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

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Introduction

Environmental Health Practitioners (EHPs) and their colleagues routinely deliver high quality, partnership-based strategies and interventions based on local evidence of how and why health inequalities prevail around housing are being tackled. Working closely with partners in health, social care, and other 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 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 at the heart 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, 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 Tasker et al, 2005; Thomson, Petticrow 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 frontline services.
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Enforcement led interventions: the private rented sector and HMOs

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Introduction
Governments since the 1980s have continued to favour the private rented sector in its potential to offer flexibility 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 there are 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 Keogh 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 Keogh 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 their conditions in addressing such housing and health inequality against a range of odds. Some landlords are disinterested in the 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 (Baratt, Kitcher and Stewart, 2012). An innovative Knowledge Transfer Partnership in Essex has published findings about the relationship between mental health and bedsit accommodation (Baratt 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 excessive 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 (HSHRS) focuses on protecting the physical health of tenants and making taking action on ground of mental health much harder when mental health may actually be a more pertinent issue for those housed in HMOs (Baratt et al, 2012a).

An additional challenge is that unless a property is recognised as being an HMO it 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 hasty. 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 it 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.

References


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 stock, high tenant turnover and an increasing demand for affordable housing. To address these issues Reading Borough Council has developed a dual approach to the management 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 households who would otherwise be forced to live in alternative housing for which there simply is not enough stock. This can be 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

Reading Borough Council (2006), Private Sector House 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 1,500 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 ageing housing stock, high tenant turnover and an increasing demand for affordable housing, the HMO sector is expected to grow. This highlights the need for landlords to be aware of the changes in the legislative framework and 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 manage their properties appropriately, and the Council is committed to working with the landlord in order to achieve compliance. The decision was made to work with the landlord in order to achieve compliance. The decision was made to work with the landlord in order to achieve compliance.

The 2006 Housing Stock Condition survey also reports that houses built pre 1919 are notoriously difficult to heat, maintain and manage, especially where listed status is granted.

Case Study

One such case that demonstrates the effectiveness of The Council’s approach to HMOs was investigated by the Council. 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 chronic obstructive pulmonary disease (COPD) as well as mental health issues, including depression and anxiety.

In line with the council’s enforcement policy, the landlord was afforded the opportunity to corrected the hazardous 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 manage their properties appropriately, and the Council is committed to working with the landlord in order to achieve compliance. The decision was made to work with the landlord in order to achieve 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, whilst ensuring high standards of HMO management. At least two of the tenants had Chronic Obstructive Pulmonary Disease (COPD) as well as mental health issues, including depression and anxiety.

Officer 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 H-HSRS, including a category 2 Damp and Mould hazard and a category 3 Excess 

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 portable heaters.

To further compound the hazard there was an existing damper problem in the basement stairwell of the property. The continually leaking rain caused great 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.

Prior to the expiration of the timescales, the landlord was invited to attend the Councils 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 agencies. The event is attended by an average of 75 landlords, and feedback continues to prove the interventions worthwhile.

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

Housing Act 2004. This enabled the landlord to apply for the grant assistance to help improve the property.

After delay 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 £3,500 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 in the roof space. The works 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.

The landlord was offered 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 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 increasing the supply of good quality housing.

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 just be as effective in achieving the same goal.

References

Chartered Institute of Environmental Health (2011), CIEH guidance on enforcement of excess cold hazards in England, Chapter 2, pp 6-7


Reading Borough Council (2006), Private Sector House Condition Survey, Chapter 2, pp 15-18
The Impact of Poor Housing on Children: a Case Study

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Abstract

The relationship between housing conditions and educational attainment is 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 (22.6%) 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 tenanted 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, one 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 despair 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 inhabited by five children between the ages of five to thirteen; the mother is a temporary lone parent and the father earns 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 effecting 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 the presence of the family, explaining the findings and how for the charges would go towards addressing the despair.

By 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 safeguarded. 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 in rooms which were filthy and the dog has been safely re-homed. Evidence of Health Protection

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 in rooms which were filthy and the dog has been safely re-homed. Evidence of Health Protection

The case has demonstrated effective partnership working between internal departments and numerous external agencies. Work has involved seeking permission from Environmental Health Management to waiver kitchen 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 wire 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 safeguarded.

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.

References


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 which 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.
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 tackling 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 London borough, accounting for 35% of Newham’s housing stock. Houses in multiple occupation (HMOs) are increasing in number due to a lack of affordable housing and high demand on rental. 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 Inner London boroughs. Newham being the most overcrowded borough in London with 301 people per 100 dwellings (Census 2011). This is 50% more than

By using a multi agency approach officer time can be used far more productively with improved enforcement outcomes. The 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.

