Healthy Homes, Healthier Lives

A review of the national initiative undertaken by Care & Repair England between 2004-2008

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Summary

The *Healthy Homes, Healthier Lives* initiative (2004-08) aimed to improve the health and well being of people, particularly older people, who are living in poor or unsuitable housing conditions.

One of the methods used to achieve this aim was *Healthy Homes Awareness* training. This has the objective of increasing the knowledge and understanding of the potential impacts of specific housing conditions on people's health amongst front line staff in health, social care and housing.

In addition to adding to the theoretical knowledge base of individual staff, the training is focussed on identifying which housing related services are available locally and the practicalities of how staff can link individual householders to such provision.

Improved cross-sector working amongst front line health, social care and housing staff in the statutory and voluntary sectors was a further intended outcome of the *Healthy Homes* initiative.

Staff trained through the programme included community matrons, health visitors, social care workers, home from hospital officers, Red Cross hospital support staff/ volunteers, home improvement agency staff, Age Concern workers/ volunteers and housing officers.

A key part of the *Healthy Homes* model was the use of home improvement agencies to act as local champions and promoters of Healthy Homes information and ideas, based largely on a model pioneered by Bristol Care & Repair.

Self training packages, a DVD/ CDRom, training for trainers and modules for use in the mainstream training of the next generation of health and social care staff were all developed as part of the training element of the *Healthy Homes, Healthier Lives* programme.

Main Findings

The response to the *Healthy Homes Awareness* training on the day of delivery was very positive. The majority of participants said that what they had learned was very useful (57%) or useful (31%) to their practice and that it would enable them to refer clients/ patients to other services (87%).

Identifying a measurable, lasting impact on day to day practice was challenging for a number of reasons. Making contact with the course participants one year after the training was difficult. The follow up exercise revealed a high rate of staff turnover and communications issues, particularly in PCTs.

However, of those trainees who were reached and who did respond, the majority reported that they took more notice of people's housing conditions (78%), were more likely to refer people on to other services (83%) and that some of their clients/ patients' housing conditions had been improved as a result of this intervention (44%).

Respondents were not able to provide exact numbers of the people whose housing conditions had been improved as a result of their input and there had not been the capacity to set this up systematically through the programme.

However, data on overall trends in referral sources to home improvement agencies, provided by Foundations, revealed that whilst levels of referral from the health sector are low, a comparison of referral sources during the periods before and after *Healthy Homes* training showed that in areas where HIAs had taken part there was a higher rate of referrals from health sector sources than in non *Healthy Homes* trained areas – 3.4% vs 2%.

Foundations also noted that most (70%) of enquiries to HIAs are recorded as "self-referral" hence these would not reveal an increase in the number of people being sign-posted by health/ care staff who had attended the training.

One of the approaches to the delivery of *Healthy Homes Awareness* Training was to provide a package of information, self training materials and a presentation pack to encourage participants and the organisers of the initial training to cascade the information amongst colleagues. Home improvement agency training for trainers also aimed to encourage local HIAs to promote and deliver the *Healthy Homes Awareness* information and training.

It was found that where a local champion had taken up *'Healthy Homes'* ideas and promoted them extensively some changes in working practice did take place, but in all cases it was the home improvement agency who had championed the issue, rather than a health sector officer. This was the experience of the original *Health Homes* model pioneered in Bristol, where a rolling programme of *Healthy Homes* training is now well established. In most areas, information was not passed on systematically and the training had not resulted in coherent changes to cross sector working.

The feedback from one Community Matron who had organised *Healthy Homes* training for a group of Community Matrons illustrates common strands in the feedback from health and social care staff about the impact of constant organisational change on service development:

"*We were very interested and excited by the [Healthy Homes Awareness] course and I wanted to organise more sessions – I am sure that awareness of housing is an essential part of what we aim to achieve in helping people stay healthy and safe in their communities. But since then everything has been in upheaval. Everybody was on temporary contracts, there have been arguments and unsettlement. Next week everybody has to undergo interviews to keep their jobs. Obviously this has affected staff profoundly. A lot of the team take time off sick with stress and they are not in the mood for developing new ideas."*

Main Conclusions

There is extensive evidence of the impact of housing on a range of health conditions, particularly the chronic conditions that many older people experience. Good quality, suitable housing can have a significant impact on health and well-being in later life.

The *Healthy Homes, Healthier Lives* model's usefulness and applicability to current key health, social care and housing policies with regard to an ageing population also remains significant. Its core aims of supporting independent living for older people in general housing stock and preventative approaches to health and social care meant that the model is if anything, even more relevant.

A potential driver for a policy and practice response to the links between housing/ health/ demographic change is the recognition that failure to address housing defects and inadequacies potentially results in higher costs via increased demand for health and social care interventions. However, there is a lack of cost benefit analysis/ impact assessment of specific interventions for the individuals who are most at risk of requiring NHS treatment or social care ie. those who could place the highest demands on health and care. Further research is needed to address this knowledge gap.

Increased targeting of any available help with housing repair, improvement and adaptation where it will have the greatest impact on preventing the need for health and social care is strongly anticipated as resources become more stretched. However, there are real issues about how system links across the health, care and housing sectors can be made to work more effectively.

The experience of working with front line health and social care staff through the *Healthy Homes* training initiative reveals that whilst there is an interest and willingness amongst many staff to adapt and change, particularly where they can see a real benefit to patients/ clients, there is a significant gap between the reality on the ground and the ideals of cross sector working. Effective comprehensive assessment of need and joining up services to achieve common goals of enabling older people to live independently with better health and well-being are some way off.

Changing established working practices and breaking down professional barriers is never easy. The *Healthy Homes* initiative has shown that it is possible for front line health and social care staff to learn to identify shortcomings in housing conditions and instigate remedial action, with the resulting gains for older people. However, most individuals will not automatically incorporate this wider approach into their day to day practice as a result of one off training and an increase in their knowledge base.

Support for significant changes to working practice also has to come from a higher strategic level, with a value being placed on staff taking a different approach to working across conventional professional boundaries. Training the next generation of community health and social care sector staff to take a broader view of their role may help in this process of change, but significant shifts in local structures, planning and service commissioning will be necessary alongside this change in individual professional roles.

It would seem that housing focussed service providers such as home improvement agencies, environmental health and housing officers will still need to take a leading role with regard to

effectively addressing the poor or unsuitable conditions in mainstream housing that impact on older people's health and well-being for the foreseeable future.

Radical changes to the policy environment are continuing across health, social care and housing. However, all still point towards a continuing drive for greater cross sector working practice across health, social care and housing. So the scope to develop and expand the *Healthy Homes* model is certainly still there.

Chapter 1: A national initiative to improve health through housing improvement

The *Healthy Homes, Healthier Lives* initiative aimed to improve the health and well being of people, particularly older people, who are living in poor or unsuitable housing conditions. It was undertaken by Care & Repair England from 2004 – 2008.

Rationale

Older people, particularly those over 75 years, are the main users of health and social care services. They are also the age group most likely to occupy non-decent homes.

Government health, social care and housing policies concerning older people are focussed on enabling greater numbers of older people to remain living independently in their own homes, with care and support increasingly delivered at or closer to home.

Part of the broader rationale for the *Healthy Homes* initiative was that greater recognition of the negative impacts of poor quality and inappropriate housing on older people's health and well-being, combined with targeted housing repair and adaptation assistance, could contribute to achieving current health, social care and housing objectives, including enabling older people to live independently in mainstream housing and better management of chronic health conditions.

Intended Achievements

The project aimed to increase awareness of the impact of poor or unsuitable housing conditions on people's health, and also to improve knowledge about the remedial actions that can be taken to improve such living conditions.

Through an innovative housing awareness initiative, it aimed to develop the public health role of front line statutory and voluntary sector health and social care staff. The intended outcome of this increased housing awareness amongst the professionals and volunteers that work with disadvantaged people was improved health and well being for those living in poor housing.

The initiative also aimed to achieve more general improvements in cross-sector working amongst front line health, social care and housing staff in the statutory and voluntary sectors in order to contribute to the delivery of more 'seamless' services and better general outcomes for individuals.

As well as influencing the current working practices of today's staff, the project aimed to bring about longer-term changes to the training of the next generation of health and social care sector professionals. It aimed to contribute to the growing development of cross-sector operation through integrating basic housing conditions information into health and social care professional training. The intended outcome from this approach is greater integration of service delivery in the longer term.

The project also had secondary aims of increasing older people's understanding of how their housing conditions could impact on their health and to consider and plan ahead for their future health, housing and support needs at a pre-crisis stage, for example, through making their homes and gardens easier to manage through simple home adaptations.

Background to the Healthy Homes, Healthier Lives Programme

In 2002 Care & Repair England published *Healthy Homes, Healthier Lives: Health improvement through housing related initiatives and services* (*Easterbrook, L. 2002*). This report explored the ways in which some of the newly-formed Primary Care Trusts (PCTs) and home improvement agencies (HIAs)[1] were working together to improve older people's health through housing-related initiatives.

The study concluded that if substantial improvements were to be made in the health and well-being of an ageing population, then more attention needed be paid to the impact that poor or inadequately adapted housing can have upon individual health. Remedial initiatives, such as those identified in the report, were considered worthy of expansion and replication.

One of the models of good practice included in the report was a programme of '*Healthy Homes Awareness'* training pioneered by Bristol Care & Repair. Here, a rolling programme of training was underpinning an effective working relationship between the PCT, HIA and Social Services.

The Bristol Care & Repair Pioneering Initiative

In 2000 a Community Link Worker for Bristol Care & Repair Home Improvement Agency (HIA) ran a few courses for their services users and referral agencies. These included a simple home maintenance skills course for home owners and training for health visitors about how the home can impact on people's health.

The training for health visitors was especially well-received, leading Bristol Care & Repair to approach the North Bristol Primary Care Group (PCG) for funding to develop the concept further and deliver 3 more sessions with front line health workers. The PCG also commissioned independent evaluation of the 3 courses. This revealed that the front line staff who attended both valued the training and also incorporated what they had learned into their daily practice. As a result they were making more effective referrals of patients living in poor housing to Bristol Care & Repair's services.

Bristol Care & Repair has built Healthy Homes Awareness training into an annual rolling programme of training days for multi-disciplinary groups of people. They have delivered around 80 courses to approximately 1,500 health, Social Services, housing and allied professionals.

An independent review of the programme found that past trainees continued to value the training and the way it had broadened their knowledge and skill. It revealed that most trainees particularly welcomed the multi-disciplinary nature of the course and its role in helping them to feel part of an inter-disciplinary network.

Bristol Primary Care Trust, Social Services, Neighbourhood and Housing Services, and Supporting People jointly fund Care & Repair Bristol's activities. The continued delivery of *Healthy Homes Awareness* training is a requirement in their service level agreement with these partners. As a result, vulnerable Bristol householders benefit from swift and timely referrals to a wide range of home improvements and adaptations that enhance their chances of improved health and prolonged independent living in their own homes.

This Bristol model was one of the inspirations for Care & Repair England's *Healthy Homes, Healthier Lives* subsequent national initiative. The potential for its wider application and consideration of its effectiveness in a range of settings were integral to the planning of the national project.

Funding was secured from the Department of Health and the Rayne Foundation to employ a *Healthy Homes* programme co-ordinator to undertake a three year programme of work (2004-07). A further year's funding to continue some of the core work, and to evaluate and disseminate the lessons from the programme was provided by the Rayne Foundation (2007-08).

Summary of the *Healthy Homes, Healthier Lives* Project Objectives

It had the main objectives of:

- Raising awareness amongst front line health, social care and voluntary sector staff of the health impact of housing conditions and of possible remedial action
- Developing the wider public health role of Health Visitors, District Nurses and others in health and social care, particularly those in positions which involve visiting people in their own homes
- Developing a housing module for inclusion in the training of health and social care professionals to enable them to better assess the housing needs of clients eg. as part of a Single Assessment Process.

