cooperation in the medium term. So far this has been successful and opportunities have been taken to focus on shared areas of interest namely fuel poverty and adaptations. This work has also led to a jointly commissioned DVD 'Happy in Your Home' which seeks to promote local services and to encourage older people to think about their housing needs in retirement.

Through the attendance at the Total Place meetings an invitation was offered to AVBC's Housing Manager to sit on the Clinical Commissioning Group Locality Board for Amber Valley and South Dales as the Borough Council representative. The invitation was made by an influential GP who sits on the CCG as well as the Health and Wellbeing Board. It is hoped that through the presentation of the Challenge document to Adult Care Board that this type of arrangement and second tier involvement will be replicated across Derbyshire.

Findings: evidence of health promotion

The main evidence is that at a key point in changing world of the commissioning of health and social care services, housing and in particular the impact of fuel poverty is increasingly understood and key decision makers that will influence decisions both locally and county wide now appear to have an increased awareness of housing's role in the future lives of Derbyshire's residents. This must not be overstated, but this has happened because a number of officers have worked hard to increase the emphasis on joint working across the County to address fuel poverty, falls and other hazards that will have a direct bearing on the demands being placed on health and social care. Effective investment in housing standards will save money. There have been recent discussions about how Commissioners might include identifying those at risk of fuel poverty within contracts for commissioned health services which could produce significant improvements in integration.

The challenge in future years will be to influence decision makers to invest sufficiently in housing infrastructure and advice for the longer-term benefit of Derbyshire's residents. The DHHG should have an important role in shaping the decision making across the county leading in certain areas like fuel poverty.

The Derbyshire Health and Wellbeing Strategy was published in October 2012 and has references to housing, housing advice and housing support within the document (Derbyshire County Council, 2012-15). There are sufficient hooks to hang the key housing themes, particularly for older people. Local needs assessments have been produced for all District and Borough's and make references to needs for tackling fuel poverty and the funding of adaptations (NHS Derby City and NHS Derbyshire County Council, 2012).

The new health arrangements are more complex and that much more work is required both locally and Derbyshire wide to achieve better integration. Participating in monthly CCG Locality meetings enables a far greater understanding of the motivations and challenges involved. The key seems to be to take small steps to build up confidence particularly as most health professionals are not traditionally trained in non-clinical interventions. Working with public health colleagues there will be an opportunity to contribute to identifying health needs of the Borough(s) and District Councils to support the improved integration of services. Coupled with high-level interest from the Health and Wellbeing Board the likelihood of housing being part of the menu of prevention is increased.

Implications for policy and practice

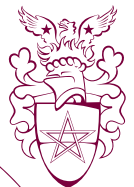
The key messages are whilst thinking strategically to take small steps to build confidence with partners in joining up services, proactively seek opportunities to influence through personalisation of the impact and understand the motivation and pressures on partner organisations to be able to sell your offer and keep trying.

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