The paper reviews current local policy and practice with use of a practical case study.

Licencing 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. Reports and observed antisocial 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 focussed. The second key benefit is associated with the additional powers that come with licensing, including failing to license accompanied with fines of £10,000. This helps 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 less likely to be registered with the Health & Safety Executive. The pilot showed 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. Consequences 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. Taking this further landlords that fail to license are more likely to be found guilty of criminality and associated with the worst 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.

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 a 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 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 into 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 skum 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 tenants is not equal.

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 Illegals 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 County Planning 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 at opposed to spurious 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. 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 both 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 by 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 6.82m2 with overlap timber walls and a flat roof with approximately 150mm of insulation between the joists in the roof. The roof had an unsuspended 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.

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Implications for policy or practice

These methods of working, using the full range of regulatory tools to target the increasing problem of a poorly regulated sector with a number of implications for policy or practice, allow the Demolition Order to go ahead with minimal disruption and with no adverse impact on the occupant and without recourse to public subsidy for rehousing

References


Overcrowding in London: establishing the context

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Abstract

There are numerous physical and mental health effects of overcrowding on the occupants 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 correlate this directly due to the need to separate out the disease from other factors. Over half of known cases of tuberculosis in the UK in 2011 and that notifications and rates are likely to have caught the disease in Britain. The graph shows a steady increase in immigrants who have been in the country for more than 2 years and have lived in Britain for 10 years to have caught the disease in Britain. The graph shows a steady increase in immigrants who have been in the country for more than 2 years and have lived in Britain for 10 years to have caught the disease in Britain. The graph shows a steady increase in immigrants who have been in the country for more than 2 years and have lived in Britain for 10 years to have caught the disease in Britain. The graph shows a steady increase in immigrants who have been in the country for more than 2 years and have lived in Britain for 10 years to have caught the disease in Britain.

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 the number of overcrowded dwellings and 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 oblate overcrowding. Enforcement is mandatory but leaves an additional dilemma of where those currently in overcrowded conditions will live.

The current statutory definition of overcrowding has been in force 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 of 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 there are two habitable rooms in a dwelling there is no need for a couple of different sexes 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 people, five rooms = ten people, six rooms = 11 people. The second test is determined by the size of the rooms. A room under 50 square feet is not counted 50-70 square feet (44.65 square metres – 6.50 square metres) ½ person 70-90 square feet (6.50 square metres – 8.36 square metres) 1 person 90-110 square feet (8.36 square metres – 10.21 square metres) 1½ persons >110 square feet (10.21 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 what is a “bedroom”. If a room in a dwelling is not used as a bedroom but at a flat level and a habitable room. Bedrooms in houses can be used as studies, store rooms, dining rooms or for various other uses. The HHSRS offers no guidance on this matter and even the objective statement that the number that could be deemed to be overcrowded depends 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 subsection 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 areas 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 5460 in 1991 to 7375 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 was 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 5.2% increase in population in 20 years (ONS, 2011b). Some of this increase can be attributed to the increased building around docklands.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Tower Hamlets</th>
<th>Newham</th>
<th>Hackney</th>
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<td>2011</td>
<td>254406</td>
<td>307894</td>
<td>246270</td>
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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 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 (DOHP, 2006: 92):

“There are difficulties in quantifying the effect of overcrowding on population morbidity and mortality. 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, or 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 death rate of the victim’s complications.

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 boroughwide 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 overcrowding 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.

The current housing crisis is evidenced by the increased overcrowding that is present in the city; 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 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. People suffering from 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, CDC, 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 were 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 local 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 oversaws 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).

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

References


Wilson (2011) House of commons Library Housing overcrowding SN0510123 Wendy Wilson 26th July 2011 – Social policy section (Author’s note – whilst Ms Wilson refers to a kitchen being large enough to accommodate a bed it is the author’s understanding that case law refers to a kitchen with a table and six chairs being a habitable room)


Acknowledgement

Some of this paper first appeared as “A Pressing Issue”, S Hamann, in Environmental Health News, Vol 27, Issue 9 (October 2012)
Introduction

The improvement of housing conditions was a major objective of the public health movement in Britain from the 1860s 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 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. (Muir 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 disposal of their home (Gibson and Langstaff, 1982).

