Consultation response

Shelter's response to Choosing Health? – A consultation on action to improve people's health

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Shelter

We are the fourth richest country in the world, and yet millions of people in Britain wake up every day in housing that is run-down, overcrowded or dangerous. Many others have lost their home altogether. Bad housing robs us of security, health, and a fair chance in life. Shelter believes everyone should have a home.

We help 100 000 people a year fight for their rights, get back on their feet, and find and keep a home. We also tackle the root causes of Britain's housing crisis by campaigning for new laws, policies and solutions.

Shelter has recently launched its 'Million Children Campaign' – the biggest in its history - aimed at ending the devastating impact of the housing crisis on over a million children in Britain. The campaign was launched with the publication of *Toying with their Future*[1], a report that reveals that over a million children who are growing up in overcrowded, unfit or emergency housing, suffer from serious health problems, poor education and have their future damaged.

Shelter welcomes the Government's decision to issue this consultation. We agree that access to healthy environments, services and information has a powerful impact on people's ability to choose healthy lifestyles. We support the consultation's aim to improve access and to work towards removing the current barriers that prevent this. We also welcome the Government's recognition of the need to collect more evidence from people who experience the worst health outcomes and inequalities. This will be essential to ensure that the new spending priorities agreed later in the year are based on accurate assessments of need and are allocated appropriately.

Having good access to housing is vital to people's physical and mental health. Good housing can alleviate health problems and also enhance access to care and improve people's quality of life. Increasing investment in good quality housing can also help address a wide range of government priorities, including long-term improvements in health and education. Despite the setting of the Decent Homes target,[2] however, many people in the UK still experience barriers in gaining access to healthy living environments. Data show that in the private sector alone, there are still 1.2 million vulnerable households living in non-decent homes.[3] Current investment priorities do not sufficiently address this as an underlying cause of health inequalities.

Acute shortages in the supply of social housing have led to record numbers of homeless people living in temporary accommodation and for longer periods.[4] As well as being in potentially poor physical conditions, people in this accommodation often live in overcrowded conditions and are forced to share cooking and washing facilities. Overcrowding has been demonstrated to have a range of negative impacts on health, including respiratory and infectious disease.

Shelter recognises the action that Government is taking to improve standards in temporary accommodation and to reduce the long-term use of Bed & Breakfast

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[1] Shelter (2004), *Toying with their Future,* London: Shelter

[2] Set by ODPM, this covers standards for fitness, repair, facilities and services and thermal comfort.

[3] English Conditions Housing Survey, 2001

[4] ODPM homelessness statistics

accommodation by homeless families. However, homeless people remain amongst the most disadvantaged in society. People who are homeless and badly housed experience a range of health inequalities – not only related to the quality of the accommodation they live in - but also because of lack of access to services and loss of social networks. Homeless people are rarely given choice about where they are accommodation and about how services are delivered to them. Shortage of social housing means that people must spend longer periods in accommodation that is insecure and that still frequently lacks adequate support services.[5] Often, homeless people are also being placed in accommodation that is outside of their local area, meaning that they are not able to access their existing services and social networks.

Some progress has been made in delivering services in a way that makes them more accessible and better able to serve the needs of homeless people. However, these services are by no means available universally. In many circumstances, homeless people still experience barriers in accessing facilities and services that would improve their health. Health services are not sufficiently engaging with housing/homelessness agencies at a strategic level. There are still gaps in the evidence being collected about the health of homeless people, especially in relation to families. Taken as a whole, this means that homeless and badly housed people are not likely to achieve health equality and continue to suffer poor health.

Shelter's response to this consultation will relate to:

- How organisations have an impact on health through their interactions with the public, employees and society (Question 7)
- Creating and maintaining a healthy environment (Question 8)
- Helping people deal with the stresses of life (Question 9)
- Developing the evidence base to enable analysis of cost benefits and in which circumstances joint action can be expected to be most effective (Question 11).