The *Healthy Homes, Healthier Lives* Main Activities

The main activities undertaken to achieve these objectives were:

1. *The development of 'Healthy Homes' materials and resources for use in a range of settings*
2. *The development and delivery of information and training to encourage home improvement agencies and others to adopt (and adapt) the model in their locality*
3. *A programme of Healthy Homes Awareness training with front line health, social care and voluntary sector staff undertaken in all of the English regions*

In addition a major programme of general profile raising of the importance of housing to health in older age was carried out, plus self help materials for older people were created and promoted.

1. Healthy Homes, Healthier Lives Resources and Materials

A range of materials was created and made available either to download freely from the Care & Repair England website or available at request on CD. These included:

- ***The Healthy Homes, Healthier Lives Training Kit*** - included a powerpoint presentation, activity sheets and illustrated case studies. These were central to the training session's interactive character. Trainer's notes annotated each slide and provided a background narrative to the case studies. Also included were materials to help local staff to set up and run training sessions.

- ***The Healthy Homes Presentation Kit*** - aimed at people who wanted to use the materials in shorter briefing sessions, or to enable cascading down of knowledge and information within a team. It was geared towards an interactive approach, and included practical tasks similar to those in the main Training Kit.

- ***The Healthy Homes Pack for Older People*** is for use at informal meetings and events for older people. Designed to encourage participants to consider the impact their own housing might have upon their health and what could be done to improve this.

- ***The Healthy Homes, Healthier Lives Self Training Toolkit*** had a dual purpose. It could be used for individual learning, and included exercises and activities to engage users in active study. It also provided context and full technical background to the topics and issues addressed in the above kits, and therefore could be used as a "primer" by people who planned to run *Healthy Homes* sessions.

- ***The Safer Homes, Safer Lives Toolkit*** was commissioned in 2006 by the Improvement & Development Agency (IDeA). It was a self training resource kit designed to explain the implications of the introduction of the Housing Health and Safety Rating System (HHSRS) for the non-specialist.

- ***The Health and Housing Practitioner Checklist*** was developed for health practitioners who came into contact with vulnerable householders. It summarised the key health risks, their housing links, possible actions and the organisations that may be able to help. This was commissioned by the Department of Health's Change Agent Team Housing Learning and Improvement Network and incorporated into their '*Health Risks and Health Inequalities in Housing Assessment Tool' (Blackman T 2005))*

- ***Good Practice Case Studies*** - illustrated how the *Healthy Homes, Healthier Lives* model had been used by some home improvement agencies to underpin effective referral networks, forge active working relationships across sectors and create local coherent, joint strategic approaches to health and housing improvement.

- ***Healthy Homes, Healthier Lives CDRom/ DVD*** – commissioned by the Department of Health's Care Services Improvement Partnership's Housing LIN, this was designed for use in a range of settings, including meetings of service commissioners and planners, cross sector events, for individual learning and for use in Universities and Colleges which are training the next generation of health and social care staff. The package included a short film focusing on what older people themselves have to say about how their home impacts on their health plus support materials including *Discussion sheets with student projects/ tasks, Facts and Figures, Policy Summary, Self Training Toolkit, Website Links.*

2*. Healthy Homes* Information and Training for Home Improvement Agencies

The starting point for the national roll out of *Healthy Homes, Healthier Lives* was *Training for Trainers* sessions for home improvement agency (HIA) staff. The HIA network covers

approximately 95% of local authorities and potentially provides a bridge between housing, health and social care.

Home improvement agencies are not for profit, locally based organisations that assist (mostly, but not exclusively) homeowners who are older, disabled or living on low income to repair, improve, maintain or adapt their homes. In order to achieve this HIAs offer a wide range of services and advice including help with finding the funds to pay for work, technical specification and supervision of building work and associated support services. They often work in tandem with local authority services, such as provision of grants for adaptations.

The services that HIAs provide can contribute to achieving a number of wider public health objectives such as:

- support and self help for people with long term health conditions
- reducing falls and hospital admissions
- improved hospital discharge
- reducing health inequalities
- increasing independent living in the community
- more effective cross sector working

HIAs were therefore obvious candidates for disseminating *Healthy Homes Awareness* training amongst health and social care professionals, following on from the Bristol Care & Repair model.

'*Training for Trainers'* sessions were undertaken to cover every region of England. These introduced the resource package to home improvement agencies and aimed to encourage agencies to take on the role of promoting and delivering local *Healthy Homes Awareness* training with front line staff in their local area.

3. *Healthy Homes Awareness* Training

A widespread programme of *Healthy Homes Awareness* information and training was undertaken across England aimed at front line health, social care and housing staff from the statutory and voluntary sectors.

Courses were often delivered in–house eg. within a Primary Care Trusts, or as cross sector events in a 'neutral' venue.

The *Healthy Homes Awareness* training used interactive methods to deliver information and encourage active learning through debate and discussion. It was divided into four main sections:

- *Setting the Scene*: used group participation to look at changing demography and tenure patterns and impact of such trends on housing and health. This was set in the context of local and national strategies that increasingly emphasise the importance of active ageing, independent living and the delivery of health and social care in the home.

- *Identifying the Problems*: used a quiz to introduce the housing factors that affect health including cold homes, damp and condensation, falls hazards, disrepair, and the mental impact of worrying about upkeep and repairs.

- *Recognising the Problems*: photographs of actual homes and case studies helped participants to observe 'real life' situations, consider what could be done about them and facilitate reflection on personal experience of related situations.

- *Finding the Solutions*: provided information about the local home improvement agency, handyperson schemes, grants and other local support services that might help to address the housing problems faced by participants patients/ clients.

All accompanying literature emphasised that the kits were intended as models and should be adapted to suit the local situation. This was particularly important for *Finding the Solutions*, because the availability of HIA services, handyperson schemes and funding for repairs and adaptations varies widely from one locality to another.

4. Wider profile raising and policy shaping

In order to achieve the aim of improving people's health through developing the public health role of front line statutory and voluntary sector health and social care staff, profile raising at a range of levels was undertaken.

Part of the rationale for this aspect of the work programme is that influencing local policy and practice with regard to cross sector working is easier if the national policy, directives, targets and guidance supports such change.

A lack of recognition of the key role of housing in many health and social care strategic documents does not encourage take up of this issue locally. The project therefore sought to bring about changes at the national policy level. The main routes to achieving this included involvement in national working groups and committees, submitting responses to formal consultation documents, meeting with ministers and policy makers, speaking at conferences and seminars, and through articles and publications.

Promoting the core message about health, social care and housing links, plus the availability of *Healthy Homes* materials as a practical resource to support policy implementation was an important part of the project. For example, a presentation by the *Healthy Homes* project co-ordinator at a North West regional conference on *'Housing and Health'* resulted in the *Healthy Homes* project running five local events and training with PCTs and district councils.

Articles in journals and specialist sector magazines were an important contributor to wider dissemination. The Department of Health's Care Services Improvement Partnership's Housing Learning and Improvement Network was an important outlet for information about *Healthy Homes* throughout the programme, culminating in the production of a DVD/ CDRom.

Healthy Homes, Healthier Lives Outputs Overview

1. Healthy Homes Training for Trainers

Healthy Homes Training for Trainers courses were offered in each of the nine English Regions with 122 HIA staff taking part during the year of the evaluation.

Trainee feedback illustrated the extent to which capacity and range of services varies from agency to agency, but more importantly showed that whilst most HIA trainees had a reasonable working relationship with Social Services only a minority had similar contact with

colleagues in the PCT. Indeed, in some cases the PCT was the only organisation not represented on the HIA's local advisory or management group.

The Action Planning part of the training required participants to consider how they could use *Healthy Homes* materials in their locality and the time scales for implementation. They were also asked to consider how to monitor the impact of local *Healthy Homes Awareness* promotion and training on subsequent HIA referrals. If the HIAs were to take up the gauntlet and run with *Healthy Homes* locally they needed to be well placed to build up the quantitative and qualitative evidence that would support the case for the serious commitment of resources into the housing-related measures that could impact on health and social care demands.

Healthy Homes, Healthier Lives comprehensive resource packs and CDRoms were provided for each trainee. In the feedback nearly all of those trained said that they would seriously consider using the kits locally and/ or would be discussing the possibility with their managers and/ or colleagues.

2. Healthy Homes Awareness training for front line health, social care and voluntary sector staff

Healthy Homes Awareness training sessions with front line professionals in the PCTs, wider health sector and Social Services, plus staff and volunteers in Age Concern and the Red Cross, had four main aims:

- to raise awareness of health and housing issues amongst the front line health, social care and voluntary sector staff who are in contact with older people;
- promote the value of further awareness raising sessions for colleagues in their organisations;
- to forge working links between front line professionals and their local HIA, handyperson and other housing related services;
- to provide opportunities for front line staff to meet their peers in other sectors and foster working relationships that could benefit patients/ clients.

The *Healthy Homes Awareness* training programme was rolled out on a regional basis. It was promoted via PCTs and Social Services, with information sent to Directors of Public Health and PCT lead officers for Occupational Therapy, Falls Prevention and Community Nursing and to Heads of Adult Services and Social Services Occupational Therapy: 457 organisations were contacted in total. Separate invitations to take up training were also made to lead officers in every Partnerships for Older People (POPP), Pathfinder and Spearhead area (See Appendix 1).

The training package was advertised to every local Age Concern organisation through the national Age Concern magazine, and to the Red Cross in liaison with their National Service Development Officer for Community Services.

Care & Repair England delivered the training sessions and provided course materials free of charge on the condition that the local organiser provided the venue and refreshments.

In general, initial enquiries came by telephone allowing Care & Repair England to establish a lead contact. This was the opportunity to provide more information about the aims of the training, to discuss the local situation and to clarify the range of staff who would potentially gain the most benefit from it.

Because a broader aim of the *Healthy Homes* programme was to encourage and promote cross-sector working, at the initial enquiry stage joint training with colleagues across health, social care, housing and the voluntary sector was recommended. This was met with mixed reactions, ranging from total dismissal to (only occasionally) a positive reception.

During the period relating to the evaluation (June 2006 & March 2007) 65 *Healthy Homes Awareness* training sessions were delivered to 969 people working in the health, social care and voluntary sectors across England.

Of these, 48 sessions were booked by a PCT or Social Services. The remainder were initiated by Red Cross, Age Concern or another local body.

Trainees by employer

PCT	575
Social Services	183
POPP	40
Red Cross	40
Age Concern	131
Total	**969**

Training set up in Spearhead, Pathfinder or POPP area

Spearhead with HIA link	2
Spearhead (other)	14
Pathfinder	1
POPP	3
Total	**20**

In all areas where *Healthy Homes Awareness* training was requested Care & Repair England contacted the local HIA and/ or handyperson scheme to invite a representative to attend and give a short presentation about the services that they could offer.

HIA representatives took up this offer in 53 of the 65 courses delivered. Of these 24 had not attended *Healthy Homes Training for Trainers* and were encountering *Healthy Homes, Healthier Lives* materials for the first time.

Only 30% of the local contacts who had initiated the *Healthy Homes Awareness* training actually took part in the training themselves.

To encourage further in-house briefing sessions or cascade training a CDRom containing all the *Healthy Homes, Healthier Lives* materials was provided for either the key training session contact, or a volunteer member of the group. A copy was also given to the HIA representative.

3. *Healthy Homes, Healthier Lives* DVD/CDRom

The *Healthy Homes, Healthier Lives* DVD/ DRom was launched at a Care Services Improvement Partnership conference and promoted via regional Housing Learning and Improvement events. Information advertising the video were sent to the Public Health Leads and Adult Care Leads in every PCT and administrative district.