Meanwhile Council building was focused on clearing the slums and ending the housing shortage at the lowest possible unit costs. By the 1970s politicians claimed these goals had been achieved and became concerned the traditional approach was disadvantaging 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 1949. 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 lead to the detriment of residents’ interests (Gibson and Langstaff, 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 Renewed 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 three 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 refenced 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 sector renewal funding (Gibson, 1994).

New approaches to local governance and housing finance

Single pot housing funding allocations were introduced for Local Authorities based on a mix of needs index 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 positioning 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 £95m 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 dwindled 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 focused on property improvement. A subsequent chapter considers how to get health and housing initiatives included in area regeneration strategies.

Relevant literature

CLG (Communities and Local Government), (2009), Key messages and evidence on the housing market renewal pathfinder programme, 2003-2009, London, DCfL


Wilson, W., (2012) Housing Market Renewal Pathfinders, evidence provided on June 1 2011 to CLG Select Committee Inquiry into Regeneration, HoC Library
Abstract
Area regeneration has grown to replace traditional area renewal as the dominant strategy. Local authorities and Practitioners 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 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 regeneration. Health and Wellbeing boards are unlikely to have the budgets once promised through such 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 task forces were included to expect job creation, business support, education and health initiatives in addition to any housing improvements and to be tailored to local needs. The Brookhouse and Bestwell 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 into 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.
• Strategic Area Regeneration

The evaluation of the schemes found that they generated significant improvements relative to national indicators in income, 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 “prioritized expenditure of health related activities” (CLG, 2007).

Newham in east London hosted an SRB project with a particular focus on redundant funding. Although it initially included renewal areas and area group repair initiatives it increasingly applied enforcement powers to transfer empty and poorly managed rented properties to RSL partners with support from the operating 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 government in 2010 and in 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 housing 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.

Locality 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 CIHE a toolkit for modelling the health costs of poor housing which has already been used to calculate for the costs for Wales and Northern Ireland. A similar report is currently being produced for London and Local Authorities can individually or in partnership ask health indicators more detailed reports to support local strategies. The CIHE has also supported the development of the Regulatory Information and Management Systems (RIMS), 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 loft’s 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 as area approach to such work with a core group of partners 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 and the need for selective licensing databases is not suitable. 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 focused 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 focused strategy although a property focus may be needed to remove a particular area of property related costs. 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 is simply displaces antisocial behaviour elsewhere. At the time of writing Newham has concluded that the entire Borough fulfills 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 services 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 or our work to current government priorities to ensure the accumulated experience it has in improving public health and well being under the Health Act 2006 is not lost. Arguing the case for inclusion in area regeneration and in wider partnerships is essential to proving the relevance of our work.

References
Cabinet Office, (2010), Building the Big Society, London: Cabinet Office
CLG (Communities and Local Government), (2007), The Single Regeneration Budget: Final evaluation, London: DCLG
CLG (Communities and Local Government), (2008), Creating Strong, Safe and Prosperous Communities, Statutory Guidance, London: DCLG
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 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 scheme’s inception was greatly influenced by economic downturn. As time went on a small minority of owners decided to sell out for unreasonably low prices, particularly 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 through 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 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 provisions, landscape, open spaces and transport space. The Council obtained committee approval to utilise CPO powers for those owners whose properties were located in key areas, such as the entrance to the open space. 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 was an economic downturn. As time went on a small minority of owners decided to sell out for unrealistically low prices, particularly 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.

**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 (2008), Hashagen (2002). Formal methods and relatively unusual measures would 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 community skills, the capacity to empathise with individuals and feel 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 sale 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 pubicans 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 project. The team decided on 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 important however that the local community 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 they were involved and supported by the Council to 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.

An entire mural has a limited life span and although sections of the community murals will be transferred back to the Council on time capsules, the team wanted a more visible outcome. The team 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 important however that the local community 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 they were involved and supported by the Council to 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.

**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 has involved 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 be able to be both responsive and flexible as required.

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Stall L (2009) Sharing memories. A2Dominion


Wilde (2012) Stanwell New Start Regeneration surveys. A2Dominion
Margate’s private rented sector: delivering housing enforcement and family support in a seaside town
Jill Stewart (j.stewart@greenwich.ac.uk); Maureen Rhoden, Annyece Knight, Nevyn Mehfem and Lyne Baster, School of Health and Social Care, University of Greenwich

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 raising 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 Meareabo (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 Banarri and 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 Meareaab, 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 partnerships working around the needs of families. Ethics approval was obtained prior to the project commencing. Interviews were recorded and transcribed verbatim before careful 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 Licensing. This high level of in-migration into accommodation originally designed for seasonal tourism has created major enforcement and 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 househods 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).