Our response focuses on the impact of homelessness and bad housing on health and the implications of these impacts for service delivery and investment priorities.

On the basis of this, we would like to make the following recommendations:

Strategic working

- Increased investment should be given to increase the supply of affordable housing and improve housing conditions. The Government should commit to a coherent strategy to address housing need, which takes a comprehensive assessment of existing and future levels of housing need as its starting point. The Government should also set more ambitious targets to reduce the numbers of vulnerable households living in non-decent homes in the private sector.
- More clarity should be given about the functions of health services in relation to housing and homelessness – ideally through the issuing of statutory guidance.

[5] See for example, ODPM/DH (2004), *Achieving Positive Shared Outcomes in Health and Homelessness*

- More joint targets are set for local authorities and Primary Care Trusts, to back up the intentions set out in the recent advice note issued by ODPM and DH. More joint guidance to be issued by other Government departments, in particular the Home Office in relation to its work with refugees.
- Homeless people should be recognised as a distinct population group for PCTs and as a group at particular risk in other social care legislation, such as the Children Bill.

Services

- There should be more access to specialist primary care for homeless people and more consideration of how this can be delivered in areas where there is a relatively how incidence of homelessness, for example, through making delivery of Personal Medical Services more flexible.
- Universal services, such as Sure Start, need to be better adapted to the needs of homeless people.
- Funding from DH should be available towards establishing multi-disciplinary teams, including specialist mental health and children's workers. These must be sensitive to the needs of local communalities.
- DH should make a commitment to providing more help to homeless children through Children and Adolescent Mental Health Services.
- Health Equity Audits should be used to evaluate access to health services for homeless people and sub-groups of homeless people.

Evidence base

- Data from Homelessness Act strategies and Supporting People reviews should be utilised as a source of information on local homelessness and the needs of homeless people.
- There needs to be more large-scale research carried out, both on the impacts of housing conditions on health inequalities and the impact of wider determinants, such as income and welfare benefits.
- New data systems should be developed that enable assessment of how effectively services and agencies are working together to achieve joint outcomes.
- There should be greater consultation of local communities about their experience of services; this should be integrated into planning mechanisms.

Q7: How organisations have an impact on health through their interactions with the public, employees and society

Enabling people to gain access to healthy living environments is vital if inequalities in health are to be reduced in the longer term. However, homeless and badly housed people still face disadvantage in this regard.

Despite the common ground that exists between health and housing, the degree of cooperation between housing, homelessness and health services has not historically been strong. A survey of health authorities in 2000, for example, illustrated that only 35% had mentioned rough sleepers in their Health Improvement Plans, with 79% of those not mentioning them stating that they did not intend to do so in future.[6] A recent study of the health and housing needs of older people found that Community Care Plans and Director of Public Health reports still frequently neglect housing issues.[7]

Current strategic initiatives are helping to facilitate closer joint working and help produce better outcomes for homeless people. The Homelessness Act, for example, places expectations on health services to liaise with their housing and social services counterparts and make productive links between homelessness issues and other programmes, such as Local Delivery Plans and the Primary Care Trust commissioning plans. Health is also one of the major strategic partners in the Supporting People programme and should have input into Supporting People strategies. We also welcome the focus of recent Government documents on the value of local authorities and health services working jointly in order to tackle the causes and consequences of health inequalities.[8] The recent advice note jointly issued by ODPM and DH is particularly positive, in its setting of out how joint action can help meet the targets of the respective departments involved and by illustrating through more detailed indicators how they might better meet the headline target on health inequalities.

