Quarterly Research Meeting – Summary Report

Creating Healthy Places in the North East: the Role of Housing

Tuesday 20 October 2015: 9.30am-1.30pm

The Forge, Teesside University, Vicarage Road, Darlington

Introduction

This report summarises the keynote speaker's presentations, and the concluding panel discussion session at the October Quarterly Research Meeting held on the topic of housing and health. This event was jointly organised by Fuse, Public Health England – North East, the Association of Directors of Public Health and the National Housing Federation. This summary report is to be read in conjunction with the slide sets kindly provided by our speakers, also on the Fuse website.

PLENARY SPEAKERS

Mrs Gillian Leng, Housing and Health Lead, Public Health England, 'Health and Housing from a National Public Health England perspective'

PHE's vision is for a home in which 'to start, live and age well' but currently poor housing affects 3.6m children, 9.2m adults and 2m pensioners. 19% of these adults in poor housing have poor mental health and 28% of people in cold homes have 4 or more negative mental health symptoms. The cost of mental health to the NHS is unknown but at least £1.4b is spent on falls and illnesses related to cold conditions in homes.

PHE has commissioned a number of housing resources including the following:

- www.cieh-housing-and-health-resource.co.uk
- Homeless health needs audit (the NE is the first region that have completed this!) which enables the comparison of local health needs with other areas.
- Care & repair
- Housing & health exchange: www.housinglin.org.uk
- www.hact.org.uk/standards-evidence-housing
- Health statistics user group: www.hsug.org.uk

Mr Patrick Vernon, Health Lead, the National Housing Federation, 'Housing and Health: perspectives from the National Housing Federation'

Patrick Vernon emphasised that there is a mismatch between housing demand and supply in the North East with 5 million people living in 2.5m homes.

The Due North report has highlighted the inequalities in the region and argued that the current spend on housing in the order of £136m could be used differently to tackle health inequalities.

However, the Inside Housing Survey completed by 135 housing providers CEOs revealed that they are currently cutting back on non-core activities and looking into mergers.

Moreover, they speak with no single voice (many housing providers work separately) and this is a challenge for NHS & social care when trying to collaborate with housing. The National Housing Federation is trying to achieve more joined-up working, which is especially important in a time of austerity, with moving resources more upstream and away from the acute sector.

Mr Phillip Edwards, Institute of Local Governance, 'National versus local housing and welfare policies'

Phillip Edwards showed that the impacts of welfare reform in the North East are comparable to national experiences but at the same time are also different. The North East economy is different and the region has been disproportionately affected by welfare reforms via the bedroom tax, under occupancy, council tax, use of Discretionary Household Payments (DHPs), arrears, gradual introduction of Universal Credit, and benefit sanctions. The ability of the North East to ameliorate this situation is very difficult. Soon there will be further problems to respond to given the upcoming restrictions of housing benefit for under 21s and benefits freezes. Unemployment rates in the North East remain the highest in the country.

The reforms have been implemented differently across the country. For instance, there is no a uniform approach to sanctions in the country with percentages of claimants receiving sanction varying between 3-15 per cent, with some concurrent sanctions of up to 3 years. The North East is particularly vulnerable in relation to under occupancy; however, it takes considerable time to change housing stock. Although the welfare reforms aim to save money there are also costs attached related to eviction costs – coming from the public purse. There is some flexibility in relation to Discretionary Housing Spend, which will be critical for alleviating the impact of the welfare reform. However, there is no longer money available for Social Welfare Assistance, as this has been absorbed into the budget. This has resulted in increasing use of food banks with more people finding themselves in crises.

Dr Tim Townshend, Newcastle University, 'How can housing contribute to building healthy places?'

Tim Townshend demonstrated that housing related ill-health can be improved with retrofitting. He presented two case studies:

Case study 1 from New Zealand: retrofitting insulation in 1350 low-income homes where at least one person had a chronic respiratory problem – this intervention found a reduction in poor health, wheezing, and the number of children attending school/adults going to work (self-reported measures).

Case study 2 from the Netherlands: dementia-friendly village in a suburban area of Amsterdam has been designed for dementia sufferers using colour and contrast (multi-sensory, green space, contrasting flooring, etc.) to encourage them to be more active and socialise in their village.

We have an ageing housing stock as well as an ageing population in this country and there is a shortfall of suitable housing for older people. However, we can ameliorate the effects of dementia via housing design (such as the example from case study 2). There are opportunities to build healthier housing with existing housing stock via retrofitting as has been demonstrated in the case studies, providing us with the chance to mitigate some of the most challenging health problems like dementia.

Mr Neil Revely, Director of Social Care, Sunderland City Council, 'How can social care contribute to building healthy places?'

Neil Revely made a plea for including housing as an item on Health and Wellbeing Boards' agendas, as housing is woven through the Health & Social Care Act guidance.