The DVD was also widely promoted amongst academic institutions and training bodies for health and social care professionals.

796 DVDs/ CDs have been provided as a result of requests following on from the promotion.

In addition, I93 DVDs/CDs have been sent out to tutors and other staff in 61 academic institutions, plus a copy provided for each of the 7 Royal College of Nursing Regional Resource Centres.

From a feedback questionnaire, it has been ascertained that the DVD is being used on courses at Southampton University (Gerontology), University of the West of England (Nursing), Bradford, Liverpool John Moores, Anglia Ruskin,(various) plus the Open University.

"I have used the [Healthy Homes] DVD and found it very useful. I use it with a group of pre-registration nursing students who examine the changing needs of an ageing and diverse population and how housing can impact upon a person rehabilitation potential and health needs. I find it very useful. I intend to use the DVD in my next modules."
Lecturer, Liverpool John Moores University

A section on health and housing is being included in the Open University's new Health & Social Care curriculum and the Healthy Homes DVD will be included in this. The course will be linked to NVQ Level 3 and will be studied by around 5000 students. The DVD is available in all 13 OU teaching centres.

Chapter 2: Context for the *Healthy Homes, Healthier Lives* initiative

One of the key features of the context within which the *Healthy Homes* initiative was operating was the rapidity of national policy and structural change during the four year life of the programme. However, a number of factors remained constant:

1. A social care and housing policy context which emphasises supporting and enabling older people to live independently in their own homes for longer.

2. A health policy context which is focussed on efficiency eg. in terms of cost effective targeting of interventions, conditions management and prevention of health problems.

3. A general policy context across the sectors which emphasises joined up provision and improved cross sector working practices.

The *Healthy Homes, Healthier Lives* initiative remained relevant to the delivery of all of these broad policy objectives throughout the period of operation.

The Public Policy Response to the Housing and Health Connection

The causal links between housing standards and a range of health conditions have been extensively documented, most comprehensively in recent years through the process of creating the Housing, Health and Safety Rating Scheme (HHSRS) (*CLG 2002, 2003*) the main health conditions with an identified causal link to an aspect of housing are summarised in Table 1 below.

One possible policy response to identification of causal links between housing and wider environmental conditions and health problems is a systematic programme of improvement to buildings and infrastructure. An early macro example of this would be the identification of contaminated water as a major carrier of diseases which (eventually) resulted in the major public works programmes of water treatment and sewage systems. A more recent example would be a large scale, area based programme of housing improvement targeted at a locality with particularly high levels of disadvantage, deprivation and health inequalities (*Gilbertson et al 2006*).

At the other end of the housing/ health intervention spectrum would be a policy response whereby the state informs the householder of the health risks posed by particular housing conditions but leaves it to the individual householder to make any alterations or improvements to their home should they so choose.

A ‘mid-way’ response is to target housing interventions at those individuals who are most at risk of the health problems which are caused/ exacerbated by housing conditions, and who are the least able to carry out the property improvements and alterations that could improve an existing health condition or reduce future health risk eg. falls. As this group is the most likely to use resources (in terms of hospital admission, social care etc) due to future health decline, they are also the group with the greatest potential for resulting cost savings through preventative intervention.

The *Healthy Homes, Healthier Lives* project was primarily concerned with this latter approach.

Table 1: Overview of Housing Linked Health Conditions
(Extracted from the Practitioner Checklist Produced by Care & Repair England for the Housing LIN for use by front line Health and Social Care Staff (www.integratedcarenetwork.gov.uk/housing)

Health Risk	Housing Link
ACCIDENTS	Home accidents caused by environmental hazards are most common amongst older people and very young children, especially in low income households.
GENERAL **FALLS** **FIRES** **CARBON MONOXIDE** **ELECTRICITY**	Burns, scalds, falls and swallowing objects are the main risks for young children. Most fatal falls are on stairs/ steps amongst people 75yrs +. Fires are largely caused accidentally, with most injuries resulting from smoke inhalation. Low level CO poisoning symptoms may be mistaken for viral infection eg. nausea, headaches, chest pain. Faulty gas fires and blocked chimneys are the main cause. Risk of injury caused by electric shock or fire, trip hazard from trailing wires where sockets are overloaded.
INFECTIONS	Inadequate, old and un-hygienic food preparation and washing facilities can add to risk of infections and gastric illness, particularly amongst older people and children.
ANXIETY AND DEPRESSION	Worry about crime, harassment, vandalism Overcrowding Worry about living alone Debt, worry about home upkeep
CANCERS	Radon gas exposure increases lung cancer risk.
CIRCULATORY ILLNESS	Cold homes with inadequate insulation and heating can cause cold related medical problems, particularly in older people. Mortality from ischaemic heart disease and cerebrovascular disease accounts for about half of all excess cold related deaths.
DISABILITY	Mobility problems in around the home can increase accident risk and depression.
RESPIRATORY ILLNESS	Damp homes and condensation may promote mould growth and dust mites, causing respiratory problems, especially among young children, older people and allergy sufferers. Restricted ventilation can increase health damage by pollutants, is linked to increase in eye and nasal infections, headaches and tiredness. Overcrowding is associated with increased risk of respiratory disease.

Targeting Housing Interventions to Impact on Health and Well-Being

One of the challenges of targeting housing interventions cost effectively, where they will have the greatest impact on the health and well-being of the most vulnerable individuals, is to identify those who are most at risk and who are the most likely to demonstrate a measurable benefit from the intervention.

The rationale of the *Healthy Homes, Healthier Lives* approach was that front line health and social care workers are well placed to identify such individuals, especially where they are visiting people in their own homes.

Far more older people use health services than access social care. Thus primary health care staff are the main professionals who are in contact with older people and are amongst the most likely to visit an older person in their own home.

There is also a range of other staff and volunteers who may visit older people in their own homes, eg. Red Cross home from hospital scheme staff, many of whom could potentially refer people to housing related services.

If more staff and volunteers are able to identify the associated health risks for individual older people living in poor or unsuitable housing, this could potentially contribute to improved targeting of specific housing related interventions.

This broader approach to assessing a person's living situation also fits in with the agenda of holistic, single assessment of need.

Potential Connection to Current Mechanisms for the Targeting of Interventions

The health sector has developed models for predicting which individuals are most at risk of an unplanned hospital admission. Using routinely collected data from hospital and GP records, tools such as PARR and 'Combined Predictive Model' are used by the health sector in England *(Kings Fund)* to target 'upstream' interventions that can reduce the risk of unplanned hospital admissions.

The Department of Health has commissioned a study into the feasibility of creating similar tools to predict the risk of a person needing intensive social care (*Lewis G, 2007),* again with a view to better targeting of preventative services.

Poor housing is one of the factors that would need to be included in such a model. The reliability of the prediction will to a considerable degree depend upon quality and reliability of all the data sources, including information about housing condition and suitability.

Thus ensuring that the individuals who are carrying out a comprehensive assessment of an older person's situation are fully aware of (and record) any shortcomings in housing condition and suitability would be important to the success of such a predictive tool.

The Housing and Health Connections to Demographic Change

The number of people over pensionable age is projected to increase from 11.4 million in 2006 to 12.2 million in 2011; to 13.9 million by 2026 and peaking at 15.3 million in 2031 (*Shaw, 2004*). 1.9% of the UK's population were 85 yrs and over in 2003; this is projected to rise to 3.8% by 2031 (*GAD, 2004*).

Thus, an important factor in the increasing policy focus on cost effective use of health and social care resources is the ageing of the population and the potential implications that this has for growth in demand for NHS and care services.

Whilst poor or unsuitable housing conditions can affect a person's health at any age, the impact on older people is particularly significant for a number of reasons.

1. *Older people are the main users of health and social care services*.

- Older people are the age group most likely to have long term health conditions (including heart disease, diabetes, asthma & other respiratory problems) many of which feature in the list of health conditions that are affected by housing.
- Long term health conditions account for 55% of GP appointments, 68% of outpatient appointments and 77% of inpatient bed days.
- Older people are three times more likely to be admitted to hospital after coming into Accident and Emergency (*DH, 2007*)
- 40% of the NHS's budget is spent on caring for people over 65 yrs *(DH, 2007)*
- On any given day 65% of hospital beds are occupied by the over 65s (*DH, 2007*)

2. *Older people spend a higher proportion of their time at home*

- Housing condition and suitability can also have a greater impact on older people's physical and mental health because of the large amounts of time older people spend in their home environment. People over 65 yrs spend over 80% of their time at home on average, for those over 85 yrs this rises to 90% (*CLG, 2007a, Adams & White 2006*).
- From an international literature search of the evidence for health and social care gain from housing adaptation and improvement, Heywood and Turner (*2007*) concluded that '*There is evidence that the most consistent health outcome of housing interventions is improved mental health'*. This report also identified evidence that depression in older women resulted in a 30% increase in factor in the risk of hip fracture.

Greater recognition at a policy level that suitable housing provision for an ageing population could play an important role in addressing the predicted growth in health and social care demand is beginning to emerge.

The Government's recent housing strategy for housing in an ageing society, *Lifetime Homes, Lifetime Neighbourhoods* (*CLG, 2007*) includes a chapter on housing, health and care links. This notes that '*Decent housing makes a fundamental difference to mental and physical health and well-being and has a critical contribution to make to the value and effectiveness of the health and care systems'*. It makes a specific commitment to continuing to promote prevention, personalisation, greater service co-ordination and integration.

Housing, Tenure and Stock Condition

Around 90% of older people live in the general housing stock (ie. housing not built specially for older people), whether rented or owned. The remainder live in sheltered housing (5%) and care homes/other (5%) (*National Statistics, 2004*).

In 2005-6, 1.5 million individuals reported having a medical condition or disability that requires specially adapted accommodation, of which 25% were living in a home that did not meet their needs. Eighty-five per cent of the people in unsuitable homes were over 45 years and over half (55%) lived in owner-occupied accommodation (*CLG, annual*).

A radical change has taken place in housing tenure over the past three decades. Owner occupation is now the primary form of tenure, accounting for just over 70% of all households (all ages) compared with only 51% in 1971 (*CLG, annual*). Amongst 'younger' retired people owner occupation is closer to 80%, rising to 84% in rural areas (*National Statistics, 2004*).

Just over half of all low income households are now owner occupied (*CIH/ CML, 2007*). The English House Conditions Survey (2005) (*CLG 2007a*) reveals that there are now more vulnerable households living in private sector housing (3.2m) than in social rented (2.8m) (all standards) and the number of vulnerable people in non-decent private sector homes has risen slightly (by 0.04m). Private rented homes are of the worst standard (41% non-decent), whilst the majority of non-decent homes are owner occupied (3.8m).

Whilst thermal comfort is the main reason for homes failing the Decent Homes Standard, 15% of private sector vulnerable households (470,000) live in homes that fail the decent homes standard on any of the repair, fitness and modernisation criteria (ie. excluding thermal comfort). A third of vulnerable people of 75+ years live in non-decent housing – the worst housed sub-group (*Adams & White, 2006*).

Thus a picture emerges of a growing number of low income, 'older old' people living in owner occupied homes, many of which are in need of repair and adaptation.

A housing policy shift has taken place over the past decade which increasingly places responsibility for the condition of owner occupied property with individual home owners. Whilst a multibillion pound programme of investment has taken place to bring social rented housing up to a decent standard, a systematic approach to the improvement of non-decent homes occupied by low income home owners has all but ended in many areas. Alongside the cessation of mandatory home repair grants, there has been a reduction in state support for private sector stock improvement, with a growing expectation by Government that use of home equity release will increase to replace state help.