However, Shelter also believes that there are still significant problems in getting health and housing and homelessness agencies to work together. This is hampering homeless people's access to appropriate services. We consider there are two main reasons for this. Firstly, there is still insufficient recognition of the vital role of housing and homelessness issues in delivering integrated health and social care services. The Children Bill, for example, whilst seeking to make better links between health and education services, fails to make explicit the impacts on children's health and education arising from poor housing conditions. Homeless children are not recognised as a group who face particular risks and difficulties; housing and homelessness agencies are not included within proposed new structures and models. In some instances, there is also a lack of recognition of the specific needs of sub groups within the homeless population. The NHS Priorities and Planning Framework, whilst a positive step to improving access to primary and secondary care for homeless people, does not pay attention to the specialist needs of sub groups of homeless people, such as older people and those from BME groups.[9]

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[6] Griffiths, S (2002), *Addressing the health needs of rough sleepers*

[7] JRF (2002), *Planning for Older People at the Health and Housing Interface*

[8] For example, Dept of Health (2003), *Tackling Health Inequalities: A programme for action*

[9] Gorton, S (forthcoming). *Guide to Addressing Family Homelessness for PCTs*

Secondly, more work is needed to ensure that health services – especially Primary Care Trusts - engage sufficiently at strategic level with other partners. As part of its work on implementation of the Homelessness Act, Shelter carried out research with a sample of local authorities to monitor their progress in relation to the new legislation.[10] Shelter's research found that health services (as represented by Primary Care Trusts) had lower levels of involvement than other statutory partners – such as social services - in the development of homelessness strategies and that their involvement produced comparatively less specific outcomes. The recent Government-funded review of Supporting People services also points to poor attendance on part of health services on Supporting People commissioning bodies and Core Strategy Groups and the impact that this is having on health input into Supporting People services.[11] Lack of involvement on the part of health services is likely to limit their understanding of how they can improve health by preventing homelessness. They may also underestimate how of how joint working can reduce demand for health services. It also reduces the likelihood of services being commissioned and delivered in a cost-effective way that bests addresses the health needs of homeless and badly housed people.

In our recent report on health and social services involvement in homelessness reviews and strategies,[12] Shelter argued that joint work between health and housing/homelessness agencies could be improved if there was greater clarity about the points at which their functions – especially those of PCTs – overlapped under Homelessness Act legislation. We re-state our recommendation that this could best be achieved through Government statutory guidance to this effect. We also believe that ODPM and DH should consider issuing guidance to reinforce some of the voluntary shared outcomes measures set out in their recent good practice advice note. Government should establish a dedicated post to improve overall coordination and liaison at national level. This should take the form of a permanent co-ordinator for health and homelessness work and would replicate the model already in existence in Scotland. Within PCTs, there should be senior level posts that have responsibility for health and homelessness. We believe that funding such posts would have longer term cost benefits to both DH and ODPM in the prevention of homelessness.

Access to primary care and other services

A central aim of the NHS Plan was to reduce health inequalities through improved access to NHS services and partnership working to tackle the causes of people's ill health – especially groups of people who are harder to reach. Homeless and badly housed people have higher than average levels of health problems/needs than the general population. Evidence shows, however, that they still experience many barriers in accessing appropriate health services. Recent research has illustrated that a range of barriers exists, including institutional factors, such as opening times and location of services and lack of integration between primary care and other local services.[13] These barriers

[10] Credland, S (2003), *Local Authority Progress and Practice: LA s and the Homelessness Act 2002 six months on*, London: Shelter

[11] Sullivan, E/Robson Rhodes (2004), Independent Review of the Supporting People Programme, p 38

[12] Lewis, H (2003), *Healthy Relationships?* London: Shelter

[13] Griffiths (2002), *Addressing the Health Needs of Rough Sleepers*

increase for homeless people who have multiple needs[14] - such as substance misuse and mental health, those who have been homeless for longer periods of time and those who live in areas where there is a relatively low incidence of homelessness.[15]

The issue of homeless people using Accident & Emergency rather than GP services to access primary health care has long been recognised as a problematic and highly expensive means of accessing primary care.[16] However, homeless people continue to use A&E services to a much greater extent than the general population.[17] Homeless people also still face major problems in accessing GP services. Recent figures demonstrate that rates of registration vary widely.[18] There is also evidence that GP practices remain discriminatory.[19] Similarly, Sure Start services – intended to improve the health and educational prospects for young children from disadvantaged backgrounds – are not available to all homeless households. *Living in Limbo* surveyed homeless households in temporary accommodation in nine local authority areas, which contained a total of 21 Sure Start local programmes. Despite this, only a fifth of families with children aged under four years were accessing the service. Shelter has recommended that funding be found to establish a mobile Sure Start service, specifically aimed at families in temporary accommodation.

