

Evaluating Westminster's Health and Overcrowding Programme

Final Report of the Overcrowding and Health Inequality Task Group



January 2011

Reporting to the Society, Families and Adult Services Policy and Scrutiny Committee



City of Westminster

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Report compiled by Simon Lewis, Scrutiny Research Analyst. For more information please contact slewis2@westminster.gov.uk.

Lead Member's Introduction



Sheila D'Souza

**Cllr Sheila D'Souza
Lead Member for
the Overcrowding
and Health Inequality
Task Group**

Overcrowding is a significant issue. The 2008 Survey of English Housing estimates that around 207,000 households in London are overcrowded and reports that its prevalence is on the increase. In Westminster, the combination of high housing demand, limited supply and a high transient population means the problem is not only heightened but finding effective solutions is all the more challenging.

Within the borough, tackling overcrowding has been highlighted as a major priority. The joint council/PCT strategy on tackling health inequalities gives it specific attention and the council has pledged to re-house 1000 overcrowded households by 2013/14. However, overcrowding is not necessarily something that easily goes away and given its strong links with poor health – stress and anxiety, increased spread of infectious diseases, and mental health disorders – it is not always satisfactory to simply wait to be re-housed.

For this reason, NHS Westminster and the council have been running the Health and Overcrowding Programme to assist overcrowded households whilst they wait to be re-housed, typically by signposting to appropriate services, supporting the educational attainment of children, and providing space saving solutions.

Along with my colleague Dr Cyril Nemeth, this Task Group set out to evaluate the effectiveness of this work. A summary of our recommendations can be found on page 5 and our key findings are set out from page 17.

I would like to take this opportunity to express the Task Group's thanks to Gez Kellaghan (Strategic Partnerships Officer (Housing), Westminster City Council) for her excellent work in ensuring the investigation had access to the right information, and to Gill Matthews (Housing Needs Officer, Westminster City Council) for her valuable input into the sessions. Mention should also go to Dr Helen Waters (Director of Public Health, NHS Westminster and Westminster City Council) and Anna Waterman (Strategic Lead Health Inequalities, NHS Westminster) who have been proactively responding to the Task Group's findings, and in so doing, increasing the impact of the programme.

This investigation has shown that there is valuable work going on but that in today's financial climate it is vital for the worth of that work to be clearly evidenced. The future is uncertain and we must ensure that what we are doing is adequately monitored and evaluated so that when tough choices have to be made, we make the right ones.

Summary of Recommendations

1. That work continues to develop an integrated approach with partners and that thought be given to how the effectiveness of these links can be evaluated and monitored. For example, by moving beyond simply measuring the number of referrals.
2. That a mechanism be put in place to record the time taken for repairs to be carried out once a problem has been reported. Additionally that reducing the time between reporting a problem and carrying out the works is made a priority.
3. That thought be given to how best caseworkers can report and record instances where barriers are encountered. This may be in terms of households inadvertently worsening their own situation or linkages with partner organisations.
4. That particular effort be taken in making households fully aware of the negative effects associated with overcrowding, so they are mindful of these when considering offers of larger accommodation.
5. That emphasis is placed on evaluating the health impacts of the project particularly through progress measured in the four month health plan. Additionally that an appropriate system be put in place to ensure households with high health needs are referred to and picked up by the health practitioner.
6. That consideration is given to having caseworkers do a follow-up survey to assess impacts on health and/or households be surveyed once they have been re-housed to gauge whether their health has improved.
7. That consideration is given to developing a cost-avoidance model to demonstrate the impact of the project. One potential area to explore is whether interventions reduce the number of hospital admissions and GP visits.
8. Ideally that an evaluation of the project be published after the end of the financial year 2010/11.
9. That consideration is given to how the Health and Overcrowding Project may form part of the council's increased role as the local leader on promoting public health.
10. That the potential for volunteers to contribute to the project by carrying out visits and assessments (particularly if funding is not available) be investigated.