Housing, Health and Social Inequality

A number of studies published as part of the *English Longitudinal Study of Ageing* (*IFS, 2002*) quantify the links between health and inequality. They demonstrate a 'social gradient' in health – the lower a persons' social position, the greater the level of ill health and loss of physical function.

Thus loss of physical function is particularly related to both ageing and social class. One in five of those aged 50 and over, and 2 in 5 of those aged 80 and over, reported difficulties with one or more aspects of basic self care – such as washing and dressing (*IFS, 2002*) - earlier loss of function was linked to category of occupation.

There is a large geographical variation for disability-free life expectancy. For men there is an 18 year difference between the worst area (Easington) and the best (Hart), and 16.4 yrs for women (Merthyr Tydfil vs Elmbridge) (*National Statistics, 2004*). This can be linked to social class/ occupation category, and the correlation of the location of people with early onset disability with the location of poor quality housing and neighbourhoods is evident.

The design of a property, its location, its overall space standards and the installation of home adaptations can make a significant difference to the ability of an older or disabled person to live independently and remain healthy. Thus the link between health, disability, social class and housing conditions requires a public policy response if demand on the NHS and Social Services is to be managed more effectively.

Health and Social Care Policy

Enabling independence, service personalisation, treating older people with dignity and respect, targeted interventions to prevent health problems and avoid hospital admissions, reducing health inequalities and providing care at or closer to home are some of the key themes that have run through a range of health related policies during the life of the *Healthy Homes* programme.

When the project was being planned one of the main drivers for health provision for older people was *The National Service Framework for Older People* (*DH, 2001*). This provided the vision for how older people should be treated by the NHS and set out a timetable for change. With regard to housing and health links, the targets for reduction in falls were seen as particularly relevant.

During the life of the project a succession of policy and discussion papers have been published which have stressed the importance of better joining up of health and social care, including '*Choosing Health'* (DH, 2004). This also emphasised prevention of health problems and the importance of tackling health inequalities.

The Government white paper, *Our Health, Our Care, Our Say*: *A new direction for community services* (*DH, 2006*) heralded radical reform for the health sector. It emphasised the importance of shifting resources into prevention, joint health and social care action, tackling health inequalities and care at or closer to home.

The NHS in England: operating framework for 2007-08 (*DH, 2006a*) set out priorities for the delivery, next steps in reform, and financial objectives. It stressed the need for PCTs to work with local authorities to improve health and well-being, reduce inequalities and achieve a shift towards prevention.

At the heart of social care policy for older people is the aim of enabling a greater number to remain living independently in their own homes. Many of the documents noted above are equally applicable to the future vision for social care, with the emphasis on prevention and support for independence. The consultation paper *Putting People First: a shared vision and commitment to the transformation of Adult Social Care* (*DH, 2007a*) emphasised independent living, personal control and quality of life. Funding is now following with the introduction of a Social Care Reform Grant of £520m over the next three years (2008-11).

A more effective housing response to deal with the condition and suitability of the housing stock that older people are living in is also needed in order to bring about the desired outcomes of many health and social care policies.

Measuring the Health Gain from Housing Interventions

Part of the rationale for the targeting of housing resources on particular groups of older people is to achieve reductions in health and social care costs.

This is in line with a culture of cost benefit analysis within the health sector which uses such systems for decision making eg. assessing the cost effectiveness of drugs and particular medical treatments. Unfortunately, there is a more limited body of evidence which costs out the financial gains in terms of health and social care expenditure resulting directly from specific housing based interventions.

Some studies have attempted to measure the health gain from housing interventions taking an area based approach. For example, analysis of the potential health impact of decent home improvements on a housing estate in Sheffield (*Gilbertson et al 2006*) aimed to predict NHS gains using models developed in connection with the HHSRS. However, this approach does not quantify gains in terms of the specific individuals who are most at risk of requiring NHS or care services. An area based approach to quantifying wider health gain also tends to result in a focus on improvements to social rented housing ie. where the landlord is responsible for the condition of the housing stock and can thus work with researchers and control the process of improvement.

Heywood & Turner (*2007*) concluded that the evidence that increased investment in housing adaptations and equipment would bring significant savings to the NHS and to Social Services budgets is not complete '*and more work is needed to disaggregate the 'multi-factorial interventions' that are known to be effective but not fully understood'*.

Effective targeting of resources for measurable gain on the highest risk individuals would be more in line with current health sector practice. As noted above, the NHS is already applying risk modelling across entire populations using tools such as PARR and the Combined Predictive Model in order to make predictions about future risk of hospital admission and then intervening 'upstream' in order to prevent such admissions (*Kings Fund*) and research is now underway to examine the applicability of such modelling to avoidance of care home admission, with poor housing one of the known risk factors in the equation.

Chapter 3: Evaluation of impact of *Healthy Homes Awareness* information and training

One of the *Healthy Homes, Healthier Lives* project objectives was to improve the level to which individuals who have a health problem and who are living in poor or unsuitable housing are identified and linked to the services that could help to address their housing problems, with consequent benefits to their health and well being.

The main model that the project used for bringing about this change was to increase the level of housing defect identification and effective intervention through developing the public health role of front line staff, particularly in the health and social care sectors, using an innovative programme of '*Healthy Homes Awareness Training*'. The model particularly aimed to encourage the delivery of this awareness raising via local home improvement agencies (HIAs).

This evaluation considers the effectiveness and applicability of this model and particularly examines the extent the *Healthy Homes Awareness* training impacted on the working practices of trainees. The evaluation looked at whether there was a lasting effect on day to day practice, and whether any such changes resulted in benefits to the individuals who are living in poor or unsuitable housing. The evaluation also considers the extent to which HIAs took up the challenge of delivering and promoting *Healthy Homes Awareness*.

Methodology

Data was collected in order to establish the following:

- The number of HIAs that used the *Healthy Homes* materials
- The impact of *Healthy Homes Awareness* training on HIA referrals
- How *Healthy Homes Awareness* training impacted on front line staff knowledge of local housing related services
- How *Healthy Homes Awareness* training impacted on the ability of front line staff from all sectors to make appropriate referrals for housing related services
- The impact of increased level of knowledge and resulting referrals by staff on patients/ clients lives
- Whether PCTs, Social Services or voluntary sector organisations have used *Healthy Homes* materials cascade information
- Whether the PCT/ Social Services followed up the HIA contact to deliver further *Healthy Homes* awareness raising sessions
- Whether the training contributed to the development of improved strategic joint working

The data sources used to inform the evaluation included:

1. *Healthy Homes Training for Trainers* 'on the day' feedback.

2. Post event (c. 3 months) telephone call feedback from all HIAs taking part in the *Healthy Homes Training for Trainers*

3. Questionnaire returns and telephone interviews with trainees six months and one year after the *Training for Trainers* course

4. National data analysing referral trends in HIAs

5. Telephone interviews and visits to locations where more extensive use of the *Healthy Homes* model had taken place

6. *Healthy Homes Awareness* training 'on the day' feedback from trainees

7. 'One year on' questionnaire returns and telephone interviews with *Healthy Homes Awareness* trainees

8. Summary notes and observations made by the presenter of the *Healthy Homes Awareness* training throughout the programme.

Data Collection Summary

1. *Healthy Homes Training for Trainers* post event follow up with HIAs

1.1 *Initial Telephone Interview*

Care & Repair undertook brief telephone interviews with the majority of individuals who attended a training session (122). These took place around 3 months after the course to ascertain post event use of the *Healthy Homes* materials and to offer support where needed to encourage increased use.

1.2 Interim impact questionnaire

An electronic mail out of a post event evaluation form took place in March 2006 to scope activities being undertaken by HIAs based on *Healthy Homes, Healthier Lives* materials since the previous contact.

1.3 *Latter stage questionnaire*

An electronic mail out of an evaluation form was undertaken in November 2007 to ascertain level of ongoing use of *Healthy Homes* materials and related developments.

1.*4 Telephone interviews*

Ten trainees were interviewed by telephone during the Autumn of 2007 to probe in more depth the issues impacting on the level of take up of *Healthy Homes* materials and related local developments.

2. Post event feedback from all those taking part in the *Healthy Homes Awareness* Training

2.1 On the day of training feedback forms

All trainees were provided with a detailed feedback form on the day of training. This was followed up with an emailed form, sent via the local course organiser, to those who did not submit a form at the time.

2.1 One year on training feedback forms

Phased sample emailing and (to a lesser degree) posting out of questionnaires was undertaken between August and November 2007.

Most of the training courses had been organised by a local intermediary, and hence in most cases Care & Repair England did not have access to a direct email address for all course participants. Consequently the questionnaires were sent to the key contact for each course with a covering note asking them to forward to the individual trainees. The success of this process was, therefore, reliant upon the key contact's level of record keeping and willingness to co-operate.

2.2 Telephone interviews with a sample of trainees

A small telephone survey was undertaken. This involved contacting 12 front line trainees and key training contacts representing the range of people who had taken part in the training programme.

3. All aspects of the Training

3.1 National referral trends in HIAs

Foundations, the national co-ordinating body for HIAs, undertook an analysis of national trends in referral source and compared health sector referral rates in areas where *Healthy Homes* training had/ had not taken place.

3.2 Records kept by the presenter of the Healthy Homes Training

Throughout the *Healthy Homes*, *Healthier Lives* programme the co-ordinator maintained detailed records of all aspects of the work, including detailed telephone call notes, summaries of each training event (which included notes of comments made by trainees/ managers/ organisers of events) plus post event follow up summaries.

Results

1. Use of *Healthy Homes* materials by HIAs resulting from *Training for Trainers*

Immediate feedback regarding the *Training for Trainers* course and the content, quality and adaptability of the *Healthy Homes, Healthier Lives* materials assessed the training as excellent (41%) or good (50%). This feedback also revealed that 75% of trainees said they expected to make use of the materials to run local training and events.

The one year later survey identified 11 HIAs which had made extensive use of the *Healthy Homes, Healthier Lives* materials to deliver training or briefing sessions with local partners. Where detailed records had been kept, this identified that they had delivered 54 sessions to 2,194 health and social care staff and run 7 older peoples' *Healthy Homes* information sessions to 101 householders.

Whilst this is a lower uptake than had been hoped for, particularly in view of the enthusiasm that most HIAs showed during the *Training for Trainers* courses, it revealed a very positive local development in a number of localities – particularly Mendip, Blackpool, Milton Keynes, Merton, Manchester and Stroud (who were using the materials with older people). Some of these are outlined in the following boxes, with further examples in Appendix 2.

Stroud Care & Repair

When giving talks to groups of older people the agency staff are now routinely using a locally tailored presentation based on the '*Healthy Homes'* package and powerpoint presentation which highlights health and housing links and the remedial measures that the HIA can help older people with.

Manchester Care & Repair.

Manchester Care & Repair adapted the training model for local use and initially obtained funding for 20 courses. They were particularly inspired by the success of the Bristol Care & Repair training and linked handyperson service provision model.

"Social Services were very keen, especially Adult Social Care Learning & Development. They did the internal marketing for their courses and produced certificates for CPD"
HIA manager

The Manchester training proved a major success. They subsequently secured POPP funding and now have a *Healthy Homes* Team Leader who has responsibility for the training alongside the Falls Prevention work. She has already run 26 training sessions for staff from the PCT, Social Services, Housing Support, Student Nurses, Case Management, Drugs Services, Alcohol Services, Resource Centre Workers, Supporting People, Project Development Officers, Senior Domiciliary Care, Resettlement Workers, Northwards Housing, Age Concern Home from Hospital, Private Sector Housing, Financial Assessment Sections, Health Trainers, Mediation Services, the Pension Service, Sheltered Wardens, Victim Support and Age Concern Day Centre staff. They also use the package for their own staff induction.