This item should include all tenures (not just council and social housing). He supported Gilian Leng's aspiration of building 'homes for life' that could be adapted during the life course and enable residents to remain in their homes as their personal and family situation changed.

He invited participants to a conference taking place on the 11th November at the Durham Centre around the Health and Housing Memorandum of Understanding (MoU; see also Closing Remarks).

Panel discussion with key note speakers

Common themes discussed in the morning's session include:

- Opportunities for health and housing in the devolution plans for the North East
- Building the evidence base for the link between housing and health base
- Develop more case studies to showcase existing work

- Use the Healthy Towns Agenda as a vehicle for promoting the link between housing and health with the NHS

Q1. What external funding is available to fill some of gaps in the evidence base on the link between housing and health?

A1. The following suggestions for potential funders were made: National Institute for Health Research (NIHR) and Economic and Social Research Council (ESRC).

Q2. What can be done in the private sector to increase the impact on health?

A2. There are some examples in the Chartered Institute of Environmental Health' Housing and Health resources (http://www.cieh-housing-and-health-resource.co.uk/) of good practice with private landlords. There are also some social housing initiatives that do not discriminate against private renters or home owners.

Break-out session 1: Tackling fuel poverty (Chair: Professor Clare Bambra)

Mr Paul Burns, Gentoo Housing, Boilers on Prescription pilot

Paul Burns presented on a retrofit programme in Sunderland working with COPD patients, which has had considerable health benefits in terms of improving arthritis, reducing visits to GPs less, reducing frequency of reported asthma symptoms, increasing school attendance and increased usage of space in the house (not restricting to one room). The programme is delivered in the Sunderland area of Hendon, where people live on average 13 years less compared to residents in the more affluent counterpart of Fulwell.

Paul Burns recommended that housing providers learn to speak the clinical language that is practised in the NHS in order to effectively engage with the health sector. (e.g. frame project aims in terms of reductions of non-elective re-admissions to hospital as a result of better housing conditions).

Paul Burns argued that investing is housing makes economic sense for the health sector: the average spend on improving homes in Sunderland is £5,500, while readmission costs to hospital for long-term conditions related to damp and cold housing is likely to be much higher.

The pilot, for instance, demonstrated a 82% reduction in hospital appointments and a 28% reduction in GP appointments (self-reported).

Mr Cliff Duff, Durham County Council's Housing Regeneration team, Durham's Warm and Healthy Homes scheme

Aim: to reduce excess winter deaths.

In Durham, 11.4% of households are in fuel poverty.

Private sector is a big challenge to Durham.

Up to 35% of fuel poverty is located in rural areas (West Durham).

The Housing Energy Database produces SAP readings to work out fuel poverty. Anything below 65 indicates that a resident may be experiencing fuel poverty (map shown).

The outcomes of this scheme have led to 82 households receiving new central health systems but there have also been some softer measures in terms of fuel tariff advice.

For more information about the 'Affordable home warmth action plan' please follow the below link: http://www.durham.gov.uk/media/1058/Affordable-warmth-action-plan/pdf/AffordableWarmthActionPlan.pdf

Discussion about both presentations:

Must talk the right language!

Need advocates strategically placed in CCGs to raise awareness. Make the system as easy as possible. Paul Burns suggests that we keep GPs out of the picture as they have no time.

We can get other bodies involved such as Age Concern or Citizen's advice (it doesn't have to be a health professional – they can be made aware of initiatives but must be mindful not to burden health practitioners).

An investment of £1 gets £3.20 back in terms of social benefits.

Break-out session 2: Promoting mental well-being (Chair: Dr Heather Brown)

Dr Zeibeda Sattar, Sunderland University, Sheltered accommodation for residents with dementia

This project evaluated a number of improvements to sheltered housing. South Tyneside demographics: 18% of population over 65 compared to 16% nationally and 17% in North East.

South Tyneside Homes (STH) developed 36 housing schemes. 9 of these schemes were evaluated.

For this project:

1) Interviews with stakeholders (staff and tenants)
2) Participatory Appraisals (before renovations, during, and after)
3) Questionnaires

Renovations were wifi, conservatory, garden, and sensory rooms

Residents who were 85+ not interested in learning how to use computers. Younger residents were more interested in training and more likely to use free wifi once available

Safety major issue for residents

Some evidence improvements impacted on benefits and health and quality of life

Mrs Clare Groves, Home Group, Social prescribing

This project evaluated how an integrated care scheme impacted on health. Social Prescribing Home Group: Provides integrated health services (lifestyle interventions for a number of CCGs)

Durham Dales, Easington, and Sedgefield

Physical Activity=> reduce health inequalities, provide individual health plan

Individuals are referred by GP

Peterlee leisure centre:

- Gym/Fitness Centre
- Table and short tennis
- Indoor curling
- Squash and badminton

The programme relies on peer support to help participants on their jorney

Benefits to NHS:

- Reduce dependency on primary care services
- Reduction in prescribing costs
- Reduction in hospital admissions

Another project that was briefly discussed was the Birmingham Carer Services provided across 3 CCGs

50 peer support groups

Prescribing decreased (based on Warwick/Edinburgh mental well-being scale)

Decrease in hospital admissions

<u>Discussion about both presentations</u>

1) How is South Tyneside home project funded? Housing + funded by STH
2) How were links made with CCGs? (social prescribing) Not easily, people with links on the ground, mental health provider forums, co-production with people with living experience
3) Methodology on cost-saving (social-prescribing,) PSSRU, Warwick/Edinburgh Scale

4) Management of long term conditions, Need planning for dementia, STH move to care homes sometimes not wish of person but other people living in accommodation, Design of property

Break-out session 3: Supporting vulnerable groups (Chair: Ms Claire Sullivan)

Mrs Helen Neal, Thirteen Group, Middlesbrough Recovering Together project

As a key partner in 'Middlesbrough Recovering Together' (the collective name for the area's drug and alcohol treatment model), housing provider Thirteen Group have developed a Recovery Project in Middlesbrough, using funding secured via Public Health England's Recovery Capital Programme and in partnership with local treatment service, Hope North East. The project is based on a recovery hub model, where those experiencing drug and alcohol addiction can access multiple support services within a single location. The model was developed in consultation with service users and in partnership with the Public Health team and the local treatment system. The client group are predominantly those already engaged in treatment for their addiction but the Hub has also identified a number of people not engaged in treatment and has been able to safely refer them into appropriate services. The project's aim is not to duplicate interventions already delivered by the treatment system but to support those accessing treatment with a range of complimentary and additional services designed to improve overall health and develop recovery capital. Services include:

- A physical activity programme, using the onsite gym facilities;
- A healthy eating programme;
- A back-to-work and skills programme, delivered in partnership with Job Centre Plus;
- A depression and anxiety support programme, delivered in partnership with MIND.

The project commenced in 2014/15 and is currently being externally evaluated by Professor Dorothy Newbury-Birch, Professor of Alcohol and Public Health Research at the Health and Social Care Institute at Teesside University. Expected outcomes include:

- Increased access of local treatment services;
- Improved rates of successful completion from treatment;
- Reduction in criminal activity;
- Increased uptake of health screening programmes;
- Reduced health inequalities.

Mr Rob Bailey, Tyne Housing, Working with homeless people in the community

Under the Bridge is a charitable subsidiary of Tyne Housing Association and is used to manage the organisation's homelessness services. Under the Bridge delivers a range of services in the Byker area of Newcastle upon Tyne, aimed at supporting people who are

homeless and often suffering from health issues, including substance misuse. Services include:

- Byker Bridge House is a purpose designed, direct access, hostel which provides accommodation to 31 single homeless men and women. Each resident has their own bedroom and bathroom and access to a shared living and dining area, kitchen and laundry. The hostel is staffed 24 hours per day and residents are provided with advice and support on benefits, housing and resettlement issues;
- The Under the Bridge Workshop renovates and recycles furniture donations which are then sold to support the project. The workshop is available to residents of Byker Bridge House and provides experience and skills in woodworking;
- The Joseph Cowen Centre offers healthcare services to homeless men and women. Medical services include access to a GP and a Community Psychiatric Nurse. The Centre also offers a needle exchange women only facilities and provides advice, guidance & support on housing and emergency accommodation.

<u>Discussion about both presentations:</u>

Move on from temporary accommodation was seen as key. Both of the above organisations employed dedicated staff who are able to liaise with local housing providers, explaining the needs of their client group and advocating on their behalf.

A question was raised about the viability of self-build projects. Both Thirteen and Under the Bridge advised caution when considering this type of model as it can often be time consuming, complex to initiate and to manage and does not necessarily create better outcomes.

Everyone agreed that, where possible, academic evaluation of these types of projects was important, especially to help gauge the overall, community wide impact they created.

Both presenters agreed that it was important to remember that any outcome achieved did not belong to a single service and would be the result of effective partnership work. It was important to promote this thinking and ensure everyone remained engaged and supportive.

Post-lunch meeting with key stakeholders

NE devolution – implications for housing and health

The current NE devolution plans provide opportunities for promoting the strategic link between housing and health; it provides a platform for working at scale with guaranteed longer-term funding. However, current examples of devolution and combined authority-working tend to be more slanted to facilitating employment by encouraging businesses to come to the region. Housing takes up a limited meaning in this approach as providing the right housing to attract the right (skilled) people for these jobs. Participants agreed that housing also needs to include human capital such as education and health, as well as attracting future work force.