Whether 85% (renting privately) is an acceptable figure is a difficult thing to say...that’s complete role reversal of the norm.” (Interview 2).

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 great 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).

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 told pivoting around poor housing, deprivation and families in need:

“...there are many young children who are inappropriately shared accommodation. I’ve found...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 inappropriate situation.” (Interview 5).
social interventions in seaside towns require local evidence based to understand issues presented. Private sector housing stock and whose economies have suffered from its decline in tourism.

Implications for policy or practice

employment where possible (Interviewee 8).

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.

References


Useful website and further reading

Coastal Communities Alliance http://www.coastalcommunities.co.uk/


Acknowledgement

The authors are very grateful to all interviewees who gave up their time to participate in this study.

Abstract

Kent County Council launched its ‘No Use Empty’ campaign in 2005, as part of its Public Sector Service Agreement (PSSA) 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 focused 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. Soliciton, 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.

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

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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 of 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.

The scheme has approved over £6 million of interest free loans, which equates to 326 units of accommodation. This has leveraged in excess of £114 million of private sector funding (owner’s contribution), giving a total investment through the loan scheme of £117.4 million (up to September 2012).

<table>
<thead>
<tr>
<th>Development Size</th>
<th>Total Units</th>
<th>Local Authority</th>
<th>Private Sector</th>
<th>Total Investment</th>
<th>Loan as % of Average</th>
<th>Repayment as % of Average</th>
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<tbody>
<tr>
<td>(Total)</td>
<td>2,201</td>
<td>Kent County Council</td>
<td>£1,540,000</td>
<td>£2,000,000</td>
<td>100%</td>
<td>100%</td>
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<td>(1 unit)</td>
<td>229</td>
<td>Kent County Council</td>
<td>£1,000,000</td>
<td>£1,500,000</td>
<td>58%</td>
<td>53%</td>
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<td>(3 units)</td>
<td>294</td>
<td>Kent County Council</td>
<td>£500,000</td>
<td>£700,000</td>
<td>29%</td>
<td>27%</td>
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Total 326 100% £6,066,840 £11,402,566 £17,409,406 100% 100% 100%

The Empty Property Initiative has been incorporated into Kent County Council’s Housing Strategy as a target to support wider regeneration projects within the partner districts and increase housing provision and quality. Specifically, the Initiative has linked with the regeneration projects to identify key properties to target for action. All districts have 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 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

Steve Habgood, Housing Improvement Team Manager, London Borough of Bromley Council: (steve.habgood@bromley.gov.uk)

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 tips from owners to brief case studies are included.

Introduction
There are approximately 930,000 empty residential properties in the United Kingdom. (Empty Homes 2011) The majority of empty properties are distributed peripherally, 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 need of housing. (Department of Communities and Local Government 2011) 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 whilst new homes are more energy efficient than old, the resources and embedded energy required for new build as against renovation and structural 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, Valuations/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 their 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 undesirable incidents such as theft, vandalism or arson

<table>
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<th>Table 1: Reasons Contributing to LTEs</th>
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<tr>
<td><strong>Person based</strong></td>
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<td>Abandonment often following financial strain</td>
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<td>Inability to renovate or rennovate a property</td>
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<td>Family disputes over what to do with a property</td>
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<td>Significant housing benefit of renovation</td>
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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)

References


Homes and Communities Agency Empty Homes Toolkit Online Available HTTP: http://www.homesandcommunities.co.uk/empty-homes-toolkit?page_id=&page=1 16th September 2012


No Use Empty. Online, Available HTTP: http://www/no-use-empty.org/ 9th September 2012
Introduction
A Joint Strategic Needs Assessment (JSNA) identifies current and future health and wellbeing needs as well as inequities 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. HHRS is 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 HHRS 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 aspects 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 inequality 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 HHRS Cost Calculator (CIEH Toolkit “Good housing leads to good health” 2008). This will show the savings to the NHS relative to the cost of remediating health hazards in the home (see examples in below).

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 occupants 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.

Acknowledgement
Some of the contents of this chapter was first published in: Emanuel S (2011) A healthy investment. Environmental Health News, 26 (18): pp 17

References
DOH (2010) Confident Communities, Brighter Futures, London HMSO

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.

Savings to the NHS from dealing with the most common health hazards
Using the HHRS 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 remediating these hazards would be £2.2m and that this would lead to 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.
### 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 occupants particularly those regarded as ‘vulnerable’ (the definition of ‘vulnerable’ is that given in the Operating guidance 2006).