However, they do find it difficult to relate new enquiries directly to the course, even though participants tell them that they do often mention Care & Repair to their service users. Quantifying the impact on referrals using existing systems has not proved viable. One of the main reasons is that when it is a self referral, it is hard to establish whether the individual found out about Care & Repair via a health worker who attended the course.

Age Concern Milton Keynes Home Improvement Agency

After attending Healthy Homes training the manager of the home improvement agency at Milton Keynes Age Concern took forward a proposal to develop an integrated home improvement and safety programme based upon the Healthy Homes, Healthier Lives model.

The resulting 'Safe at Home' initiative aims to reduce fire risk, crime and fear of crime amongst vulnerable adults by maintaining people safely in their own homes for as long as they wish and improving their quality of life. It is based upon a "first across the threshold" fully integrated referral network, which is co-ordinated by Milton Keynes Age Concern and brings together key stakeholders in Milton Keynes including:

- *The Primary Care Trust*
- *The Community Safety Partnership*
- *Social Services*
- *Public and Private Sector Housing*
- *Community Alarm*
- *Trading Standards*
- *Thames Valley Police*
- *Buckinghamshire Fire & Rescue*

Healthy Homes training was key to the creation of this successful programme, which was formally launched by Baroness Andrews, Housing Minister at Communities and Local Government. The agency has undertaken training for over 300 people. Comments about this include:
"I liked the interaction with other agencies with whom I would not normally meet" and "We are able to refer clients quickly and easily without the hassle of finding the appropriate person in a particular department".

In an evaluation of the impact of the impact of a *Safe at Home* intervention on older people (based in an 89% response rate):

- 51% of respondents felt safer at home
- 62% felt less vulnerable

In exploring why there was a lower take up than anticipated from the immediate post course feedback, many HIAs reported negative experiences with trying to set up training or more generally improve working relationships with the health sector, primarily with PCTs. The majority reported that approaches to PCT leads to work strategically with the HIA eg. taking part in joint service planning or joining the HIA steering committees/ management committee, were seldom responded to positively.

Several said that they had been openly rebuffed by PCT managers or were still waiting for a reply to their offers to provide *Healthy Homes Awareness* training.

> "*What really disappoints me is that Commissioners and Senior Managers don't attend the sessions. If they did they would be more in touch with reality and have a better feeling for what is happening on the ground and the simple, effective services that can*

really make a difference. The OTs who came to the Healthy Homes session we presented have really found it useful but if they tell their managers this I'm not sure that they really listen to them. Also, if Managers knew more about the issues and local services they could filter information down to their staff'.
HIA Manager

The prevalent opinion that emerged from the HIA feedback was that PCTs are singular institutions, driven by narrowly focussed, medically defined objectives that do not necessarily acknowledge the bigger health picture; whilst individuals within the PCT may appreciate the relevance of housing to general health, this does not translate into policy or strategy.

"After re-organisation of the Primary Care Trusts, our local MP arranged a meeting with the new Chair of the PCT. We met over lunch and she was very enthusiastic about our work, especially the fast track adaptations, handyperson and repairs schemes. She could see that working together on these was just what the Trust needed. I followed up our meeting with a letter thanking her for coming, and setting out suggestions for taking things forward. I've heard nothing since."
HIA Manager

During the training sessions HIAs often commented on the negative impact that health sector restructuring was having on their attempts to liaise with PCTs, believing that such uncertainty resulted in the development of external partnerships or innovation being put on the back burner until internal changes had been sorted out. The *Healthy Homes, Healthier Lives* programme coincided with another period of health sector restructuring and this may well have had an effect upon HIA success in local implementation.

Despite these reservations, *Training for Trainers* delegates remained enthusiastic about the *Healthy Homes, Healthier Lives* concept and its longer term potential to help them to build bridges with health sector organisations.

HIAs were concerned about the staffing and resources required to set up and run *Healthy Homes Awareness* courses. None saw any prospect of getting the PCT to pay for such training, at least in the shorter term. And they were also aware of the internal pressures on colleagues in health and social care.

"We get a lot of initial interest [in Healthy Home Training], mainly from OTs, and we offer them dates, but nobody then gets back to us. I think this is because PCTs and Social Services are so stretched. They realise they want training, but when it comes to actual commitment of the time involved in setting up and populating a course it slips down the list of priorities. Social Services have undergone so many changes that it is difficult to organise anything. Line managers are changing on a regular basis so there is no commitment or continuity."
HIA Manager

The majority of HIAs are managed by a Housing Association or local authority. Some of the trainees contacted said that they had been hampered by wider organisational strategies which did not allow them to prioritise *Healthy Homes* initiatives.

"*We are firefighting. The requirements of Supporting People, other funders and our managing agent gets in the way of generating new partnerships and referrals*"
HIA manager.

2. Client Referrals to HIAs Resulting from *Healthy Homes* Training

To provide one measure of the impact of the *Healthy Homes* training initiative as a whole, Foundations, the national co-ordinating body for HIAs, undertook an assessment of referral source trends in HIAs based on their Femis data collection system.

They confirmed that referrals from health sources were nationally very low, with an average of 2.6% in 2006-7, and even this low level was an increase on previous years.

When they mined this data, separating out the HIAs that had taken part in *Healthy Homes training* and contributed to the delivery of local *Healthy Homes Awareness* training from those who had had no connection with *Healthy Homes*, this revealed that:

- The number of referrals from the health sector had increased to an average of 3.4% in the group of agencies who had used *Healthy Homes* materials, compared to 2.0% for the whole HIA sector after removal of those *Healthy Homes* linked agencies.

- Referrals from Social Services Occupational Therapists also show a faster increase in *Healthy Homes* linked areas.

Thus the proportion of enquiries from the health sector was 70% higher in the areas represented by the *Healthy Homes* group of HIAs than it was elsewhere.

Whilst this is a small step from a low base, it is still a useful indicator of the potential impact of *Healthy Homes Awareness* training.

When individual HIAs were asked whether referrals from PCTs, Social Services and the voluntary sector had increased as a result of them providing *Healthy Homes Awareness* training for front line staff in their areas, whilst all thought that it had, only Blackpool Care & Repair had collected specific data to measure local referral trends. This had clearly demonstrated a local increase in referrals from the health sector. None of the other HIAs had specifically tried to monitor the effect.

> *We have used materials with PCT staff at Home Safety Days and with older people's groups at Celebrating Age events. In general we find it quite hard going with the PCT and Social Services but think that the Healthy Homes work has helped. Generally referrals have increased, but we have no documentation to connect this to the training."*
> HIA officer

All of the HIA staff who were contacted individually as part of the final evaluation and who reported not making use of the *Healthy Homes* materials cited lack of resources as one of the main reason for not using *Healthy Homes* to promote their services. This corroborated concerns expressed during *Training for Trainers* about the capacity to invest time and money into awareness raising and the fear that this would generate referrals that the HIA couldn't cope with.

At all stages of the data collection HIAs voiced concerns about the impact that local *Healthy Homes* promotion might have upon their capacity to deliver a good service to more people. There was a fear that referral rates might rise dramatically as a result of running *Healthy Homes Awareness* training sessions and that they would not be able to meet subsequent demand. Many were already stretched in their capacity to respond to existing referrals, and so whilst seeing in theory the importance of health and housing links, they were reluctant to increase promotion of their services because this could add to their waiting lists.

"We held a few Healthy Homes briefing sessions with around 70 professionals per session [after the Healthy Homes Training] and this increased the number of jobs we are doing. Our main focus now is on getting out and getting on with [the jobs for individual clients]."
HIA Manager

3. ***Healthy Homes Awareness*** training for front line staff - impact on working practices

3.1 Immediate Response to *Healthy Homes Awareness* Training

The response to the *Healthy Homes Awareness* training evaluation on the day of delivery was very positive. At every event a feedback form was provided for each participant. A return rate of between 60 – 70% at each event was achieved.

- 88% of participants said that what they had learned was very useful (57%) or useful (31%) to their practice
- 87% said that it would enable them to refer more clients/ patients to other services (87% assessed it as very useful/ useful in this respect).

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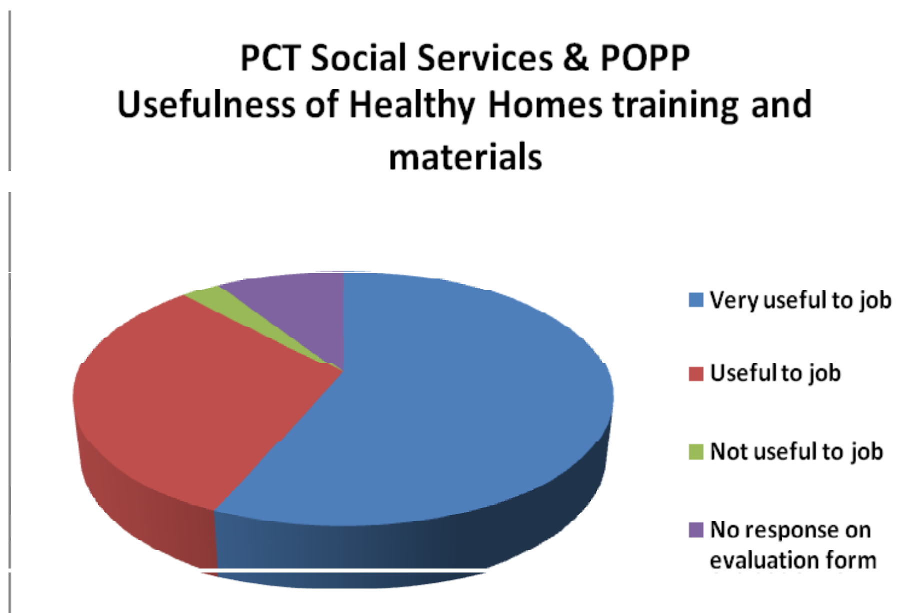
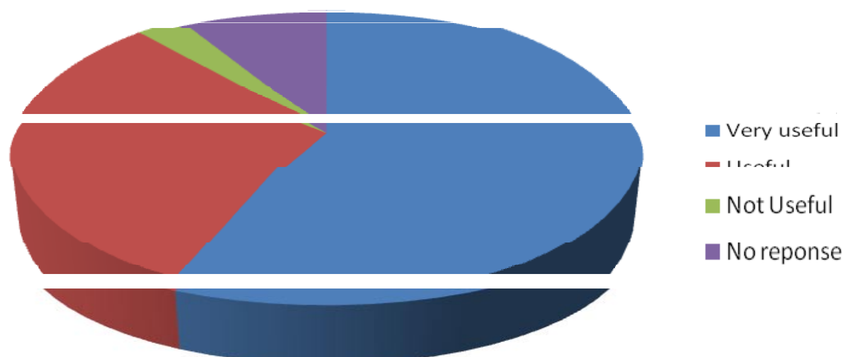


PCT Social Services & POPP
Healthy Homes training and enabling referrals



Comments on the feedback forms were equally positive, the terms occurring most frequently being:

Informative……..thought-provoking…………useful………information I will use again……..Good use of photographs to illustrate issues……..Good use of activities to illustrate issues

Below are some comments from those undertaking *Healthy Homes Awareness* training:

"Well overdue. An excellent information sharing session".

"Brilliant session and great opportunity to network and gain excellent information from colleagues''.
Delegates Sandwell PCT

"I have thoroughly enjoyed the session. It was very interesting. Some of the issues discussed could lead to more in depth sessions".
Delegate St Helens MBC

"Thinking about the home situation of a patient and the effects on their health is useful reminder especially with regard to providing holistic care".
Delegate South Tyneside Social Services

"Very informative, statistics supplied assisted in highlighting the impact of poor housing, and the depth of the problem".

"Learned some very interesting facts that I can pass on to my service users."
Delegates Wigan POPP

"Very interesting and will sit very well within my work role".