We recognise that work is being carried out to improve access to healthcare for homeless people. Personal Medical Services, for example, have delivered a range of benefits - improving flexibility of response to problems, access to care and, in some cases, improving protocols around mental health services.[20] We also welcome the establishment of National Enhanced Services for GPs, because we believe they offer positive opportunities for homeless people, in terms of increased access to services, flexible delivery of services and greater integration between GPs and local housing and homelessness agencies. However, both of these services are only likely to be delivered in areas of high concentration of homeless people.[21] PMS schemes responding to the needs of homeless people are only currently operational in approximately one third of PCT areas and very few cater for the needs of homeless families.[22] We are therefore concerned that homeless people will continue to face severe difficulty in accessing specialist primary care services and that this will be particularly severe in areas where there is a relatively low incidence of homelessness.

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[14] Croft-White, C and Parry-Crooke, G (2004), *Lost Voices*, London: Crisis

[15] Gorton, S (2003*) Guide to models of delivering health services to homeless people*, London: Crisis

[16] *Go Home and Rest* (1996), London: Shelter

[17] For example, ODPM/DH (2004), Achieving Positive Shared Outcomes in Health and Homelessness

[18] 92% and 24% respectively in surveys of families living in temporary accommodation and rough sleepers. Quoted in ODPM, Homelessness Statistics, March 2004.

[19] Crisis (2003), *Mental Health and Social Exclusion*

[20] National Evaluation of First Wave NHS Personal Medical Services Pilots 2002 – Summary of Findings www.npcrdc.man.ac.uk/Publications/pms2002.pdf

[21] BMA (Feb 2004), *National enhanced service – enhanced care of the homeless*

[22] Gorton, S (forthcoming). *Guide to Addressing Family Homelessness for PCTs*

Question 8: Creating and maintaining a healthy environment

The physical quality of people's living environments is well established as a major underlying determinant of physical and mental health and a potential source of health inequality.[23] There is strong evidence, for example, that poor physical quality accommodation increases the percentage likelihood of developing diseases such as bronchitis, TB or asthma[24]. There are also strong links between overcrowding and health, including the spread of infectious disease, mental health problems, such as diminished psychological health in children and increased likelihood of developing severe ill health in later life.[25] Half a million households are estimated to be overcrowded, with BME households at least seven times more likely to live in overcrowded conditions than their white counterparts.[26] On the other hand, there is evidence that making modifications to dwellings has beneficial impacts on public health and that improving housing conditions can be a key component in improving people's mental and physical health. A study carried out in 2002, for example, demonstrated that people living in a housing estate where conditions had been improved made less visits to the doctor, used less medication and had a general lower incidence of disease than those living in cold, damp conditions. [27] Findings from *Living in Limbo*[28] illustrate the prevalence of poor physical conditions in temporary accommodation and the impacts that these have on the health of people living there:

Findings from *Living in Limbo:*
More than one third of respondents (35%) agreed with the statement that their housing was 'damp and mouldy'.

Thirty one per cent felt that the cooking facilities in their home were 'poor and unhygienic'.
Half of the survey respondents stated that their family's health had suffered due to living in
Temporary accommodation. A quarter felt that their health had got 'much worse'.

People living in temporary accommodation for more than a year were more likely to report damage
To their health because of it.