The prospective qualitative HIA report draws on this using a methodology developed by the BRE Trust and published in the ‘Real Cost of Poor Housing’ publication as a dwelling with a Category 1 hazard. Local costs of 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).

### 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 1 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 on also be calculated e.g. the cheapest 50% and 20% of required works. An also be calculated e.g. the cheapest 50% and 20% of required works. 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 over a number of years. 3, 5 and 10 year scenarios are usually considered but this can be altered to suit LHAs needs.

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

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
<th>Class 4</th>
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</thead>
<tbody>
<tr>
<td>Damp and mould growth</td>
<td>Not applicable</td>
<td>Type 1 allergy (£1,998)</td>
<td>Severe asthma (£1,120)</td>
<td>Mild asthma (£180)</td>
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<tr>
<td>Excess cold</td>
<td>Heart attack, care, death (£19,851)</td>
<td>Heart attack (£22,295)*</td>
<td>Respiratory condition (£519)</td>
<td>Mild pneumonia (£84)</td>
</tr>
<tr>
<td>Radiation (radiation)</td>
<td>Lung cancer, then death (£13,267)*</td>
<td>Lung cancer, survival (£13,267)*</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Falls on the level</td>
<td>Quadraplegic (£59,246)*</td>
<td>Femur fracture (£25,624)*</td>
<td>Wrist fracture (£745)</td>
<td>Treated cut or bruise (£67)</td>
</tr>
<tr>
<td>Falls on stairs and steps</td>
<td>Quadraplegic (£59,246)*</td>
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<td>Wrist fracture (£745)</td>
<td>Treated cut or bruise (£67)</td>
</tr>
<tr>
<td>Falls between levels</td>
<td>Quadraplegic (£59,246)*</td>
<td>Head injury (£6,664)*</td>
<td>Serious hand wound (£1,693)</td>
<td>Treated cut or bruise (£67)</td>
</tr>
<tr>
<td>Fire</td>
<td>Burn, smoke, care, death (£11,754)*</td>
<td>Burn, smoke, Care (£7,878)*</td>
<td>Serious burn to hand (£3,188)</td>
<td>Burn to hand (£107)</td>
</tr>
<tr>
<td>Hot surfaces and materials</td>
<td>Not applicable</td>
<td>Treated cut or burn (£4,652)</td>
<td>Minor burn (£1,234)</td>
<td>Treated very minor burn (£107)</td>
</tr>
<tr>
<td>Collision and entanglement</td>
<td>Not applicable</td>
<td>Punctured lung (£3,439)</td>
<td>Loss of finger (£1,536)</td>
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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%.

### Abstract
HHSRS hazard 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 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 for statistical robustness.

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

### Hazard class 1: Damp and mould growth

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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 authority’s potential savings is shown in Figure 1.

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

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

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 £77,603 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 3

Health cost hot spots in Barnsley

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.

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 effect 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.

References


Barnsley HIA BRE draft client report 2012

ODPM 2003 Statistical Evidence to Support the Housing Health and Safety Rating System volumes I.II and I ODPM London

ODPM 2006 Housing Health and Safety Rating System Operating Guidance Housing Act 2004 Guidance about inspections and assessments given under section 9

ODPM 2004) NECE a review of reviews of interventions for improving health December 2005


England Retro HIA BRE client report 2012

www.housinghealthcosts.org September 2012

Local Authority Housing Statistics

Introduction

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

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 £2.5 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 (Royo et al., 2010) (the CIEH HHSRS Cost Calculator was a byproduct 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 those into a spreadsheet devised as part of previous work (Royo 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 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 CS 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.

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 (Royo et al., 2010) (the CIEH HHSRS Cost Calculator was a byproduct 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 those into a spreadsheet devised as part of previous work (Royo 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.

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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 (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.

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 60% 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 £313 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 Score, 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 Gilbertson, 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 would 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.

References


Further reading and websites

Warwick University http://www2.warwick.ac.uk/fac/sci/ges/healthatwork/research/devgroups/healthyhousing/hhsrs/


RHE/BRE Housing Health Cost Calculator http://www.housinghealthcosts.org/
Accident Reduction in Home Environments

Dr Alan Page, Principal Lecturer in Environmental Health, School of Science and Technology, Middlesex University (a.page@mdx.ac.uk), and Ruth Plume, Senior Lecturer in Environmental Health, School of Science and Technology, Middlesex University (r.plume@mdx.ac.uk)