"An excellent afternoon, worth taking time out of work as much can be used in work".
Delegates Scunthorpe PCT

“The course was full of interest and concentrated on many aspects of my home visit work as a physio – I have some idea how to help the patients now”.
Delegate East Sussex PCT

“This session has really brought “Healthier Homes” alive for me and I will be able to feed back to other frontline groups”.
Delegate South West Essex PCT

There were a few voices of dissent. For example, a group of podiatrists said that whilst they had enjoyed the training session they did not think that they would use the content or make referrals.

“*We are there [in the patient’s house] to do their feet. What the house is like has nothing to do with us. We don’t have time to think about that”.*

Overall, there was an unusually high level of positive feedback about the *Healthy Homes Awareness* training from a spectrum of delegates in every Region of England.

3.2 Reported Impact of *Healthy Homes* training one year on

For a variety of reasons, some of which are noted below and include staff turnover and reliance on local course organisers to forward the questionnaire, it proved difficult to obtain feedback from delegates one year after they had attended *Healthy Homes Awareness Training*. However, through repeated mail-outs and telephone follow up with course organisers, one year later feedback was eventually obtained from our target of 50 trainees.

The trainees completing questionnaires one year after they had undertaken *Healthy Homes Awareness* training reported that as a result of the training they were;

- more likely to take notice of housing conditions (78%)
- that they had found out about services they were not already aware of (93%)
- were more likely to refer people for housing related help (83%)
- some of their clients’/ patients' housing and living conditions had improved (44%)

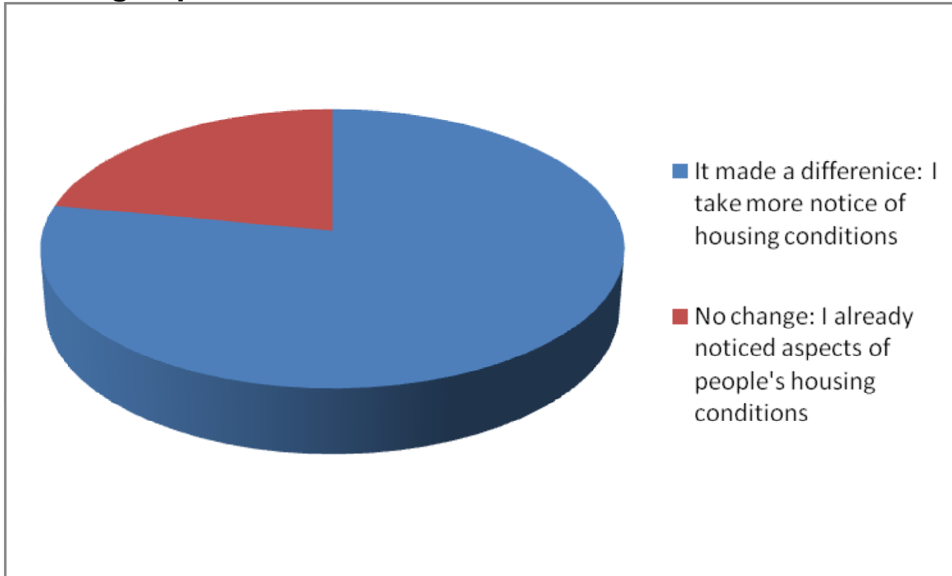
A number of the comments made by trainees:

“*The moment I saw his house it struck a chord with me and reminded me of the examples we’d talked about during the training session. I knew that if I referred him straight to C&R they could sort out all of the things that were making it hard for him to go on living safely in that house*.

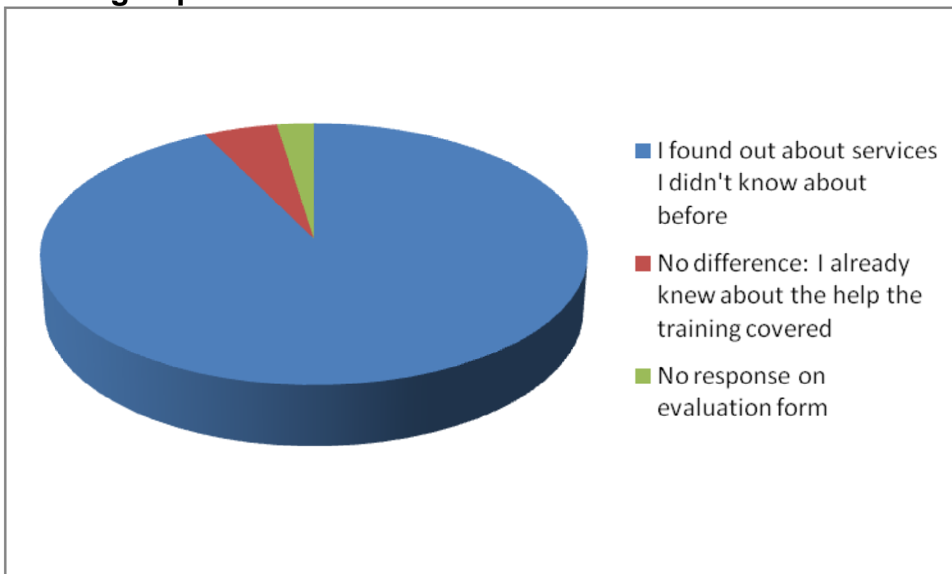
Besides the installation of numerous grab rails to help Mr A get around safely, the kitchen is now on the ground floor [it was previously in a basement], and his C&R caseworker has helped him to get a Warm & Well grant for insulation and an improved heating system”.
Community Nurse Advisor for Older People, PCT

“How can you treat someone effectively who lives in a cold, damp home?”
Community Matron

Training Impact One Year On: PCTs Social Services & POPPs Trainees



Training Impact One Year On: PCTs Social Services & POPPs Trainees



Whilst this data revealed that 44% of trainees had taken action that had resulted in their patients/ clients housing conditions improving, there was no reliable method for quantifying the extent of this rate of referral. A few cases were described, one of which is illustrated below, but it is not possible to state with any certainty exactly how many individual householders accessed housing help as a result of the training of front line staff.

Mrs Pucknall **Helped by Blackpool Care & Repair**

Mr Pucknall already had a heart condition and related poor mobility when he suffered a stroke in 2006 resulting in memory loss and worse mobility. In 2007 he had several bad falls. Mrs Pucknall, who has high cholesterol and blood pressure, is his main carer.

To enable his early discharge from hospital, he was referred to Blackpool Care & Repair to arrange for the installation of some grab rails. These were installed within 3 days of the referral. The Care & Repair worker also carried out a Home Safety Check, identifying a number of other housing measures that would reduce the risk of falls and increase Mr Pucknall's mobility around the home. This included installing a ground floor wet room.

Mr Pucknall can now live comfortably at home and his wife believes that without these measures he would probably by now have been admitted to a care home. "*I'd never heard of Care & Repair*," said Mrs P, "*but I'm glad that the OT knew about them. It's made a terrific difference to [Mr Ps] quality of life and it has given me more confidence because I know that he will be safe when I have to go out*".

3.3 Taking things further - cascade training and further development

One of the intended consequences of providing local training contacts with a CD and pack of *Healthy Homes* materials was for PCTs, Social Services and voluntary organisations to use these to cascade the learning by running briefing sessions with colleagues.

On the day of the course the majority of trainees had said that they would recommend the training to their colleagues and would tell them about what they had learnt. On the basis of this feedback we estimated that for each person trained, some information would be passed on to an average of 25 colleagues.

However, in the evaluation we were looking for harder evidence of more formal cascade training. Trainees were asked whether they had made use of the actual *Healthy Homes* training materials.

Only 4 people (8%) reported using the actual *Healthy Homes* materials to pass on information to colleagues in a more structured way.

From the in depth telephone interviews (12) with lead contacts and managers none had organised more actual *Healthy Homes Awareness* training sessions, although some general comments were made in most cases about informal passing on of some information. However, it was not possible to quantify this.

The main reasons given for not organising more actual *Healthy Homes Awareness* training, even though they had personally valued the session that they had attended, included changing priorities, other work pressures and lack of time and/ or resources.

One enthusiastic manager who had attending a course had since been promoted due to reorganisation of the PCT. She reported that she had briefed her successors about *Healthy Homes Awareness* training but doubted that they would take things further.

> *"I've passed on the suggestion for more training to clinicians at department level but I think they probably have things of greater priority to sort out."*

There were a number of other positive local outcomes identified through the one year on responses from the 50 delegates. Nine respondents (18%) reported increasing the level to which they worked with their local HIA. In one PCT a member of the team reported using the knowledge that they had gained from the training when drawing up an information booklet to distribute to older people. A Red Cross participant illustrated the potential benefits of increased liaison with the local Care & Repair scheme.

> *"This knowledge has proved invaluable in my role as Home from Hospital co-ordinator with the British Red Cross in Bristol, where volunteers and myself are in contact with such people on a daily basis. Having attended the Healthy Homes training with Care & Repair, it was only a matter of days before we came across someone with a significant damp problem in his home, and we make our first referral to Care & Repair. This was very easy and since then I have made more referrals and even spent a day with their Urgent Response Team to further develop links between Care & Repair and the British Red Cross"*
> Home from Hospital Co-ordinator, British Red Cross

3.4 Wider issues

The national *Healthy Homes, Healthier Lives* programme co-ordinator organised and presented all of the courses across England – both Training for HIAs and *Healthy Homes Awareness* for over a 1,000 front line staff. She kept records of key features and the comments made at the courses and on this basis noted a number of general observations from the delivery of the training.

On the positive side, she came across local champions of cross sector working who were keen and enthusiastic. Where they had a strategic vision and saw the *Healthy Homes Awareness* training as part of a broader programme of change and improvement this could make a significant difference to its impact.

In Blackpool, which is now running regular *Healthy Homes Awareness* training, there was support for the initiative at every level. This was reflected by senior officers sometimes speaking at the training session:

> *"This is a good opportunity for you to learn about the housing services that are available to help your service users from getting ill or becoming more ill than they are already. I did this training some time ago and it was a real eye opener. I thought wow, I had no idea about how much our houses can affect our health. You will be able to use this information to make a concrete difference to your service users' lives."*
> Assistant Director of Adult Social Services

Some HIAs, as noted above have grasped the potential of the model, adapted it locally and are making a significant impact on the health of local people via housing interventions.

However, she also identified factors which she saw as indicative of the low priority that was given to staff training and development and to making front line links across the health, social care and housing sectors, including;

- Unwillingness to host joint training
- Difficulties with local liaison - being passed from 'pillar to post' even after an organisation had requested the training
- Poor levels of course organisation (such as offering the trainer no information about who the trainees were, or failing to inform trainees of times/ location)
- Lack of basic training room facilities and poor provision of even simple refreshments (in one instance delegates were even told to bring their own bottles of water)

One aim of *Healthy Homes, Healthier Lives* was to demonstrate the potential practical benefits of cross sector working through multidisciplinary training sessions. The cross sector nature of the training was a key element of the Bristol initiative where this aspect was rated very highly by participants.

Joint Working	**Very Useful**	**Useful**	**Not Useful**	**Not applicable**
How useful was it having other disciplines on the course?	**162**	**30**	**18**	**6**

However, reluctance to organise joint *Healthy Homes Awareness* training was encountered in most areas, sometimes even absolute refusal to consider sharing a course with other disciplines where it had been requested/ was being hosted by a particular organisation. On several occasions this meant a return visit by the trainer to the same location in order to run separate sessions for the PCT and Social Services.

In the event there were only 9 truly joint courses out of the 65. All of these 9 received the most positive feedback.

The lack of delegates lists impacted upon the opportunity for trainees to follow up individual contacts made on the day and also affects any in-house assessment of the effectiveness of the training and utilising the information gained to impact on wider practice and policy.