1. Introduction

Overcrowding is a particularly acute problem in Westminster, due to a high demand for housing, a significant transient population, limited supply and a mismatch between housing stock and demand. Figures show that as of 1st April 2010 there were 1,335 overcrowded households on Westminster City Council's waiting list and an additional 470 on Registered Social Landlord (RSL) lists.

Tackling overcrowding is a key priority in the "Westminster Tackling Health Inequalities Strategy" with the City Council pledging to re-house 1000 overcrowded households between 2009/10 and 2013/14. The Westminster Local Area Agreement 2008 – 2011 reflects the importance given to tackling overcrowding with the inclusion of two targets, one based on increasing the supply of affordable units and the other measuring the number of interventions to overcrowded households.

Research has shown that poor housing can have significant direct and indirect adverse physical and mental effects on both adults and children, and is a contributing factor to health inequalities. Children's education, for example, may be affected directly, through lack of space for homework, as well as indirectly because of school absences due to illness, which may be related to overcrowding. The effects of overcrowding can also be underestimated, especially in inner London where the conditions are concentrated by densely developed areas, more families living in flats, less garden space and shared public play space.

Specifically overcrowding has been shown to have strong links with poor health such as:

- Spread of infectious diseases
- Respiratory conditions in children
- Common mental health disorders
- Accidents around the home
- Tuberculosis for adults

Shelter's publication, 'Full House? How Overcrowding Affects Families' (2009), also highlights clear links between overcrowding and:

- Stress, tension, and sometimes family break-up
- Anxiety and depression
- A lack of privacy, particularly for adolescents
- Disrupted sleep patterns

As part of the pledges to strengthen partnership approaches and address the wider determinants of health inequalities set out in the Tackling Health Inequalities Strategy a bid under the Local Area Agreement was agreed to fund a joint Health and Overcrowding Project to tackle the health inequalities of people living in overcrowded conditions across the borough.

2. Research Approach and Scope of the Investigation

As part of a Centre for Public Scrutiny (CfPS) facilitated project, Westminster has been participating with six other North West London boroughs in a Scrutiny Development Area looking at the links between housing and health inequality.

The programme of Scrutiny Development Areas forms part of CfPS's Health Inequalities Scrutiny Programme, a two-year programme to raise the profile of scrutiny as a tool to promote community well-being and help councils and their partners in addressing health inequalities within their local communities. It is commissioned by the Healthy Communities Team at the Improvement and Development Agency as part of meeting the increasing need to strengthen the role of local government in reducing health inequalities.

Within the Scrutiny Development Area each borough chose to focus on a particular issue associated with housing and health inequality. Westminster's investigation aimed to address an identified need to assess the impact of interventions to mitigate the negative effects of overcrowding – work that fell under the Local Area Agreement-funded Health and Overcrowding Project. As part of this project an overcrowding casework team – consisting of three caseworkers – has been visiting overcrowded families to discuss the potential impacts on their health, manage their expectations in terms of re-housing, make assessments for space saving solutions and sign-post to wider health improvement services. Other services such as homework clubs have also been developed.

The caseworker service is currently monitored through a number of targets (such as number of visits made and referrals to other services) and through a quarterly project steering group meeting in which each caseworker presents two qualitative case studies. Although Local Area Agreement funding for the project is due to cease in April 2011, it was felt that a thorough examination of the work would help develop a more rigorous evaluation process which in turn would assist in identifying future priorities.

2. Research Approach and Scope of the Investigation (continued)

The North West London Scrutiny Steering Group, consisting of officers from the six boroughs, was responsible for developing the project brief in consultation with respective scrutiny chairmen. This culminated in an official launch on 9th July 2010 and the work was subsequently taken forward in Westminster by the Overcrowding and Health Inequality Task Group consisting of Councillors Sheila D'Souza and Cyril Nemeth. This group reported to the Society, Families and Adult Services Policy and Scrutiny Committee chaired by Councillor Sarah Richardson.