There was a significant Increase in the use of GPs

Shelter is pleased to see that the issue of physical conditions and standards in housing is included in the Programme for Action in Tackling Health Inequalities. However, we do not consider that the current targets set by Government are sufficient to substantially reduce health inequalities. If better health outcomes are to be realised by all homeless and badly

[23] For example, NHS Health Development Agency (2003), Health Equity Audit Made Simple

[24] Shelter (2004), *Toying with their Future*

[25] For example Evans, 2001

[26] Survey of English Housing 2000/01

[27] Ambrose, P (2001), study of new or improved housing under Central Stepney SRB programme

[28] *Living in Limbo* is a survey of over 400 households living in temporary accommodation

housed people, we believe that investment in improving housing supply and conditions needs to be increased. Recent research commissioned by Shelter[29] illustrates that in England there is a shortfall of 55,000 in the number of social sector houses being built when compared to need. An investment of £4 billion is needed to close this gap. There is also a need for a more ambitious target for addressing housing conditions in the private sector.

We are pleased to see that Government has made a commitment to change the overcrowding standard. We also consider that measures should be put in place to ensure that minimum physical standards apply across all housing tenures. This should include all forms of temporary accommodation. In our response to the Government's recent consultation on this issue,[30] Shelter supported the Government's proposal to issue statutory guidance to ensure that existing minimum standards are met for all temporary accommodation and that additional measures are set for B&B accommodation. Shelter hopes to see this measure supported by Government.

The Housing Bill proposes to replace the existing Housing Fitness Standard with a Housing Health and Safety Rating System (HHSRS). Shelter is broadly in support of this, as it includes a wider range of hazards to residents' health and safety than was previously the case and because it introduces a mandatory duty on local authorities to ensure that local authorities to take enforcement action in respect of serious hazards. The Housing Bill also proposes to introduce licensing of Houses in Multiple Occupation (HMOs), as a means of addressing the higher risks posed to the health and safety of tenants in this type of accommodation due to higher levels of occupancy and the sharing of common areas and facilities.[31] Whilst we consider these begin to address underlying problems, Shelter believes they need to be expanded if they are to produce real health benefits for poorly housed people. In relation to HHSRS, we would like to see stronger guidance issued to local authorities to ensure that unhealthy and hazardous housing is tackled in a strategic way. In our response to the Bill, we recommend that local authorities formulate 'healthy housing' strategies for their local area and conduct regular district-wide surveys of all sectors of housing to inform this. We would also think it is essential that the current proposal in relation to HMOs is expanded to cover smaller properties and those with fewer occupants. At present, these are not covered – meaning that thousands of tenants remain vulnerable in potentially hazardous properties.

To back up these proposals, we would like to see a new performance indicators or targets added to the existing measures in the 'Housing and Environment' section of the Health Inequalities Programme for Action. This could include an indication of the percentage of accommodation meeting minimum standards in a local authority area.

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[29] Holmans, A, Monk, S and Whitehead, C (March 2004), *Building for the Future – A Report pf Shelter's Housing Investment Project*, London: Shelter

[30] ODPM (August 2003), Improving Standards of Accommodation for Homeless Households Placed in Temporary Accommodation

[31] Of the total of 1.1M HMOs, 118,000 (10.1%) are unfit under Sections 604 0r 352 of the Housing Act 1985. Source: English House Condition Survey 2001

Question 9: Helping people deal with the stresses of life

There is a large body of evidence linking poor mental health and homelessness. Becoming homeless brings a range of disruptions to people's lives. Being placed in temporary accommodation, for example, is insecure - often involving several enforced moves for administrative reasons, such as leases with private landlords expiring, before permanent housing is allocated. People are spending increasingly long periods of time in temporary accommodation, with more people being placed in accommodation that is out of their local area.[32] This means dislocation from networks and social support. Many of the respondents in *Living in Limbo* survey had also been placed in accommodation that was a long way from shops and schools and in high crime and high drug user areas. There are particular pressures for families, involving difficulties of maintaining school places, attendance and academic attainment.

***Living in Limbo* respondents:**

- Half stated they were suffering from depression
- Two thirds said that their children had problems at school and half described their children as being 'often unhappy or depressed'
- Forty four per cent were experiencing feelings of social isolation.

