**Workshop 1 - Housing and Health Inequalities in Lancashire and Cumbria to inform the Lancashire & Cumbria Health Equity Commission (HEC)**

**10am Tues 12th October 2021**

**Overarching messages:**

* The relationship between the housing sector and health is more than housing conditions – extensive package of community investment that needs to be recognised
* The sector has established relationships with the most vulnerable/marginalised groups in society and its contribution is therefore integral to reducing health inequalities
* Covid-19 showed the capacity for partnership working across sectors which now needs to be further exploited to enable ‘big picture’ thinking about how to work together in a pro-active, sustainable, and long-term way
* Extensive expertise in the housing sector, and excellent partnerships/services already in place (especially those that are people-driven and that centre lived experience) – must not be overlooked in quest to implement something ‘new’

**Key points for each question (see appendix for verbatim nearpod contributions):**

**1. What are the local issues for housing and health inequalities?**

* **Profit-driven model in the housing market creating problems; need a people-driven model:** 
  + large investors buying up beds but not providing the levels of intensive housing management/support needed
  + private rental market fills the gap for people who are not in a position to buy their own homes but often there is a lack of quality landlords, people don’t get extra support and wrap around care that other housing organisations would provide
  + private landlords approach social landlords with a view to deliver supported housing in partnership – but the motive is solely profit and wanting to extract money out of the system
* **Lack of affordability due to:**
  + Insecure work (e.g. zero hours contracts)
  + Poverty
* **Poor benefit rates, high rents, and associated/resulting debt:** 
  + Local housing allowance doesn’t meet full rent, people have to dip into UC, and the lag in payment leads to people falling into debt
* **Range of complex issues:**
  + Mental health; substance misuse; fuel poverty; transience; antisocial behaviour; criminal activity; social isolation; falls.

**2. What actions are working and what actions should be taken to improve housing for better health and wellbeing? Who should be responsible/leading this?**

* Part of the purpose of the ICS’s is to address wider determinants of health and there is an opportunity to do this through partnership working and anchor networks locally
* Covid-19 created new opportunities for collaborative working across sectors (e.g. homelessness and health) which now need to be further developed
* There is a need to make more explicit the cost to the NHS of failures to invest in wider determinants - this would support more ‘big picture’ thinking across sectors about how everyone can direct energy and resources to bring about the best outcomes for both people and the public purse
* **Specific recommendations:** 
  + Extend and invest in social prescribing
  + Better liaison between health service and housing to support discharge and ensure people’s changing housing needs are being met
  + Invest in good advice services because they have a key prevention role to support people dealing with money, debt, and housing issues

**3. What message would you send to the HEC that you feel would make the greatest changes to housing to improve health inequalities?**

**The HEC needs to:**

* think together about where the root causes of health inequalities are coming from (instead of reacting to the crisis of the day): Is it ? poverty; ? poor quality housing; ? unregulated housing
* move away from one-way conversation of everyone feeding into health – what is the health service doing to link in with and contribute to wider services and organisations that support prevention and reduce inequalities
* recognise that housing associations are a direct link in to people who, in effect, cost the NHS the most money – need to create a platform where housing can have a proper conversation with health about shared priorities
* put lived experience at the very hard of these conversations and engage in ‘radical commissioning’ to ensure that the right services are being funded – can’t be fixated on evidence and KPIs that don’t capture the human element of relationships, trust, and care
* recognise the wealth of information, support, expertise and capacity available working in partnership with housing, voluntary sector and communities; and existing partnerships that work well and have excellent results
* promote the importance of community-based people who can bridge the interface between health services and wider housing services/lived experience groups to fully understand the profile of homeless and other marginalised groups

***4. What are the barriers that prevent you from making a step change in health inequalities?***

* NHS England gets in the way of innovation locally – need to let local partnerships on with local priorities and avoid the short-termism where resources are not committed
* Failure to recognise what is working well and making the difference, and instead duplicating effort and wasting resources by commissioning similar services
* Market led approaches (to housing and support services) rather than community led
* Cultural ‘drop in and fix it approach’ which is unrealistic, often badly delivered, and limits engagement in long-term thinking

***5. Where are the greatest opportunities for improvement?***

* Develop an understanding of the investment potential within the housing sector to encourage health to recognise housing’s value as a partner
* Identify shared outcomes that can enable big picture thinking and collaborative working between sectors
* Need to have the right ‘strategic conversations’ that can enable the joining-up and a move away from short-term projects to a long-term plan
* Numbers and money do talk – there is enough evidence to make a very strong case for quantifying the value of acting and potentially teasing out which sectors can and should contribute (£)