During September and October 2010 the Task Group organised and attended the following sessions to gather evidence:

- Meetings with representatives from Housing and Housing Needs;
- Site visit to view properties that had been modified to house larger families and discussion with prospective tenants regarding their views about moving into the properties;
- Accompanied an overcrowding caseworker in carrying out their work and talking to tenants;
- Guided visit with environmental health to properties being renovated to bring them up to standard;
- Attended a quarterly performance monitoring meeting of the Health and Overcrowding Project Steering Group where quarterly targets and case studies were presented by caseworkers.

These sessions informed the findings of the investigation which are outlined in section six.

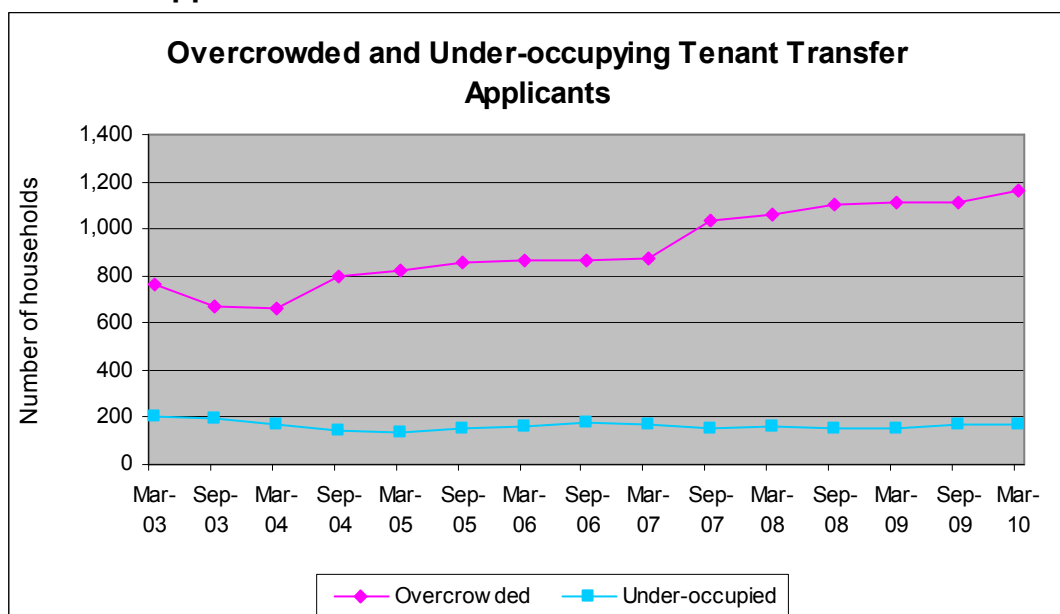
3. The Nature of the Challenge in Westminster

Overcrowding is the general term used to describe people or families living in housing that has inadequate space or rooms for the number of people living there. There are a number of different definitions and standards used to describe and measure overcrowding, which cause difficulties in defining the scale of the problem at any one time, assessing trends over time, and comparing levels between local authorities.

With a variety of data sources and definitions, the data most frequently used is the 2001 census, which is now somewhat dated. The census also uses a definition that is different to the more commonly used bedroom standard. The Mayor's "Tackling Overcrowding Action Plan" (Tackling Overcrowding Action Plan 2010, GLA) does however use more recent data for London some of which is quoted below.

The Survey of English Housing (2008) shows that there are approximately 207,000 overcrowded households in London – 6.8% of all households (Survey of English Housing, CLG, 2008:24). In London, levels of overcrowding have increased whereas for the rest of England it has remained relatively constant. Similarly in Westminster overcrowding in council housing has increased over time with levels of under occupancy remaining constant as shown in figure 1 below. However, both sets of figures need to be treated with care as there may be some under reporting particularly for under occupiers who will only feature in this data if they have approached the council for a transfer.