Homelessness compounds existing mental health problems and places people at higher risk of the onset of new ones. As well as the huge impacts on feelings of security and stability, homelessness can severely compromise people's ability to maintain relationships and perform tasks such as finding work.[33] The emotional and mental health effects on families with children, in particular can last long after the homelessness has ended.[34] Recent Government research into support for homeless people states the need for people's support needs to be addressed via a comprehensive assessment process and support plans and to be delivered through multi-disciplinary teams.[35] The evaluation of the Rough Sleepers Initiative (2002) also pointed out the value of having specialist workers – such as those dealing with mental health problems – within multi-disciplinary teams, because this enables more tailored support to be given to individual homeless people. At present, however, local authority practice in this area is very variable and many do not have adequate support services for homeless people'.[36]

In our response to the Government's consultation on temporary accommodation, Shelter argued that specific provision should be made in the Draft Order to ensure that the provision of appropriate support is a factor taken into account by local authorities in determining whether or not accommodation is suitable for a person. We are pleased to

[32] For example, in London, half of all households in bed and breakfast accommodation and 15% of all homeless households in other temporary accommodation were housed outside their home borough in March 2003 – figure supplied by GLA.

[33] Crisis (2003), *Mental Health and Social Exclusion*

[34] CPHVA, 2000

[35] Randall (2003), *The Support Needs of Homeless Households*, London: ODPM

[36] Randall (2003), *The Support Needs of Homeless Households,* London: ODPM

see this recommendation accepted by Government. However, we also consider that the effectiveness of the Order also depends on Guidance given to local authorities. We would therefore like to see accompanying guidance covering practice with regard to assessments, placements and provision of services.

Homeless to home – benefits

Shelter's Homeless to Home services are an example of a successful support service for homeless people. Homeless to Home has been working since 1998 to provide resettlement support to homeless families, with the aim of helping them to sustain their accommodation and become established within the local neighbourhood. Homeless to Home teams now operate in 4 areas: Bristol, Birmingham, Sheffield and Nottingham.

Apart from enabling people to sustain their tenancies, Homeless to Home workers have provided support that has helped service users to improve their physical and mental health needs. This support has included, helping users to access GP and other medical services; providing emotional support; dealing with quality of life issues, such as increasing social and community participation.

Because many people living in temporary accommodation have high levels of social, support and health care needs, Shelter believes that resources need to be made available to meet these needs. We consider that an innovation fund should be set up to provide support services for all homeless people - to enable them to cope with staying in temporary accommodation and to link into services to meet their health and social care needs. This should be partly funded by the Homelessness and Housing Support Directorate (and eventually be absorbed into the Supporting People programme). However, as there are clear physical and mental health benefits to be had, we also consider that DH should consider contributing funding to any such initiatives.

Supported temporary accommodation

Leicester Family Support Service is temporary accommodation used by Leicester City Council. The Housing Department employs a Family Support Team and a Children's Team to support families in temporary accommodation. The service is linked to a local Children and Adolescent Mental Health Services (CAMHS) working with young people who are vulnerable and difficult to engage with. The CAMHS team provides supervision support and training to the Family Support Team. They are also able to refer any children on to other services. The CAMHS team provides supervision support and a club has also been opened on the hostel site with play equipment, an after school club and classes and courses for parents. The courses cover a range of subjects, including English as a Second Language, confidence building, computing skills and cooking.

Shelter believes that this model of support can help people maintain their social roles and make the transition in and out of homelessness much less damaging than would otherwise be the case. We therefore consider that DH should make funding available for similar projects. This could be achieved within its plans to establish a comprehensive child and adolescent mental health service in all areas by 2006 and through Positive Futures schemes.

Question 11: The evidence base

Shelter believes that the health inequalities agenda is bringing some positive benefits in developing the evidence base in relation to housing and homelessness. The model of health inequalities now utilised by the Health Development Agency recognises health inequality as being multi-layered and relating to socio-economic environment, but also their lifestyle and access to effective health and social care. Evidence from *Living in Limbo* survey demonstrates the importance of all three of these elements – housing conditions, lack of social networks and lack of appropriate support - in determining health outcomes for homeless people.