Abstract

This chapter reviews effective interventions aimed at reducing the incidence of accidents and fire, in a variety of settings and is particularly focused on the two primary risk groups identified in the Housing and Safety Rating System (ODPM 2006) i.e. those under 14 and those over 50. The approach taken in developing this is to use some of our own practice and experience adapted 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 towards the most highly vulnerable. 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 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 2011). 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 2009 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 alone and a further 2234 deaths where the location is not noted (ROSPA, 2012), using ONS statistics, suggest approximately 5000 home accident deaths in 2009 pointing to continuing increase within the home. 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 82.5% of all related death in the UK. Holburn et al (2003) identify smoking, alcohol, old age, disability/lifestyle, living environment, and social deprivation as risk factors. Ahrens (2011) adds cooking, potable space heaters, candles, lighters and matches, and electrical failure 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 accident reduction. What is of concern is the EHP is that the distribution of accidents is not uniform within the at risk groups. It is clear that there is a difference 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

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

Disadvantaged groups are more likely to live in poorer housing and the resultant health and social 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 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 ovid using the search terms accident reduction, effective accident reduction in the 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, risk education from home and enforcement of safety standards, coupled with a focus on at risk groups (Maronniche 2003, WHO 2008, Towner and Myttton 2009). Environmental health practitioners play a key role through advice, education, clinical intervention, advocacy, and enforcement (Burridge 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 there is a very small amount on adults. There has been a notable increase in adult education programmes aimed at at risk groups, however, the majority of these are provided by charities and other organisations. There is a need to target education at at risk groups to ensure that individuals at risk are fully aware of the dangers 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 windows at and above the second floor windows; WHO (2005) suggested a further focus on cupboard door restrictors, handrails, socket protectors, CD detectors, safe thresholds and safe kitchen design and equipment 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 under 5’s, 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.

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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 deprisation 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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Chartered Institute of Environmental Health (2008). Good housing leads to good health: A toolkit for environmental health practitioners. London, CIEH.
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 (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 indicating 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, 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 actions 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.

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 its areas (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 1: Mental Health and Wellbeing effects of category 1 and 2 Hazards from Noise.

Approach

As early as 2008, a study by the Chartered Institute of Environmental Health (CI EH) 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 moving 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 (CI EH, 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.

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.


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.

Table 2: Bristol Good Practice Model 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.

Disregarding the findings of the above surveys, 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.
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


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 in 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, closer 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 of previous years, for example), under occupancy of houses, inefficient heating systems, unfair energy pricing (limiting the most vulnerable the hardest, for example because they cannot afford the extra two degrees 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 attack, 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 sedation, 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 warmth, 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 enabled more 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 how to utilise more expensive 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 then 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 being used, the effects of climate change are already apparent and will become more so in time; all of us alive today must try to 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 waste 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 available assistance and a strong presence at a community level are all key elements to success.

References
Tackling Energy Efficiency in Hard to Heat Areas

Brett Warren, Environmental Health Officer, Central Bedfordshire Council (brett.warren@centralbedfordshire.gov.uk)

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 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 (Web 1) 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 25,000 properties located in wards with the highest percentage of off gas and solid wall. Access to Council Tax benefit information allowed us to identify any areas of wards that were low socio-economic status.

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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

<table>
<thead>
<tr>
<th>Insulation Type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loft Insulation: Under 60mm</td>
<td>43</td>
</tr>
<tr>
<td>Loft Insulation: Over 60mm</td>
<td>42</td>
</tr>
<tr>
<td>External Wall Insulation</td>
<td>29</td>
</tr>
<tr>
<td>Grand Total</td>
<td>114</td>
</tr>
</tbody>
</table>

* 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 loft (i.e. >60mm insulation thickness present) occurred in solid wall properties where the occupants 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 Councils 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 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 budgets 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 BREE HHC, Housing 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.

References


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). Many 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 as ‘shadow’ form 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 EH 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, Barnsby et al. 2009); these include Joint Consultative Committees (Humphries 2011), Health Action Zones (Glendinning 2002), Local Area Agreements and healthy setting boards 2006. Challenges identified in these earlier initiatives include ‘deep-rooted political, organizational and cultural barriers’ (Evans and Kilkar 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, Gales 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.

References
Humphries and Social Care Act 2012, Chapter 7. 19978 19585.


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

Sunanda Dhesi, Charteried EHP and PhD Student, University of Manchester (sunanda.dhesi@postgrad.manchester.ac.uk)

Abstract

This chapter outlines early findings of a qualitative research project exploring how Health and Wellbeing boards (HWBs) are tackling health inequalities, focusing on environmental health (Dhesi 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 influence 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 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, JSNAs 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 and PSH involvement and recognition in four HWBs during the shadow and pre-shadow phases.