Figure 1. Westminster Overcrowded and Under-occupying Tenant Transfer Applicants



3. The Nature of the Challenge in Westminster (continued)

Westminster City Council and RSLs submit data on overcrowded households to the Department of Communities and Local Government (CLG) on a quarterly basis. This data is taken from transfer lists (of tenants registering a wish to move) held by the council and RSLs (CWH & RSLs hold tenant transfer lists recording those tenants who apply for social housing and who are overcrowded. This does not include tenants who may be overcrowded and have not applied to be rehoused or those living in temporary accommodation that may be overcrowded). Table 1 below shows that there were 1,805 overcrowded households across social housing in March 2010. The largest numbers of overcrowded households (813) were living in a 1-bed property followed closely by 772 households living in a 2-bed property.

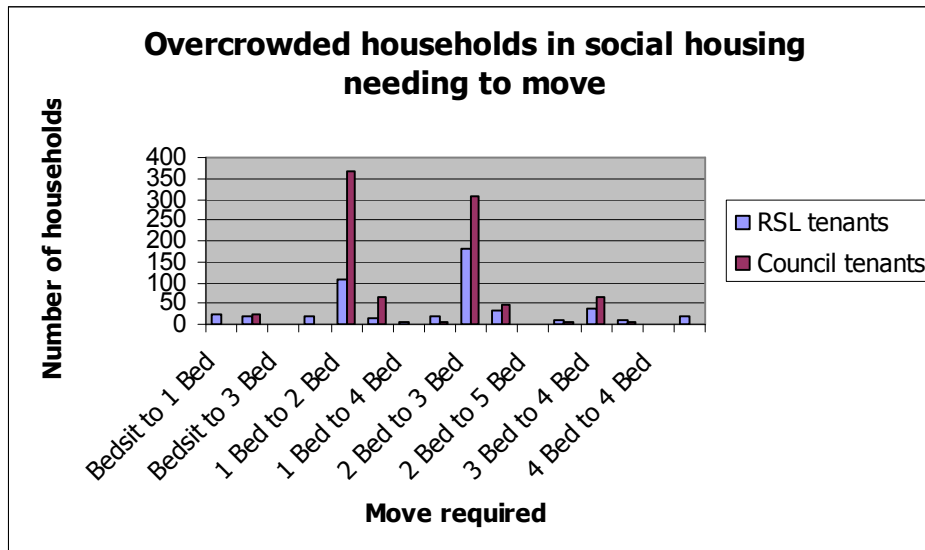
Table 1: Overcrowded households from all tenures on both LA and RSL waiting lists.

Overcrowded households on WCC and RSL waiting lists wanting to be re-housed as on 01/04/10			WCC waiting list	RSL waiting list(s)	Total as at 01/04/10
No. of households recorded as overcrowded by the Bedroom Standard		Total	1,335	470	1,805
Of these households how many are currently living in each size of accommodation?	1 bed	total overcrowded	644	169	813
		of whom severely o/crowded	86	20	106
	2 bed	total overcrowded	521	251	772
		of whom severely o/crowded	48	28	76
	3 bed	total overcrowded	145	64	209
		of whom severely o/crowded	25	14	39
	4+ bed	total overcrowded	25	3	28
		of whom severely o/crowded	4	1	5

An analysis of WCC and RSL tenant transfer lists also shows that most of the demand for properties is from overcrowded households needing to move from one bedroom into two-bedroom accommodation, and from two bedrooms into three – see Figure 2 below. This is significant in the sense that requirements for housing are not just for larger family size homes but also for two and three bedroom properties.

3. The Nature of the Challenge in Westminster (continued)

Figure 2: Overcrowded households needing to move



Source: WCC Tenant transfer list (September 2009) and RSL Performance questionnaire (September 2009).

People living in overcrowded households often have to wait many years to be re-housed due to the shortage of family sized accommodation in Westminster. In 2008/09, the average waiting time for overcrowded households on the Councils tenant transfer list waiting to be re-housed was 2.8 years, however those waiting for 3 and 4 bedroom properties waited on average between four and five years. See table 2 below for more information.