**Appendix:**

**Contributions from nearpod**

**1.** **What are the local issues for housing and health inequalities?**

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| * Dual diagnosis – mental health and substance misuse * Poor substandard housing creating major mental health issues * Lack of understanding/empathy to help fix what should be minor issues e.g. damp * Gap between benefit for housing and real cost * Fuel poverty * Transience * Antisocial behaviour and criminal activity * Lack of commitment to the community which means people access public services at a crisis level/structural problems with properties * HB/UC housing payments have no relationship to quality of accommodation driving the poor quality private sector housing * Houses being used as holiday lets * General housing isn’t right for ~40% - proper housing for older people; supported living for people with learning/physical disability; and proper housing for younger people that meets social needs * Secondary impacts of poor quality housing – general apathy, why bother, * Employment * Environment * Addiction issues * Poor childhood experience * The competitiveness of the market for quality and affordable housing makes it difficult to persuade landlords to accept prospective tenants with complex needs * Poverty * Social isolation * Trips and falls * Access to services * Connectivity * Online affordability * Knowledge of services provided by NHS and voluntary sector * No money or available land to build new council properties * Lack of investment in prevention as it doesn’t have the visual impact that crisis work does * New models of supported housing are profit and not people driven causing a massive disbalance in the market and house prices * Challenges for young people to get a deposit together * Relationship with NHSE – investment in housing stock to reduce health inequality. Blackburn empty homes model around investment in empty homes * Lack of a secure income (i.e. zero hours contracts) makes it very difficult to get a mortgage – hence the need for affordable rent in areas with low/insecure unemployment * We don’t view housing as a human right – it’s a broken market. Different starting point needed by policy makers * Energy efficient homes are critical but also education that goes alongside. Tenant need to understand how to use the technology, otherwise it’s not used properly when fitted and can make it detrimental to living conditions * More resources put into case management – people are complex and need more direct support, much of which isn’t health related * Need to deal with existing housing stock as a priority and empty homes – not sustainable to try and build our way out of this * Benefits rates – housing allowance doesn’t match rent levels – people go into debt to get a rental * Legal aid cuts means people struggle with legal issues/support * Building communities to improve areas that people do not want to move to – issues with litter, graffiti, crime, bullying * We need a cost effective way of retrofitting and a new way of heating our properties. |

**2. What actions are working and what actions should be taken to improve housing for better health and wellbeing? Who should be responsible/leading this?**

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| * Health services should acknowledge the expertise and support services provided by housing providers e.g. employment support, lifeline, lifting services, financial inclusion, community engagement, foodbanks, hospital discharge * Covid created some great joint working between homelessness and health – but was triggered by a crisis * Local councils cannot enforce private landlords without strong legislation * Health system can be quite challenging to navigate and command and control – push the responsibilities and budgets down the chain to make the biggest impact * Extend and invest in social prescribing across the ICS footprint, to include housing and voluntary sector * We have some great examples of place-based working in Burnley including our health trust and PCNs * Community Resilience in Cumbria was great, people came together to help their neighbours, volunteers carrying out repairs etc. * Hospital discharge coordinators should liaise with external local support providers prior to discharge * Covid did create great join working – continued the wellbeing calls post covid and developing networks to encourage and build on this but a district basis which doesn’t always fit with the health footprints * We keep telling the health service what we do but unfortunately things change so frequently that nothing can be fully developed. Help through this process would be appreciated * We need to find a better solution to ensuring houses meet need. On discharge from hospital, a person who has recently had a stroke and need to move their bedroom downstairs – that house is no longer suitable for them, how do we ensure homes fit needs. * Asking the right questions i.e. within health service to identify where housing or lack of housing is affecting health and linking with local authorities and partners to address this. Continue joint working to develop a workable approach. * There is already some good work happening locally such as the changing futures work to address complex needs. This is involving a range of partners including health |

**3. What message would you send to the HEC that you feel would make the greatest changes to housing to improve health inequalities?**

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| * Legislation to stop cowboy landlords * Consider shared budgets and longevity in projects – links between health and housing are not new * Please recognise the wealth of information, support, expertise and capacity available working in partnership with housing, voluntary sector and communities that can affect change for individuals * More control over private landlords to ensure good quality accommodation * We need to look at longer term solutions to addressing poverty * Too many people are living in houses that do not fit their needs – we need to assess people’s health needs and match them to the right houses * Stop tinkering around the edges. Create RADICAL change. Address causes of poverty * For many years we have talked about people focused services, shared information and knowledge, but in reality this doesn’t work in practice * Create a platform – use the common ground of shared personal outcomes to do something productive * It’s not housing helping health, or health helping housing, its working around shared priorities and outcomes * There is tonnes of evidence – we know that this link is real. Challenge the sticking plaster approach and create functional communities which support wellbeing. Challenge the ideology that housing is just a commodity. * The big conversations about building new homes are a distraction from solving the problems of poverty * Do not forget about existing partnerships that work well and have excellent results * Use commissioning better to create services that have a real impact on people’s lives * Engage with local housing groups and other local groups to consider joint solutions/commissioning involve all the relevant partners and those with lived experience. * Penalise second home owners far greater and invest that money back into the community * Many partners work very hard to make an impact, there are lots of strategies and action plans to try to reduce inequalities , but a lack of budget to actually implement the plans |

