Housing LIN

Viewpoint 24

Shaping the concrete before it sets: Building effective health & housing partnerships - the leadership challenge

This Xiewpoint highlights the opportunity inherent in the immense challenges posed by an ageing and more diverse society, fiscal pressures and radical policy changes.

We have known for some time, and evidence accumulated in recent years supports the conclusion that, for best quality of life, best value for money and for sustainability, productive collaboration between agencies is essential. As highlighted in the February 2012 Health Select Committee report on social care, *'This Government, like its predecessors going back to the 1960s, has stressed the importance it attaches to joined up services. Growing demand, coupled with an unprecedented efficiency challenge, makes it more urgent than ever before to convert these fine words into fine deeds.'* Now is the time to act!

Few senior managers have previous experience of squaring the complexity of challenges confronting the UK at the moment. So there is a leadership opportunity in generating a different dynamic. Community leadership focussed on the public good, which reaches across the divides inherent in different organisations with different financial and political drivers, is the only way to make sense of the current uncertainties and shape a creative infrastructure to sustainably support the best outcomes for citizens.

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Introduction

It is widely understood that housing and health are intimately connected, inextricably linked. Having a home, living in good housing conditions and in a good neighbourhood with the right kind of support, are vital ingredients to health and well-being. And, the evidence shows that good quality housing and support is also a significant cost saver to the public purse. One pound spent on housing and support saves £2.12 on acute health and social care services.[1] Housing conditions are well established to be amongst the key determinants of an individual's health[2] with issues such as air pollution levels, over-crowding, condensation and adequacy of heating having serious health impacts and in particular some of these factors have a significant contributory effect on seasonal fluctuations in respiratory and cardiovascular mortality.[3] This is true throughout Europe.[4]

But why does good housing on its own not equal good health and well-being? If we take the example of social housing – homes provided by local authorities and housing associations[5] - the quality provided has improved dramatically in recent years due to significant investment following the introduction of the decent homes standard[6] and the quality standards for new housing built under the Homes and Communities Agency's Affordable Homes Programme. And yet it is not enough because the health outcomes for this group of people are still poor compared to the rest of society.[7]

This may be due to a lag factor, but may also be due to the high degree of dependency and poverty characteristic of this group of tenants. Local authorities and housing associations provide housing to meet the greatest need. This inevitably means that such tenants have multiple issues, demands and requirements in addition to needing a home. There exists a complex interplay of needs; good housing is a foundation but on its own does not lead to good health and well-being.[8]

An anecdote illustrates the point. Harry became homeless years ago following mental illness. He turned to alcohol to cope but kept finding himself in prison for causing a disturbance, stealing etc. Each time he left prison Harry's situation was no better. More recently though, he has been provided with a basic furnished flat in a supervised block, together with a support worker and Community Psychiatric Nurse who can help deal with anxieties, advise and coach in becoming a settled citizen and Harry is doing much better.

[1] Research by Cap Gemini for the Department of Communities and Local Government, quoted in NHF, *Invest in Housing,Invest in Health,* 2010
[2] Ineichen, B *How Homes and Health Interact*, Spon, London, 1993
[3] See for example Raw, G and Hamiliton, R ed *Building Regulation and Health,* Building Research Establishment, 1995 and Wilkinson, R et al, *Cold Comfort: The Social and Environmental Determinants of Excess Winter Death in England*, The Policy Press, 1993
[4] Bonnefoy R, et al, *Housing and Health in Europe: Preliminary Results of a Pan-European Study*, American Journal of Public Health, 2003, 1559-1563
[5] Sometimes referred to as Registered Social Landlords or Registered Providers – Housing Act 1996 and Housing and Regeneration Act 2010
[6] ODPM, *Housing Planning Local Government and the Regions*; Decent Homes 2004
[7] Braubach M, Jacobs D, Ormandy D. *The Environmental Burden of Disease of inadequate housing: a method guide to the quantification of health impacts of selected housing risks in the WHO European Region.* World Health Organisation, 2011
Marmot M. (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*
[8] Diana Wilkinson in *Poor Housing and Ill Health: A Summary of Research Evidence*, The Scottish Office, 1999 draws out the problems of attempting to isolate housing as a factor which is causally linked to poor health due to the extent of "confounding factors": "people in poor housing suffer so many deprivations that assessment of any one risk factor is almost impossible…"