When more senior managers or directors did attend the *Healthy Homes Awareness* sessions these were amongst the most successful with regard to having a lasting impact and were more likely to result in wider application of the ideas raised for improved cross sector working.

For example, in Mid Devon the Falls Prevention Nurse invited the local authority's Head of Environmental Health to attend the training. He was impressed with the relevance of the course and by the level of interest shown by the delegates and advocated for more sessions to be commissioned. In response to this Devon & Cornwall Housing Association (the managing agent for HIAs in Devon) have delivered further *Healthy Homes* events with plans for a regular schedule of sessions in the future.

Sandwell PCT

Over 30 people from a range of professional backgrounds attended a Healthy Homes Awareness raising event, including key people from Private Sector Housing and Social Services in addition to the PCT. The session took place in the morning, finishing with a buffet lunch provided by the PCT, where delegates took full advantage of the opportunity for networking.

Although the home improvement agency staff did not attend, representatives from the local authority Private Sector Housing department provided information about local housing services. They were in the process of putting together a "matrix" of local provision and were able to provide information about this initiative. Equally importantly, the Healthy Homes event provided the perfect forum for both capturing more information for the matrix and promoting it amongst front line health sector staff.

The session provoked lively debate and interchange of ideas, including discussion about including housing questions on the Single Assessment Process form which could bring about longer term change.

Chapter 4: Conclusions

The *Healthy Homes, Healthier Lives* Model

The founding rationale for the programme, that greater recognition of the negative impacts of poor and inappropriate housing on people's health and well-being combined with targeted housing repair, improvement and adaptation can contribute to gains in population health and the achievement of some health and social care objectives, remains as valid today as it was at the start of the programme.

The *Healthy Homes, Healthier Lives* model's usefulness and applicability to key health, social care and housing policies with regard to an ageing population also remains significant. Its core aims of supporting independent living for older people in general housing stock and preventative approaches to health and social care meant that the model is if anything, even more relevant.

And the model of forging cross sector working links across the health, housing and social care sectors, with home improvement agencies playing a key role in housing related service delivery, has also proved itself an effective one where it has been applied coherently and properly backed and supported, as in the case of the landmark schemes (such as Bristol, Blackpool, Milton Keynes, Mendip, Manchester) described in the report.

However, what has become clear through the programme is that replicating a successful local model is not straight forward.

Providing models, toolkits, materials and support, however good, is simply not enough to ensure their local take up and effective application. Such activity can facilitate implementation but there also needs to be in place a combination of:

- A strong local champion for joint working across health, housing and social care with associated service delivery, preferably a person with some power and influence
- Support at all levels for joint working – at strategic, senior and middle management levels as well as front line
- A willingness by service providers to develop and adapt the ways that they operate and provide services in order to meet the requirements of all three sectors.

Appropriate service commissioning is also needed to back up the theory of holistic assessment and service provision. Put simply, there is no point in health workers noticing the housing problems that are exacerbating a person's ill health if there is nothing available locally to remedy that housing defect. The linking of the commissioning of an expanded, fast track, low cost small repairs and minor adaptations service to the delivery of *Healthy Homes Awareness* training was one of the keys to the success of the Bristol pilot and some of the beacons schemes that have followed, eg. Blackpool.

The *Healthy Homes Awareness* training is a good package (see results below) that has proved itself a popular, relevant and effective tool. But it is only part of the picture. There also has to be a willingness to link training for the front line with:

- a review of and changes to day to day working practices,
- changes to wider strategic planning and
- changes to service commissioning and delivery mechanisms.

A number of HIAs have grasped the concept of *Healthy Homes* and have been locally supported by service planners and commissioners. The results of their efforts have been exceptional. In many ways the outcomes from these successful beacons alone make the national *Healthy Homes* programme a worthwhile enterprise.

However, in far more areas, a number of factors have resulted in lower take up of the *Healthy Homes* model and less effective use of the materials than had been hoped for. These factors include

- health sector reorganisation,
- wider issues of morale and culture
- financial constraints by one or more parties (housing, health and/ or social care)
- a limited view of respective roles and responsibilities and
- resistance to change

The gap between the rhetoric of joined up working and the front line reality in some areas has become evident as a result of the *Healthy Homes* initiative. For example, of the 56 *Healthy Homes Awareness* courses that were included in the evaluation, only 9 were set up as joint, cross sector training events. This was despite such a joint model being strongly promoted, with evidence given that there were clearly identifiable benefits.

Impact of *Healthy Homes Awareness* Training

A key part of the main evaluation was to ascertain to what extent the *Healthy Homes Awareness* training impacted on the working practices of trainees, whether there were lasting effects on practice and whether any changes in practice resulted in benefits to individuals living in poor or unsuitable housing.

Based on the level of data that it was possible to collect through this modest evaluation, it is possible to conclude that:

- *Healthy Homes Awareness* training was very relevant to the working practices of trainees. 57% said it was very useful, 31% useful to their job. Its content and approach was highly valued, with 87% saying that it was very useful/ useful in enabling them to refer patients/ clients for housing help.

- *Healthy Homes Awareness* training appears to have had a lasting impact. One year after training the majority of respondents were still reporting an impact on their working practices. 78% reported that they were more likely to notice housing conditions than before the training and 83% were more likely to refer people for housing related help.

- Individual people living in poor or unsuitable housing were more likely to be referred for help which subsequently resulted in an improvement in their living conditions. 44% of the ‘one year after training’ respondents reported that some of their patients/ clients living in poor or unsuitable housing had been helped to remedy those housing conditions as a direct consequence of their attendance at the training.

- *Healthy Homes Awareness* training and the involvement of HIAs in this delivery resulted in a measurable increase, albeit from a low base, in the level of referrals to the HIA by a health sector staff member. Non *Healthy Homes* linked HIAs recorded 2% of referrals from a health sector source, *Healthy Homes* linked HIAs recorded a 3.5% health sector referral rate. However, this is possibly an underestimate because the HIA database mainly records self referral, even though the person may have been informed about the HIAs services by a health sector worker.

Because this was outside the scope and capacity of the evaluation, it was not possible to categorically quantify the impact of the training and measure actual numbers of individuals whose homes have been improved as a consequence of the *Healthy Homes Awareness* training.

However, it is possible to make some tentative projections based on the evaluation. Taking both the HIA data and the feedback from trainees and assuming that each of the trainees who reported that their patients/ clients housing situation had improved as a result of action that they had taken following the course (44%) helped an average of just 10 people per year, this amounts to approximately 5,000 people helped to address housing problems as a direct consequence of the courses that were the basis of the evaluation.

An aspect of the *Healthy Homes* initiative that it was not possible to evaluate within the resources available was the wider impact of the programme resulting from making the *Healthy Homes* training and associated materials freely available via the website for local use. Information has been sent out to, or downloaded for use by, 244 individuals who completed the online questionnaire, plus an unknown quantity downloading the materials without completing the on-line questionnaire.

Summary

For two decades Care & Repair England has tried to increase the level of engagement by the health sector on housing issues.

Healthy Homes, Healthier Lives was a relatively small scale project with large ambitions; one worker covering England, operating in a complex and challenging policy and practice environment aiming to bring about lasting change in local practice.

As a result of *Healthy Homes, Healthier Lives*, in at least five areas of England home improvement agencies are now working much more closely with health colleagues at all levels – front line, planning and strategic commissioning. This is a very positive step forward, directly impacting on older people and is a lasting legacy from the project.

There is also a larger scale, less clearly quantified and project linked shift, with more areas making some use of the *Healthy Homes* model and beginning to make some headway.

What is clear from the initiative is that to bring about far reaching and lasting changes to both front line delivery and local policy and practice across health, care and housing requires strong commitment at all levels – within senior management to provide leadership and vision, amongst middle management to find creative ways to implement change, and amongst front line staff to change the ways that they work. And this applies equally to service providers, particularly home improvement agencies, as to the planners and commissioners across health, social care and housing.

Resources also need to follow rhetoric. Key to the successful local cross sector initiatives are both the will to make changes and some level of funding to support delivery. Not always large amounts, but enough to make a difference. Jointly agreed outcomes, priorities and joint service commissioning seem to have a key role to play in the effective delivery of local *Healthy Homes* related provision.

For example, prioritising the use of private sector housing funding for people whose health and well-being is affected by poor housing, fast tracking home adaptations for those waiting to leave hospital, jointly funding handyperson schemes that include in their remit home safety, falls prevention, security, home from hospital etc, can all contribute to improved front line housing related delivery and better outcomes for individuals.

Looking to the future

Radical changes to the policy environment are continuing across health, social care and housing. However, all still point towards a continuing drive for greater cross sector working practice across health, social care and housing. So the scope to develop and expand the *Healthy Homes* model is certainly there. Below are outlined some of the main changes that could support this application.

A potential driver for a policy and practice response to the links between housing/ health/ demographic change is the recognition that failure to address housing defects and inadequacies potentially results in higher costs via increased demand for health and social care interventions. However, there is a lack of cost benefit analysis/ impact assessment of specific interventions for the individuals who are most at risk of requiring NHS treatment or social care ie. those who could place the highest demands on health and care. Further research is needed to address this knowledge gap.

National Targets

In the 2007 Comprehensive Spending Review (*HM Treasury, 2007*) a new set of Public Service Agreements (PSAs) were set, some of which should add to the drive for cross sector implementation. Particularly;

PSA 17: Tackle poverty and promote greater independence and well-being in later life

Three of the 5 indicators are particularly relevant to housing related provision:

- Healthy life-expectancy at age 65
- Over 65s satisfied with home and neighbourhood
- Over 65s supported to live independently

PSA 18: Promote better health and well-being for all

Three of the 5 indicators are particularly relevant to housing related provision:

- All age, all cause mortality rate (AAACM)
- Gap in AAACM mortality rate in disadvantaged areas
- Proportion of people supported to live independently

There are some concerns that the ending of the previous Public Service Agreement (PSA) on Decent Homes improvement, and dropping the target of reducing the proportion of vulnerable people living in non-decent private sector housing, could impact negatively on the impetus for

current housing stock improvement. However, there are hopes that locally the new PSAs will be used to argue for action to improve the current housing stock.

The extra government funding for housing was primarily allocated for new housing and at a Regional level less money in relative terms has been allocated for private sector housing stock improvement. Again, local joint action by health, social care and housing may be needed to ensure that any help is available to improve private sector property where linked to health problems.

Local Area Agreements

At a local level, a significant change is taking place with regard to the power and control that national government wields over the detail of local services and activities. A new framework for setting local priorities came into force on 1st April 08; Local Area Agreements. These became the key focus for local service planning and prioritisation from April 2008.

Each locality now sets its own priorities by choosing up to 35 of 198 National Indicators for inclusion in its Local Area Agreement (LAA). These NIs are then meant to determine the priorities of all parties involved in the LAA, including all levels of local government, PCTs, police and others.

There are at least 14 NIs which it can be argued straddle health, social care and housing considerations, particularly in the case of vulnerable people, and hence which will be easier to achieve if services are more joined up and if priority is given to commissioning services which address related housing conditions. The *Healthy Homes* approach would be relevant to each of these.

National Indicator
NI 119 Self-reported measure of people's overall health and wellbeing
NI 120 All-age all cause mortality rate
NI 124 People with a long-term condition supported to be independent and in control of their condition
NI 125 Achieving independence for older people through rehabilitation/ intermediate care
NI 129 End of life access to palliative care enabling people to choose to die at home
NI 131 Delayed transfers of care from hospital
NI 134 The number of emergency bed days per head of weighted population
NI 136 The number of people supported to live independently through social services (all ages)
NI 137 Healthy life expectancy at age 65
NI 138 Satisfaction of people over 65 with both home and neighbourhood

NI 139 People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently
NI 141 Number of vulnerable people achieving independent living
NI 142 Number of vulnerable people who are supported to maintain independent living
NI 187 Tackling fuel poverty – people receiving income based benefits living in homes with a low energy efficiency rating

The Future of Social Care

A fundamental review of social care provision is underway, with a Government Green Paper anticipated later in 2008 / early 2009. The links to housing provision are expected to be made in this document. Self directed care, personal choice and individual control are expected to remain key themes, following on from the policy directives relating to individual budgets and direct payments.