We also welcome the introduction of Health Equity Audits as a requirement in the NHS Planning and Priorities Framework. We believe they offer a means of addressing health inequalities more systematically at a local level and for resources to be more appropriately allocated in response to need. Their introduction should also provide a means of analysing where there are remaining problems in access to services and where gaps in services exist.

Whilst we believe the current focus on the health needs of particular groups, such as geography and ethnicity, will bring more detailed knowledge of how different factors impact on health inequalities, we do not consider that this will be sufficient to accurately determine the needs of homeless people and ensure that they get access to the services they need. Homelessness is a cross-cutting issue and as such, it is easy for the needs of homeless people to lose its focus. Shelter believes that the most effective means of understanding the needs of homeless people is to consider them as a distinct population group. Establishing this would also enable further research and analysis could then be carried out to fill in gaps in knowledge about the needs of sub groups of the homeless population and about how best to deliver health care to them. At present, for example, there is a lack of research of the needs of homeless families[37] and gaps in understanding about what would be the most effective responses in terms reducing health inequalities for them.[38] There are similar gaps in knowledge about BME groups.

Work has already been carried out to estimate the financial impact of some housing conditions on health. In some cases, it is possible to estimate national figures for these issues. The cost of domestic accidents, for example - due to dangerous heating appliances, faulty wiring and smoke alarms - has been estimated as £300M per annum. Studies have also demonstrated benefits of improving housing in terms of changing patterns of use of health and social care services. Use of services has been demonstrated to significantly differ between people living in cold and damp housing and people living in improved housing conditions. In this case, health and social care costs were reduced by £450 per person p. a.[39] At a national level, this indicates a cost to the NHS due to damp housing of up to £600M p a.[40] Shelter has also estimated the increased costs of homelessness and bad housing in terms of the take up of welfare benefits. This analysis compared the needs of currently homeless people with those of formerly homeless

[37] ODPM (2003), *The Support Needs of Homeless Households*

[38] Gorton, 2003

[39] Ambrose (2002), study of new and improved housing under Central Stepney SRB programme. Actual costs: £72 for improved; £512 for cold and damp housing.

[40] Based on a figure of 10% of houses in the UK with damp

households now living in social housing. Shelter estimates the following extra costs could be incurred annually due to the use of temporary accommodation:

- Approximately £30M on additional take up of sickness benefits (incapacity benefit)
- Around £10M on additional visits to the GP due to worse health. [41]

Shelter believes that this kind of analysis is valuable in highlighting areas where investing in housing and services can produce benefits for individuals and government departments. However, at present research of this type has only been carried out on a small scale. We therefore believe there is a case for more large-scale and longer-term research on how housing conditions impact on health inequalities. This would complement the findings of existing studies and provide a stronger evidence base for decisions about investment priorities. In addition to assessing housing conditions, however, we also believe there is also a need to evaluate how broader inequalities, such as income and welfare gaps, impact on health inequalities.

If homelessness and health services are to work together more effectively, it is vital that they are able to demonstrate the impact of their joint work. Evidence gathered during Homelessness Act and Supporting People reviews now means that the evidence base on local homeless populations and their needs is much more comprehensive than previously. However, there is also recognition from Government that at present, data collection systems are inadequate to enable organisations to measure performance and outcomes against any shared outcomes measurements they may wish to develop. We agree that it will be necessary in many cases for new systems to be developed and suggest that this piece of work is given priority within DH.

Finally, we would also like to recommend that more data on performance of services be collected from service users themselves. This could enable assessment of specific initiatives and also how services could be better delivered in future.

[41] Based on estimate of 1/12 households out of work due to health problems caused through living in temporary accommodation; an estimate that a quarter of ill households are in health due to living in temporary accommodation.