His issue now is loneliness, understanding the puzzling complexities of the benefits system and occupying his time in a way that re-builds his self-esteem. At current prices, without court and police costs, prison alone costs £35-40,000 a year. Organising a package of support that draws on a number of local agencies from several sectors can keep Harry settled and out of jail whilst saving a substantial amount for the public purse.

Good housing of course does matter, plus good environment, equality of income levels,[9] employment status,[10] good society and the right support to live an independent but connected, active, learning, curious, contributing and meaningful life.[11] Good housing alone, although vital to well-being, is not enough. This piece explores that core question and offers some key observations for policy makers as well as the community leadership that health and housing boards and senior executives must display if we are to tackle the growing health inequalities gap. This widening gap shows that, despite the public investment of recent years, the fragmented nature of our support to those families in the most difficult circumstances is failing to really address their needs.

Housing as a Human Right

Housing is a fundamental human right. Shelter is a necessity for a settled way of life on a number of levels: for safety, for belonging and simply to meet all the basic human physical and psychological requirements. In the UK an address also provides a vital key to be able to access many other services. Interestingly a home is not seen as a necessary freedom right under the Human Rights Act. Under Article 8 rights only extend to the "right to respect for private and family life, home and correspondence" and not a home in itself. There have been various attempts to interpret Article 8 as a Right to a Home, mostly on the basis that this right cannot pertain unless a person has a home, but these attempts in the English Courts and the European Court of Human Rights have all failed, the Court pretty well sticking to a decision made as long ago as 1956.[12] Under English law some people do have the right to a home if they are homeless. However, the right is not a universal one. There are significant exclusions. For example, "intentionality": did a person intentionally make themselves homeless? These exclusions are too detailed to go into here, but the point is that the law does not provide the right to a home for the homeless in all circumstances and in many instances the support is to provide temporary accommodation.

Homelessness and Ill-health

Nonetheless it is a fact that the homeless suffer more ill health than those people who have a stable home. These problems are particularly acute in low temperatures. They experience more untreated illness and more crime related injury than any other group in society. Mortality levels are higher and death comes 30 years earlier compared to the rest of society.[13]

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[9] See Richard Wilkinson and Kate Pickett, *The Spirit Level: Why Equality is Better for Everyone*, Penguin, 2009

[10] See for example Mike Haynes, *Unemployment and its Health Effects: A Review*, Wolverhampton University, June 2009

[11] See New Economics Foundation, *Five Ways to Well-Being*, July 2011 and *Well-being evidence for policy: A review*, April 2012

[12] See *X v Germany* (1956) 1 YB 202

[13] See for example Crisis report, Silent Killer, December 2011 or Dearbhal Murphy*, Exploring the Complex Relationship between Housing and Health through Consideration of the Health Needs of*

There are some exemplary projects in the UK where wrap-around care and support help solve some underlying problems for this group. The inspirational Dawn Centre in Leicester supported by Inclusion Healthcare, a social enterprise, provides vital "drop-in" healthcare services to homeless people and other marginalised groups with the aim of improving their health and well-being, recognising the particular health inequalities that this group experiences. At University College London Hospital a GP, Dr Nigel Hewett, and a full-time homeless healthcare nurse practitioner have access to all wards where a homeless person is admitted, and multi-disciplinary support. They have a trained team of ex-homeless volunteers as care navigators on honorary hospital contracts, employed by the charities Thamesreach and Street League, who help the patient in hospital, support them on discharge and in settling into the community. Social housing is provided and the results have been hearteningly better. Net annual savings for the NHS are £300,000 but the improved quality of life for the individuals – both recipient and volunteer – demonstrate the efficacy of the collaboration.