Taking a holistic view from the individual's perspective of what would improve a person's life is part of these developments. This contrasts with a service driven approach. Again, the Healthy Homes model is applicable, particularly if extended to informing individuals about housing/ health links and possible remedial action. Put very simply, would a person choose to spend their individual budget on paying a care worker to come in and help them to wash instead of paying for an adapted shower?

Future HIA project

The Department for Communities and Local Government has commissioned a report on the future possible direction of home improvement agency provision – the Future HIA project.

This is expected to flag up a range of possible ways forward for individual local agencies, but in accordance with the 'new localism', will not put forward a single blueprint. However, joining up with health and social care and working towards provision of services that contribute to the performance targets of those sectors will be part of the recommendations in the report.

Extra money for HP services

Alongside the launch of the Government's new housing strategy for an ageing society, Lifetime Homes, Lifetime Neighbourhoods, came the announcement of £33 million being allocated for the expansion of rapid small repairs and minor adaptations services. This extra funding comes on stream from April 09. One of the stated intended aims for this expanded provision is to make it more proactive and joined up:

> *"We will work with local authorities, health sector service commissioners and other partners, including home improvement agencies, to ensure that the delivery of handyperson schemes is linked into related services. Linked services include falls and accident prevention, home security, fire safety, energy efficiency, adaptations and targeted health improvement*. " (p.70)

Clear cross sector provision links are being made here. As noted above, *Healthy Homes Awareness Training* was particularly effective where linked to handyperson provision. It is hoped, that this local service expansion will also provide opportunities to use the *Healthy Homes* model and improve links to the health sector.

Future of Health Care

Lord Darzi's final review, *High Quality Care for All (DH 2008),* gives a ten year vision for a world class National Health Service. The review emphasizes the need for the health sector to focus on improving health as well as treating sickness, noting the need for PCTs to work with local authorities to commission preventative services, to work with the third sector and others to improve wider health outcomes and to help patients reduce risk of health problems. *Healthy Homes* and the linked services are all relevant to this proposed change.

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Related Resources

Healthy Homes, Healthier Lives (2007) [CD-Rom/ DVD] London: Care Services Improvement Partnership. Weblink: http://www.icn.csip.org.uk/housing/

Healthy Homes, Healthier Lives. Weblink to training materials: http://www.careandrepair-england-hhhl.org.uk/index.htm

Appendix 1: POPPs, Spearheads and Pathfinders

POPP
The Department of Health Partnerships for Older People Project grant provided £60 million ring-fenced funding to Local Authorities to test and evaluate innovative approaches that should sustain prevention work in order to improve outcomes for older people. The scheme commenced in 2006 The first round of 19 sites started in May 2006 and the second round of a further 10 sites commenced in May 2007.
http://www.changeagentteam.org.uk/index.cfm?pid=595

Spearhead
The Public Health White Paper *Choosing Health – making healthier choices easier* sets out the importance of ensuring that '*as the country strives to improve its health a priority must be given to tackling health inequalities so that all groups in society benefit from improvements in public health'.*

The Government subsequently set a Public Service Agreement target to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. This target set the aim of seeing faster progress towards the targets for disease reduction (compared to the national average) in the 20% of areas with the worst health and deprivation indicators. In 2006 the list of the 70 Local Authorities and Primary Care Trusts was finalised and these are called the **Spearhead Group**.
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_4138963

Pathfinders
Market renewal pathfinders are partnership led projects set up by the Office of the Deputy Prime Minister (ODPM) in April 2002 to take forward new approaches to tackling the housing problems of low demand and abandonment in parts of the North and the West Midlands.
The areas cut across local authority administrative boundaries, with the expectation that the partnerships established to managed by the pathfinders would involve all relevant stakeholders in developing strategic plans for their whole housing markets.
http://www.communities.gov.uk/communities/respect/housingmarketrenewal/

Appendix 2: Local Beacons

Case Study: Mendip

The Home Safety Action Partnership (HASAP) in Mendip brings together Mendip Care & Repair, Somerset Fire & Rescue Service, Avon & Somerset Constabulary Crime Prevention Team & Bobby Scheme, the PCT Falls and Accident Prevention Team, and Care Direct in a "first across the threshold" referral scheme.

Front line staff who work for these organisations are required to complete a Home Safety Action Form, which helps to identify people who could benefit from referral to one of the other agencies in the Partnership. The County Council funds the position of a county co-ordinator and their associated costs to handle the Home Safety Forms and ensure that referrals are made to the appropriate organisation.

Mendip Care & Repair were one of the key moving forces behind the HASAP concept, which is based around a one-day training session to introduce the programme and provide the right level of information to enable front line personnel to refer the clients/householders they meet during the course of their work.

HASAP Training
The training day is popular and in its first year HASAP delivered 15 sessions. Between 60 to 80 people attended each session, meaning that 1,000 front line people were trained to participate in the scheme.

Mendip Care & Repair used the *Healthy Homes, Healthier Lives* training materials to run 45 minute sessions that raise awareness of the links between housing and health.

"*It is a long day, but delegates get a thorough briefing from every angle, and they seem to like this. They get information about personal and community security, fire risk, the care packages that are available as well as the session we do on housing. The Healthy Homes materials really help to drive the point home, particularly the photographs showing the conditions people can live in and what we can do about them. They speak volumes about how housing affects health, and give rise to some very searching questions from the floor*." (Kevin Lake Manager, Mendip Care & Repair)

The range of delegates at each session includes:

- Community police
- Fire officers
- Neighbourhood Watch representatives
- Carers
- Care Agency Managers

Despite the fact that PCT managers sit on the HASAP group there has been poor attendance by health staff at the training days. Other members of HASAP hope that the situation might be ameliorated by running sessions at a wider range of venues and that more Community Nurses and Matrons will be able to attend.

Outcomes
Front line staff and community workers have made 674 Home Safety Form referrals to HASAP to date: 614 of these have been dealt with by the appropriate agencies and the "cases" are closed. Mendip Care & Repair have received around 30 referrals to help homeowners improve their houses.

A recent referral through the scheme demonstrates how HASAP can bring all round benefits to older and vulnerable people. A fire prevention officer who was making house calls as a result of a county-wide fire prevention scheme saw that an elderly lady was struggling to manage in very poor living conditions. He returned a completed Home Safety Form to the county co-ordinator and the HASAP team swung into action. Mendip Care & Repair is currently improving the condition of her home whilst her local Social Services Adult Care team are putting together a package of care to help her remain independent and stay in her own home.

Joint Working
The latter case exemplifies the most important aspect of HASAP's success: its multi-agency character, which not only brings obvious benefits at ground level, but also underpins its success at a strategic level.

HASAP is a decision-making group with regular round table meetings of officers and representatives at the highest level from the emergency services, local authorities and the Primary Trust. Their involvement means that the burden of maintaining and resourcing the programme, particularly the training days, is broadly spread and that things get done.

It also ensures that HASAP maintains a high profile, HASAP group members take it in turns to keep up the pressure on Public Relations. The scheme gets regular press coverage as a result, keeping it in the forefront of the minds of everyone in the County.

"With a lot of schemes like this there is often a lot of enthusiasm at the beginning, but once the honeymoon period wears off interest can wane. This hasn't happened with HASAP and that is down to the fact that top level people are actively involved in keeping it going". (Kevin Lake, Manager Mendip Care & Repair).

The most obvious gap lies in the limited involvement of the PCT, particularly in terms of the number of front line health staff coming to the training days. This situation supports the view that it is often difficult to engage the health sector in multi disciplinary schemes, even when they are of palpable benefit to public health strategies.

Mendip Care & Repair receive no direct funding from the scheme, but is committed to the concept because they are fully aware that they have already helped at least 30 people whom otherwise would not have found out about them.

Case Study: Blackpool

SEASHORE Home Safety programme is a partnership venture between Blackpool Care & Repair, Blackpool Primary Care Trust and Blackpool Council, and contributes to the agenda of the Local Strategic Partnership by offering a “shopping basket” of shared services to reduce the number of deaths due to accident amongst older people. SEASHORE initially operated in areas of Blackpool where falls and accidents in the homes of people over 60 are most prevalent but due to its success has expanded its area of operation.

Front line health and social care workers refer their eligible patients to Blackpool Care & Repair for free ‘environmental inspections’ to assess people’s homes for potential risks to health and safety. Where a risk is identified the householder is advised about remedial action, which can be undertaken by Care & Repair Blackpool, free of charge in most cases.

How SEASHORE works

Aims and objectives:

- to carry out 800 environmental inspections per annum;
- to accomplish 3,000 interventions during the 3 year period of the programme in order to:
- reduce the number of deaths and severe injuries due to falls by 21% by 2008

There is a further long-term aim that by 2020 the mortality rate will be either at or lower than the national average.

The Programme has 3 main activities:

- cross sector training with up to 50 front line health and social services staff per session to enable them to identify potential hazards and refer householders to SEASHORE;
- a Home Safety Check carried out by Care & Repair case workers, in most cases leading to;
- installation of adaptations/repairs and/or application for grants to remedy potential health hazards

The PCT and Blackpool Council jointly fund the administration of the scheme and the Home Safety Checks; they also provide funds for some of the practical measures where eligible householders do not otherwise qualify for grants.

Intervention and practical measures:

- minor adaptations
- security and falls prevention measures
- draught proofing
- smoke alarms
- replacing old or defective blankets
- exchanging chip pans for deep fat fryers

Although not technically part of SEASHORE, the PCT also co-funds the Winter Warmth campaign which benefits all of Blackpool’s residents, including those in the SEASHORE area. PCT money enables Care & Repair to offer clients in deprived wards:

- temporary heaters to replace inadequate appliances whilst arrangements are made to install central heating;
- electric blankets to people who do not already have them
- draught proofing work .

A large pot of money from the Housing Capital Fund pays for the installation of central heating measures.

The benefits of partnership working:

- the programme involves a wide spectrum of staff from health and social services in the referral process, contributing to falls prevention, hospital discharge and public health aims and objectives;
- it enables a broader service delivery which now includes housing questions/referrals within SAP
- it has opened up opportunities for Care & Repair to contribute to PCT and Social Services targets e.g. Care & Repair home safety assessors have been trained to provide information for Medical Reviews by taking medication into account when assessing falls risks
- joint funding gives the SEASHORE case worker the time to conduct the thorough assessments and adopt a *whole person* approach to the Home Safety Check that is critical to the programme's success
- joint funding has also made it possible to develop IT systems to monitor and expedite referrals.

Outcomes and evaluation to date:

- positive feedback from front line staff in health and social services about the training
- the resulting referrals from programme partners will help Care & Repair to exceed their target of 800 Home Safety Checks in the current year.
- positive feedback from SEASHORE clients
- admissions to hospital of people over the age of 65 recorded as due to falls have fallen from 398 in 2005/06 to 355 in 2006/07 resulting in potential saving to the PCT of £86,000*
- the number of people over 65 presenting at Accident and Emergency recorded as due to falling has fallen by around 11% from 2005/06 to 2006/07

* 55 fewer admissions at an average cost per admission of £2,004.00

About Care & Repair England

Care & Repair England is a national charity established in 1986 to improve the housing and living conditions of older and disabled people. Its aim is to innovate, develop, promote and support housing policies and initiatives which enable older and disabled people to live independently in their homes for as long as they wish.

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