**4. What are the barriers that prevent you from making a step change in health inequalities?**

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| * NHS England * No joint commissioning between County Councils and CCGs * Lack of resources to services that are designed to make real changes to people’s lives * Recognition of projects that work well and make a difference for the individuals and local communities * Duplication of services is wasting resources – NHS duplicate with LA’s do and never ask before they commission * There aren’t any if we invest the time and energy in building relationships with our NHS colleagues * Market led approaches (to housing and support services) rather than community led * Lack of legislation * Lack of place-based, joined-up approaches working with local communities * System approaches – sometimes work in soles so systems need to change alongside commissioning. Understanding what is already happening locally and how to build upon this work |

**5. Where are the greatest opportunities for improvement?**

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| * It would be great to have a unified approach showcasing the impact that we can make * Equal relationship and shared outcomes * We implement short term projects that raise expectations and are very successful. Then the funding ends and the project is shelved. We need to learn from the lessons and build on them. * Health and Housing are not just the most important partners, the council and third sector as equal * Develop an understanding of the investment potential within the housing sector to encourage health to recognise our value as a partner * Any work that is genuinely shared and stops the silo mentality * Non-medical staff speaking to people about their housing status when they are in hospital. It’s a golden opportunity to begin relationship building * Value of housing is very important and needs to be known * Joint working to increase supply through new housing, addressing existing housing conditions, joint work to address inequality and issues that lead to homelessness and spiralling needs. Use existing groups and build on that work. |

**6. Any other comments?**

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| * Bring health services into local areas especially poor housing areas * There are some really committed people and organisations working in our localities. Caring and compassionate approaches will always be here |

**Attendees (roles pulled from LinkedIn/internet, might not be 100% correct):**

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| Andrew van Doorn | Chief Executive at HACT | Andrew.VanDoorn@hact.org.uk |
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**Notes from talk from Andrew van Doorn, Chief Executive of HACT:**

* Statistics on housing and health not surprising because of how resources have been taken away from housing and housing support for the past ten years especially, and in particular funding for preventative services (e.g. the Supporting People funding introduced in 2003 has been reduced by 80%)
* Emphasis from Andrew today is not on housing conditions – this is often the lens through which health and public health view housing but there is a need to extend that lens beyond housing conditions to also appreciate the importance and role played by housing professionals and providers
  + One point on conditions though is that 20% of the carbon emissions that need to be reduced are driven by housing, of which 50% is driven by social housing (17% of all housing stock) because they are both older and colder - £106B needed to retrofit and provide more sustainable homes and need to consider how that investment is used and linked to health equity objectives
* Andrew keen for people to see housing associations, not just as social landlords, but also as providing a whole range of community investment and support
  + The provide the majority of housing/homes for different groups (older adults, people with learning disability, people experiencing domestic violence)
  + They are also anchor institutions – they are long term actors in their communities and have a long-term perspective – hence a real opportunity for connections between housing and health through **anchor networks**
* Social landlords invest heavily in the community (‘jewel in the crown’ of the social housing sector) - £750M per year
  + Funds an ‘army of community investment professionals’ are tackling things like education, training and employment, health and wellbeing etc.
* Need to connect the ‘community investment mode’ of the social housing sector to the health equity agenda to harness the potential and opportunity it offers, and start to view the sector as **providers** – providers with staff, resources, and who provide investment and care in the community
* The sector is also not just working with the public but also supporting workforces – Andrew gave the example of how the housing affordability crisis is also affecting NHS staff
* In making change happen, it is not about doing stuff to people, but doing stuff alongside people
* **Examples:** 
  + Developing a relationship between the ICS and the local housing providers in Cheshire and Merseyside (e.g. Regenda; Torus; YHG; and others) and looking at how can they help people who live in the social housing into NHS and social care jobs – strategically exploiting the education and training programmes that housing associations already provided to contribute to addressing workforce issues within health and social care
  + Housing associations coming together with public health in Bedfordshire running a range of programmes on the priorities of public health to achieve more coherent approach across housing associations
  + Harrogate ICS has a strong housing focus, driven by organisations like WDH
* Housing associations were the first port of call for many people and they have reach into communities and have reach to people who experience the worst **health inequalities** – this is where Andrew sees the most opportunity for linking housing and health together in place-based collaborations, and in a way which complements concerns and focus around the physical housing conditions