However, such services are not available to the homeless across the UK; access to this quality of personal support and health service care is highly variable. The level of homelessness is growing rapidly with reports at the beginning of 2012 of a trebling of the level of street homelessness compared to only three years ago. The adequacy of access to health care services by the homeless will be crucial to their well-being and at a time of austerity and the reduction of public sector debt it is unlikely that better and fairer access to services for the homeless will be rolled out in the near future. A better coordinated approach between housing agencies, third sector organisations and the NHS is vital to combat this growing problem. This could well be a role of Health and Well Being Boards run by the local authority, taking broad and bold leadership within the communities they serve. They are well placed to tackle housing related health inequalities and encourage effective partnership, collaboration, co-operation, co-design and co-production through key local agencies, including the private and third sectors. Each local authority area will usually have a local housing partnership. Such partnerships and Health and Well Being Boards should forge strong alliances, encouraging housing providers to contribute and engage with the Joint Strategic Needs Assessment (JSNA) to create a greater sense of ownership in tackling housing related health inequalities.

Poor Housing, Poor Health

Having a home saves a person from the ill-health of homelessness, but the quality of housing and its location is vital too. It is one of Marmot's "social gradient" factors, a key determinant of health status and health outcome.[14] People living in the most deprived neighbourhoods and in the poorest accommodation have the worst health outcomes. There is a confluence of factors – poorer groups in society can only afford the lowest cost accommodation, with the overhaul of the benefits system creating a further and growing pinch factor. This accommodation is often located in areas which have been historically described as areas of multiple-deprivation. They have the highest levels of unemployment, crime, benefit dependency and poorest health outcomes. They are also areas which are characterised by poorer physical conditions for houses, the environment and urban form. Just by way of example, a 15 mile train journey in the West Midlands starting from leafy

People who are Homeless, FEANTSA, June 2006
[14] The Marmot Review, *Fair Society, Healthy Lives*, 2008

Lichfield travelling into inner city East Birmingham, sees life expectancy drop by 15 years for both men and women.[15]

Role of Directors of Public Health (DPH's)

DPH's - the independent advocate for the health of the people in their area - are moving back into local authorities with the changes in the Health and Social Care Act 2012 and will be able to assist Health and Well-being Boards to rethink service provision. This could provide a point of contact for service providers and give DPH's a greater opportunity to influence decisions which affect the wider determinants of health such as social care, housing, education and environment. Through their leadership role in the development of both the JSNA and Health and Wellbeing Strategy they will be in a prime position to drive the prioritisation of issues such as housing and health. They have a strategic population overview with access to detailed demographic and epidemiological intelligence and a vital role in the three domains of public health: health improvement; protection; and in assessing the quality of health and social care. They are skilled in interpreting such intelligence to help decision-makers understand health profiles and the likely impact of health and social interventions. When finances are tight this aids the targeting of investment to those communities where the benefit may be greatest.

Quality of Housing Across the Life Course

Safe secure housing can be a contributory factor to health outcomes across the life course. A child born to a mother in poor housing conditions is not only likely to suffer poorer health outcomes but also lower life expectancy. Longitudinal analysis of three British Birth Cohort studies (1946, 1958 and 1970 cohorts)[16] shows that "*being in social housing as a child increases the risk of multiple disadvantages in adulthood*". For vulnerable groups support services to help them sustain their housing are important and yet there are risks at present that such support is being undercut by public expenditure constraints at a time when individuals' income levels are dropping due to welfare benefit reform. Placeshaper housing associations[17] are responding to this challenge as set out in *Localism that Works* by widening their range of community services providing support to individuals around jobs, enterprise creation, supporting community business, tackling loan sharking, healthy eating and building low energy timber homes. Cross Key Homes and Peterborough PCT are working in partnership to provide health trainers – people of the local community - trained to help fellow citizens tackle obesity, diet, physical activity, smoking and alcohol problems within communities with relatively low life expectancy.[18]

Housing cooperatives and mutuals provide better health and other outcomes for people. These organisations are housing agencies, usually small, which are run by tenants themselves. A recent Commission found a whole range of outcomes are better within these agencies than for other forms of social housing. In brief there is less crime, better health, less dependency and higher levels of employment. There is also improved social fabric and