Table 2: Waiting times for overcrowded households
(from registration to rehousing)

Bedroom	RSL	WCC
Studio	1.5 years	1.6 years
1 bedroom	1.8 years	2.0 years
2 bedroom	3.4 years	4.3 years
3 bedroom	4.1 years	5.5 years
4 bedroom	4.1 years	4.5 years
5+ bedroom	4.4 years	1.7 years
Average	2.8 years	

Source: WCC tenant transfer list 01/04/10

Overcrowding is concentrated in the north west and pockets in the south of the City. The most severe overcrowding is in the Westbourne, Queens Park, Church Street, Harrow Road, and Churchill wards, where there are high levels of social housing. Overcrowding in these five wards account for over half of the overcrowding in Westminster. Westbourne Ward has the highest level of overcrowding with 200 households (16%), followed by Queens Park with 187 households (15.1%), and Church Street with 169 households (13.6%).

4. Westminster's Health and Overcrowding Programme

The Health and Overcrowding Project is supported by three key documents which outline the supporting evidence and working procedures for the project:

- **Overcrowding in Westminster: Joint Strategic Needs Assessment 2010;**
 - **Health and Overcrowding Toolkit: NHS Westminster and Westminster City Council 2010;**
 - **Overcrowding and Health: Mental Well-being Impact Assessment (MWIA), July 2010.**
-

The Project officially started on 10th May 2010 following the recruitment of three caseworkers to conduct visits. This built upon the previous recruitment of an overcrowding officer from April 2009 who visited overcrowded households on the council's tenant transfer list. Unfortunately due to the loss of one of those staff and cutbacks in funding the team was not operating at full capacity again until late September. The cost of the caseworkers is £42k each per annum with two caseworkers being funded through the PCT's contribution to the Local Area Agreement (LAA) and the other funded through the Department for Communities and Local Government (DCLG). Current funding for the project will allow caseworkers to be in post until 31st March 2011.

The purpose of the project is to provide a coordinated and holistic approach to address the range of issues people living in overcrowded conditions suffer from. Underpinning this approach is active case management, providing tailored interventions packaged according to household needs. These are developed in conjunction with the households by the three caseworkers. The project is therefore underpinned by three main aims:

- To mitigate the impacts of overcrowding on health and wellbeing;
- To support educational attainment of children in overcrowded households;
- To raise awareness among those waiting to be re-housed of the limitations of housing stock in Westminster and the range of housing options available.

The caseworkers visit overcrowded households to provide assistance whilst they wait to be re-housed through:

- Providing support to overcrowded households with space saving solutions and minor adaptations to houses;
- Assessing the home for repair, hazards, and other poor housing conditions and referring to appropriate service providers for action;
- Making referrals to mainstream health and social care services;
- Going through a health status checklist to identify and address existing health issues, signposting to other health and social care services as appropriate;
- Improving knowledge and uptake of the range of local support services through signposting, referrals and support;
- Connecting families with the range of support services available to improve and promote educational support such as homework clubs.

4. Westminster's Health and Overcrowding Programme (continued)

One particular service that the caseworker team provide is space saving solutions. In consultation with households, officers are able to offer practical support with furniture and storage solutions such as the provision of bunk beds, shelving and fold away tables. The current budget for Space Saving Solutions is £40k for 2010/11 funded through the PCT's contribution to the Local Area Agreement.

Importantly, in addition to the three caseworkers, it was initially planned to have two health practitioners who would visit households upon referral by the casework team. The duties of the health practitioners were to include:

- Discussing the potential impacts of overcrowding to clients' health and wellbeing;
- Undertaking health checks/healthy lifestyle assessments;
- Discussing their health needs and developing health goals to form part of a plan to be followed up within four months;
- Sign-post to wider health improvement services such as smoking cessation.

Unfortunately, funding was not found for this additional element to mitigate health inequalities. At the time of reporting, NHS Westminster had commissioned Central London Community Healthcare to provide a health visitor to pick up referrals from the caseworker.