<table>
<thead>
<tr>
<th>HWB</th>
<th>Level of PSH involvement and recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HWB 1</td>
<td>Low</td>
</tr>
<tr>
<td>HWB 2</td>
<td>Low</td>
</tr>
<tr>
<td>HWB 3</td>
<td>Medium</td>
</tr>
<tr>
<td>HWB 4</td>
<td>High</td>
</tr>
</tbody>
</table>

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 health and this is reflected in the draft JHWS 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 housing, 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. HWB members and managers who had been involved in writing the strategy paper and had more direct access toEH reps.

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 they are keen to be involved in developing their roles. The project would like to see the new HWB role as one that would be effective in improving the health of the local population, and that they are willing to take on new roles and responsibilities.

Gaining recognition

As HWBs are in their shadow stage, it is a time of development and change for HWBs. The members are well aware that they would like to see the new HWB role as one that would be effective in improving the health of the local population, and that they are willing to take on new roles and responsibilities.

Implications for policy or practice

Readers will see that the project has suggested a number of strategies for improving the role of EH in local government, including working with the directorate, developing a strategy for the board, and increasing the involvement of EH staff in public health planning. The project has made a number of recommendations, including the need for HWBs to be more proactive in engaging with EH, and for EH staff to be more involved in HWB meetings. The project has also highlighted the importance of involving EH staff in the development of the new HWB role, and for EH staff to be more involved in HWB meetings. The project has also highlighted the importance of involving EH staff in the development of the new HWB role, and for EH staff to be more involved in HWB meetings.

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Wirral Healthy Homes

Joanna Seymour, Senior Housing Standards Officer (joannaseymour@wirral.gov.uk) and Emma Foley, Private Sector Housing Manager, (emmafoley@wirral.gov.uk) Wirral Council

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 Homelessness 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 adapted (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 behaviour 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 (ODPh, 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.

References

Dhese, S. (forthcoming). Exploring how Health and Wellbeing Boards are tackling health inequalities, with a focus on the role of environmental health. Manchester Medical School, University of Manchester. PhD

Further reading and websites

Healthy Homes looks at a more holistic response to the full range of hazards in the home and has developed a referral network of individuals experiencing in working with vulnerable people. The scheme relies on effective inter-agency working and the development of a simple single assessment form from which referrals in services such as fire safety checks, home improvement agency support, energy efficiency grants, adaptations, the handyperson scheme and health advice 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, Handyperson 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 focused 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 (Mersyside Fire & Rescue Service), Energy Projects Plus, Reachout, Wirral Handyperson Scheme, Age Uk Wirral, District Nurses from Wirral Health Visitors, P.O.P.I.N (Promoting Older People’s Independence Network), DAAD (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

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 years old, second was the under 5’s and 15.5% 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 breakdown 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.
Home Improvement Agencies – helping vulnerable, disabled and older people live independently

Peter Archer, Chair, Care and Repair, England (peter.archer@thcp.org)

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 about 200 HIAs in England, 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 local councils (Lancashire Borough as part of the councils’ private sector housing teams. HIAs are being forced to diversify and scale down their services as the government withdrawals 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 Fenland in the Rhineland. It was sponsored by Shelter and HACT (Housing Associations Charitable Trust) and supported by the Labour Government’s Manpower Services Scheme (MSS). Fenland ‘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 1980, there were more than 200 small repairs 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 adults living in their own homes. The Government of the day was keen to promote the benefits of owner occupation, but successful local and national surveys of the condition of the housing stock revealed the continuing over-representation of older people in poor standard owned 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 5 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 Care & Repair work in 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 understood and supported by Care & Repair England, having a high profile with successive housing ministers.

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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 and 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 financial 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 EHVs 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 cuts in the housing budget. Without adequate funding for handyperson services, HIAs may not be able to continue providing essential home improvements.

In 2011/12 the HIA completed 7,822 handyperson jobs. 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 578 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

References

Online available www.communities.gov.uk/publications/housing/lifetimehomesneighbourhoods


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 Social Care) and the Health Service. This has resulted in many HIAs closing or being forced to merge with neighbouring services and scaling down operations. 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 the housing capital allowance has ceased making it very difficult for HIAs 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 (WE Care) introduced additional funding for handyperson services to support local authorities. This has resulted in many HIAs closing or being forced to merge with neighbouring services and scaling down operations.

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 Handypersons are all experienced and multi-skilled tradespeople.