[15] West Midlands Strategic Health Authority, West Midlands Annual Public Health Report 2008/09. NHS

[16] M Bartlkey al. *Birth weight and later socioeconomic disadvantage: evidence from the 1958 British Cohort Study*. BMJ 1994;309:14

[17] A group of around 70 community focused housing associations, see www.placeshapers.org

[18] See Placeshapers, *Localism that works*, December 2011

social capital and a greater sense of belonging. All of these factors have an impact on well-being.[19]

Forging strong relationships between Health and Well Being Boards and local housing agencies is vital in tackling housing related health inequalities as we have already mentioned. It is equally important that leaders within housing organisations recognise the important role they can play in designing and managing housing and the surrounding areas in ways which encourage healthy outcomes. Designing space which assists in community interaction, constructive play for children and young people and providing and accessing the sports activities of other healthy venues perhaps by providing appropriate space or by forging partnerships with other organisations. The proximity and positioning of amenities could equally “nudge” healthy behaviours whether physical or through the encouragement of social interaction for young and old alike.

In later life housing is pivotal in ensuring a good quality of life and ability to maintain independence. Services and support provided in a person’s home are dependent on a quality home that may also require accessibility and/or adaptability with the right kind of tailored support for older people to live independent lives. According to Age UK over 750,000 people aged 65 and over need specially adapted accommodation because of a medical condition or disability and 145,000 of them report living in homes that do not meet their needs. The Accord Housing Group in the West Midlands introduced a voluntary social programme to its extra care schemes meeting the needs of older people with dementia in 2008 called the Eden Alternative. At the start of the initiative more than 70% of the residents in the project were taking “psychotropic” drugs prescribed by clinicians to help with the effects of dementia. The initiative introduced touch and sensory techniques, with greater family contacts, pets and animals within the schemes and a range of other changes. As a result of this radically different approach, by 2012 less than 20% of residents are now taking prescriptions drugs specifically for the dementia. The application of a different therapy has been transformational to the quality of life of the residents concerned and delivered a significant reduction in NHS costs.

The critical role of housing in achieving better outcomes for older people is recognised as a major Government priority, underpinned by the cross-cutting national strategy for housing in an ageing society, published by the Department for Communities and Local Government in February 2008 and reiterated in the ‘new deal for older people’ included in the Coalition Government’s national housing strategy.[20] However, with funding constraints growing at a local and national level it is a concern that provision of appropriate levels of care and support will be threatened. Again, effective leadership is required within housing organisations in rising to this challenge of delivering better services for less money and in forging effective partnerships with other agencies to deliver services where they can’t. It also requires leaders who are willing to campaign and fight for the needs of groups whose lives may be negatively impacted by funding and welfare reforms.

One way forward to understand health impacts of housing may well be to roll out health impact assessments for new projects and existing housing schemes in order to more fully understand what actions can be taken to lessen adverse health outcomes. A partnership between public health and a housing association in Sandwell identified different and new measures to address health inequalities on a new large housing scheme near to the West

[19] Commission on Co-operative and Mutual Housing, *Bringing Democracy Home*, 2009
[20] Department of Communities and Local Government, *Laying the Foundations*, 2011

Bromwich town centre.[21] Such an approach can be applied to existing housing areas as well as new schemes to better align investment decisions, in other words to jointly commission to reduce health inequalities.

Affordable Warmth, Preventable Excess Winter Deaths

Turning now to fuel poverty which affects every stage of the life course, the number of fuel poor households dramatically increased between 2004 and 2010 from 1.2 million to 4.6 million. With rising fuel prices since that point the situation is now undoubtedly much worse. The Marmot review found evidence of impacts on mortality, morbidity and other social impacts. Countries which have more energy efficient housing have lower excess winter deaths.