The Current Monitoring Process

The Health and Overcrowding Project is currently monitored through a mix of quantitative targets and qualitative case studies. These are summarised in a monitoring report which is provided on a quarterly basis to the Project Steering Group which includes representatives from NHS Westminster, Central London Community Healthcare, CityWest Homes, RSLs and council officers from housing, housing options and residential environmental health.

1. Quantitative Monitoring

Quantitative information is collected on the number of visits and outputs such as referrals into other services such as Sure Start, after school clubs, sports and leisure services and other support services. The table on the following page illustrates the data collected.

4. Westminster's Health and Overcrowding Programme (continued)

The following table shows the quantitative data for the first and second quarters ending on 30 June and 30 September 2010.

No of visits (total)	1st	2nd	Total
• City West Homes properties	50	78	128
• RSL	0	4	4
No of households that have had changes to their points as a result of visits.	6	5	11
No of furniture space saving solutions provided	27	32	59
No of bespoke (i.e. shelving) space saving solutions provided	14	6	20
No of households referred for alterations	5	3	8
No of households referred for repairs and potential hazards	20	33	53
No of referrals into other services (total)			
• Children's Centres	8	5	13
• After school clubs (extended services)	11	16	27
• Sports / leisure	30	40	70
• Cultural activities	8	9	17
• Employment / training	5	14	19
• Health services	11	17	28
• Other	7	14	21
No of referrals to health nurse	N/A	N/A	N/A
No of households taking up alternative housing solutions	20	65	85

2. Qualitative Monitoring

In addition to the quantitative figures, qualitative information is collected in the form of caseworker reported case studies. Each caseworker currently produces two case studies per quarter (totalling six per quarter for the whole team) to promote good practice, assess the impact of the interventions, evaluate the sustainability of lifestyle changes made by the overcrowded households.

5. Good Practice Examples

In December 2007 the Department of Communities and Local Government published an Overcrowding Action Plan and invested resources in five local authority pilot schemes in London over a three-year period. Whilst most of these projects focused on schemes to move overcrowded households into more appropriate accommodation, the Camden Council pathfinder's main priority was the mitigation of negative health impacts that may result from living in overcrowded conditions.

The pilot project was developed in recognition of the worth of interventions to improve the well-being of overcrowded households as a valuable response for households who do not want to move to a different area and/or whose prospects of re-housing in the short or medium term are poor. Camden's approach has been considered good practice internationally and is based on the following principles:

- It is designed to deliver multiple benefits, not to relieve overcrowding in isolation. The process of engaging with tenants to identify improvements that could be made to their homes is managed so as to challenge the perception that mitigation – whether by re-housing or other means – is the sole responsibility of the local authority. It also aims to highlight the educational, health and emotional impacts of overcrowding and develop responses in partnership with other authority services.
- Underpinning the approach is active case management, providing tailored interventions packaged according to a household's needs. Interventions can include physical improvements in the house, help with life skills improvement and family support.

Since the start of the pilot 585 overcrowded tenant households have engaged with the team; 198 families are actively considering or have pursued alternative housing options as a means of resolving their overcrowding; 146 homes have been identified for property improvements; and 57 families have engaged with education, training or employment, or other wellbeing services. The Department of Communities and Local Government's summary report of the lessons learnt from five pilot schemes in London can be found on the Department's website. The Overcrowding and Health Mental Well-being Impact Assessment (Abrams et al., 2010:19) summarises the position by stating that, "although the full evaluation of the pilot is not complete, and there is no evidence specifically of the impact on the wellbeing of the residents supported by the scheme, the pilot in Camden has revealed a significant demand amongst tenants for positive, personal interventions by multi-skilled advisors to help resolve housing and work/life problems".