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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 on still unmonitored the potential benefits for occupants of residential accommodation. Westminster Council and NHS Westminster (PCT) worked together to target vulnerable households in older, poorer housing to improve their health. This collaboration was 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 £302k of non-recurring 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 households 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 (53.1%) of which is privately rented: much higher than the national average (15.1%). At the same time, the Borough has both very wealthy, 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 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 ofrented accommodation (80%), mostly social housing (71%) provided by the Council or housing associations. Half of the resident population were of an ethnic minority origin. 60% 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 Westminster, 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 working 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 self-reported 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 NHS Westminster, 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 HHSR 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 representatives from 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 in whose 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. Referral 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 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.

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

Fig. 2

Issue Raised in Health & Wellbeing Checks

- Mental health
- STD
- Smoking
- Hearing
- Skin
- Respiratory
- Cervical Screening
- Alcohol
- Depression/Anxiety
- Arthritis
- Diabetes
- Cardiovascular
- Eye

The 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 appropriate 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.
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 10,000 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 13.3% 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 2,300 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.

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%)
• 19,600 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%).

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.
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.

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
7. Category 1 hazards by electoral ward - % category 1 risk 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
10. Ratio (per 1000 population) of emergency hospital admission episodes between 2008 and 2010
11. Residential for hospital admissions for falls

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

Figure 4

In 2008, accidents were the 6th highest cause of death in Liverpool with 154-4 deaths (Tivinger 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 been 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 Assessment has identified housing quality as a contributor to health inequality (Liverpool NHS Primary Care Trust and Liverpool City Council, 2008), with the latent 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).

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.

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.
Healthy Homes on Prescription

The project has recently secured £750k 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 particularly vulnerable to sub-standard housing and fuel poverty, 55 agreeing to an “alert” being added to their patient record system to deliver home safety messages.

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 £439,605 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 £1 trillion 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)
- 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 an reduction in health deprivation since 2007 (fewer SOAs in most deprived 10%) and a reduction in excess winter deaths – see Figure 7.

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.

References


Liverpool NHS Primary Care Trust and Liverpool City Council (2012) Annual Report of the Joint Director of Public Health 2011-2012, Liverpool Primary Care Trust, 1 Ashhouse Square, 61-69 Peel Street, Liverpool, L1 4AZ.


Further reading and websites


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.
Abstract
This paper seeks to share some of the steps that have been taken to raise the profile of housing as a significant determinant of health. It is hoped that professionals across the NHS and Public Health will take a more holistic view of health promotion which will take into account the social circumstances and housing conditions of patients.

Introduction
This paper sets out some of the approaches taken in making the links between health and housing. 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 the NHS and other organisations.

Background information and literature
When the DHWG was 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 support the new DHHG. 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 she 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 in the bungalow had low temperature 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 meet a better standard (the lady as she was over 70). The radiators were barely warm, so with the permission of the owner the radiators were boxed out and they became instant warm. We worked 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 some of the case studies that had been used internally to show the value of the service (Arlke, 2011).

This document has been widely circulated and used for the benefit of raising awareness about a range of issues. With the new arrangements for public health development it was proposed through the Derbyshire Health and Housing Group to produce a more substantial 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 site of a range of local partnerships to link to a joint publication of the paper on ‘Housing & Health’ with employment and health professionals, emphasising the value of personalising health.

An initial draft of the challenge document that had input from public health colleagues Housing officers and their Housing Care Board colleagues. This paper was produced 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 beginning to use this evidence which is outside their normal range of clinical interventions. There have been recent decisions about fuel poverty.

The difficulty lies in ensuring that while the evidence is shared on the agenda it is not lost in the pack. This is not a new phenomenon but has been an issue in the past. Over the years the Group has received funding from the PCT to promote the transfer of Public Health functions to first tier Local authorities to support the new DHHG. This work has been led by the PCT with ambitions for the transfer of Public Health functions to first tier Local authorities to support the new DHHG. This work has been led by the PCT with ambitions for the transfer of Public Health functions to first tier Local authorities to support the new DHHG. This work has been led by the PCT with ambitions for the transfer of Public Health functions to first tier Local authorities to support the new DHHG. This work has been led by the PCT with ambitions for the transfer of Public Health functions to first tier Local authorities to support the new DHHG.

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 offices have worked hard to increase the emphasis on joint working across the County with partners including the PCT and local authorities, and with fuel poverty groups and other housing providers that will have a direct bearing on the demands being placed on health and social care. Effective investment in housing standards will save the health services significant sums of money and the recent decisions about fuel poverty or Housing Commissioners might include identifying those at risk of fuel poverty within contracts for commissioned health services which could produce significant improvements in integration.