Early lessons from the Manchester devolution deal on Health and Social Care suggest that we:

- Need to be clear about the problems that housing can solve (with detailed evidence and a specific offer);
- Need to specify what the offer translates to in terms of outcomes (e.g. reducing A&E submissions and delays of care) and costs savings;
- Build the evidence base to support this.

A discussion followed on what we mean with building the evidence base and who we are making the case to with this evidence. Suggestions were made for building on the existing evidence in the Due North report and for identifying key stakeholders in the devolution plans writing process to target with the collated evidence. Participants agreed that a clear strategy needs to be developed between Local Authorities (comparable to the Combined Authorities' Transport Plan but then for Housing) for the next Health and Social Care Commission meeting in April 2016 with invites being secured for housing representatives to attend the meeting. A number of issues were mentioned that the devolution plans could focus on: regulation, local authority borrowing capacity and inspections.

Commissioning and evaluating housing-based health and wellbeing interventions

Accessing, linking and collecting existing data

A specific role was identified for PHE to develop the evidence base for housing associations; making them aware of the health issues that relate to housing and giving them access to existing health data, which they can use to inform and evaluate their interventions.

An example was given of a CCG not releasing their health data to inform commissioning decisions within their local authority area. This situation might improve now that local authorities have been given access to HES data. However, many health services are currently not collected data on housing related indicators. For instance, A&E departments

do not record tenure information and local authority health profiles do not include housing data. Housing providers do collect basis tenant data and could also collect relevant health data but would need support from academics on selecting useful questions (e.g. Warwick-Edinburgh Mental Well-being Scale and the EQ-5D) and indicators, which are standardised measures. Developing neighbourhood plans using JSNA data might be a useful tool for combining health and housing data.

Participants also argued that better use could also be made of existing data that local authorities collect on social housing, such as profile data of residents on social housing waiting lists, monitoring data from housing team officers on their appointments with prospective tenants, etc. Health questions could be added to these data collection tools.

However, to focus new and existing data collection and analysis, participants emphasised that key strategic priorities around housing and health need to be specified to inform which questions are most relevant to ask and to who (e.g. which communities to target?). The QRM in the morning, for instance, highlighted the growing health needs in the private rental sector; should new interventions therefore be tenure blind?

New research

Other participants argued that, apart from making better use of existing evidence and linking housing and health data, new collaborative research was needed to evaluate the impact of interventions being developed by housing associations that impact on health. Some housing associations have commissioned their own research (e.g. Gentoo commissioned Bangor University to model the findings of their Boiler on Prescription pilot in terms of Quality Adjusted Life Years (QALY)) but this does not always make use of local expertise (e.g. the health economics team at Newcastle University).

A particular need was identified for translational research that explores implementation barriers and opportunities of interventions, even when there is a strong evidence base for impact to use them. How do we know what works where for whom? Different local authorities have different social care and health systems: how can interventions work better across these different systems?

It was acknowledged that there is a disconnect between the timescales required for developing and conducting academics research and the need for this evidence to inform policy and practice, with ethical approval processes at Universities causing considerable delays.

Recruiting a sufficiently large sample size was also cited as a problem for detecting significant effects in academic studies, while larger studies are often too expensive. It was suggested that qualitative studies can be more effective with small sample sizes.

Universities were urged to be creative in finding resources, for instance making best use of available students. Also, high level health (population) data might be initially sufficient, if it can be linked to existing evidence bases. For example, the existing evidence base on the

impact of poor housing on respiratory conditions could be used to target a specific sub-population in a community that would most likely benefit from an intervention. Simply monitoring the engagement of this sub-population in a house improvement intervention might be enough to argue the initial case for impact.

Moreover, evidence of impact is not always required to secure funding, according to some participants: seeing an intervention at work ('on the ground') is sometimes sufficient to convince commissioners.

Closing remarks

Participants were encouraged to contact existing research resources with the North East, such as AskFuse (www.fuse.ac.uk) and ongoing research by NSF (email address?) that aims to develop a research tool for housing associations, which includes before and after checklists for assessing change and impact.

Patrick Vernon from NHF made an explicit call for evidence about what works in terms of housing provider interventions.

PHE also launched a public consultation on their standards of evidence for housing, produced by HACT: http://www.hact.org.uk/standards-evidence-housing

Participants were invited to attend the North East Housing LIN Annual Conference in Durham, titles 'Improving health through the home in the North East', which is a free one day event supported by ADASS, North East Councils, National Housing Federation and the Housing LIN. The event taking a 'deep dive' into the health and housing Memorandum of Understanding and its implementation regionally. For more info please see:

http://www.housinglin.org.uk/Events/ForthcomingEvents/HousingEventDetail/?eventID=851

Finally, participants were encouraged to link up future events on this the theme of housing and health.