Warmth is a key issue, a wide range of physiological and psychological conditions are exacerbated by low and high temperatures. Sandwell, for example, in the West Midlands has the highest rate of excess winter deaths in Europe and this is put down to the relationship with poverty and fuel costs in winter months. We have known since 1985 that fuel poverty is a contributing factor in a number of cold, and poor housing, related health conditions.[22] One study found that every £1 spent on reducing fuel poverty saved the NHS 42 pence.[23]

Some existing health conditions can be seriously affected by cold while others can be caused by prolonged exposure to it. Sustained low indoor temperatures can make respiratory disorders worse and there is an increased tendency to suffer colds, flu, bronchitis and pneumonia. Cold makes condensation and mould growth more likely, an environment which exacerbates allergies and asthma. Low temperatures also affect the circulation. Below 12°C blood tends to thicken, increasing blood pressure, in turn leading to an increased risk of heart attack and stroke as the heart works harder to pump blood around the body. The chronically sick, disabled and those with lower mobility levels are particularly at risk from hypothermia.

A cold snap, even in a mild winter can sharply increase health emergencies. *'After two days there is a sudden rise in heart attacks, by up to a third; after five days there is a big rise in the number of strokes; and twelve days into a cold spell there is a rise in respiratory illnesses.'*[24]

Investing in existing housing through initiatives such as 'retro fit' and 'green deal' to improve energy efficiency is crucial at this time of both welfare benefit reform and rising fuel costs to ensure better health outcomes for the poorer groups in society.

Engaging health partners

The purpose of the NHS is enshrined in the NHS Constitution.[25] *'[The NHS] is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.'* It is a noble purpose. Delivering that promise while accommodating a 5%

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[21] Kaur, B, Eastern Gateway: *A health impact assessment*, Sandwell PCT, 2011
[22] World Health Organisation, *The Health Impact of Low Indoor Temperatures*, 1987
[23] Liddell C, *The Impact of Fuel Poverty on Children*, Policy Briefing for Save the Children, 2008
[24] Energy Action Scotland, *Fuel Poverty and Health:* The Impact of Cold Temperatures on Health (accessed 31 May 2012) www.eas.org.uk/page.php?id=2305
[25] Department of Health, *The NHS Constitution for England*, 2012

drop in tariff prices year on year necessitates thinking increasingly differently about service models and care pathways. Any contribution housing providers can make through tighter engagement with health providers for those patients with disabilities, mental illness or the infirmities of old age will be welcome. The most useful contact points are the GP lead for a specific patient group within the local Clinical Commissioning Group, the service manager within community health services or the relevant director in the local hospital. The acronym most current in the NHS is QIPP – quality, innovation, productivity and prevention. This is the framework being used to assess progress against the 2011-2015 £20 billion savings target. Framing proposals to demonstrate success in any of these four domains, whilst also cutting costs, is very likely to engage the interest of senior NHS leaders.

Conclusions

Having a good quality home is essential to good health. But on its own it is not enough. The right kind of support is also required so that vulnerable people can live independent lives and these can rarely be provided by one organisation working alone. Issues within poorer neighbourhoods have to be tackled in a coherent way so that the complex interaction of deprivation factors can be addressed through the collaboration of agencies. The alignment of decision making and investment has been shown to have deeper, broader and more cost-effective impact. Inter-agency and multi-professional working through the use of health impact assessment may be a key and practical way forward to better understand measures which can address health inequalities in individual homes and within neighbourhoods.

The opportunities to increase impact are there, the evidence is growing.[26] The structural changes currently underway may support more cohesive thinking within local areas. However, it is too easy to watch and wait to see how new systems bed in and then to find that they have created new constraints to making the right things happen. Fortune favours the brave. It is time for leaders from all sectors to seize the space, to craft a clear vision, to harness courage and to collaborate across organisational and professional boundaries to shape the concrete before emerging system specifications set.

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[26] Porteus J, *Housing prevention and early intervention at work:a summary of the evidence base*, Viewpoint 21, Housing LIN, 2011

About the Housing LIN

For further information about the Housing LIN and to access its comprehensive list of online resources on housing with care for older people and people with a long term condition, visit www.housinglin.org.uk

The Housing LIN welcomes contributions on a range of issues pertinent across housing, health and social care. If there is a subject that you feel should be addressed, please contact us.

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