5. Good Practice Examples (continued)

Similar work has been undertaken in New Zealand where a Healthy Housing programme has focused on reducing the risk and rates of housing-related diseases, conditions and injuries and improving wellbeing for tenants, particularly children. Importantly in this project, in addition to design alterations, housing staff and a public health nurse meet with participating tenants to identify housing and health issues and then a clinician reviews the information and ensures they can access healthcare for any health problems. The outcomes evaluation conducted in 2006 showed that tenants identified positive changes in family life, participation in community activities and improved health and wellbeing. This was partly evidenced through a reduction in hospitalisations, with acute housing-related hospital admission rates falling by 37% in areas of South Auckland with the worst pockets of overcrowding.

These examples of good practice are important in highlighting the importance of Westminster's Health and Overcrowding Project. However, there is still a relatively limited amount of literature assessing the impacts of initiatives to improve health in overcrowded households. For this reason, it is all the more crucial that a systematic approach is used to collect reliable evidence on the impact of Westminster's project.

6. Key Findings

6.1 The role of caseworkers

It was notable from the site visits and case studies that caseworkers were greatly valued by the families they visited. Once initial scepticism of the involvement of the council was overcome and the purpose of the visit realised, tenants tended to engage proactively. On this point, the capability of caseworkers to build empathy with tenants in order to better provide the service should be duly commended. Furthermore, the capacity within the caseworker role to allow such engagement is important in distinguishing the service from others that households might be less willing to cooperate with.

Early results from the analysis of the project would appear to mirror those from the pilot scheme in Camden. Whilst it is difficult to demonstrate the impact on a household's wellbeing, there seems to be a significant demand for positive, personal interventions by skilled advisors to help resolve housing and work/life problems.

A core element of the project has been the adoption of a holistic approach to address a range of issues and provide interventions tailored according to each household's needs. This has required significant partnership working, which is reflected by the diverse membership of the Project Steering Group, and this investigation found this integrated approach to be of particular benefit to the households involved. Indeed, the workshops conducted as part of the Mental Well-being Impact Assessment (2010) highlighted similar themes such as the requirement for childcare provision and the importance of relationships with agencies that provide complementary services. However, it also found no literature which looked at the barriers to the successes of interventions. One issue that was picked up by this investigation was the need for repairs to be carried out quickly once they had been acknowledged and reported.

Subsequent analysis of evidence from caseworkers has shown that the development of a holistic approach has been supported by the way caseworkers have been allocated particular neighbourhoods, allowing them to develop strong relationships with other organisations working in the area and build up in-depth knowledge about the services and activities available in the locality of the household. What is clear is that the success of the project lies in its links with a number of partners and agencies, which in turn facilitates the provision of a holistic and integrated service. In order to further improve the service it is important that these relationships continue to develop and that there are clear connections between the caseworkers and council and partner provided services in order to promote proactive signposting. To monitor this it would be worth considering moving beyond simply measuring the number of referrals to other services. Other measures could include how easy tenants find it to access those services, how many actually take up services after being referred and what benefit they derive from those services. The value of high calibre caseworkers that are trained to gather and analyse the data should also be stressed.

6. Key Findings (continued)

Whilst the work of caseworkers clearly has an impact and is generally valued by households it is important to stress that ultimately individual tenants and households have the biggest impact on their health through their own personal choices. In many cases examples can be identified where space saving solutions and good advice have been provided by caseworkers, but personal practices and decisions (such as apathy to taking up referrals or purchasing inappropriate furniture) have acted to lessen or negate the impact of that intervention. Therefore the success of interventions and the project more generally is at least partly affected by the ability of households to change and recognise how their actions impact upon their living conditions.

6.2 The priority given to overcrowding by tenants

When visiting properties that had been made available to families living in overcrowded conditions and after discussions with prospective tenants, Members were struck by the reasons given for declining offers of larger accommodation. In some cases, issues such as access via stairs and the distance from schools were raised but in others less rational reasons such as the desire to hear street noise and a sense of belonging in cramped dwellings were cited.

What was apparent from the findings of the review was that overcrowded families often have different priorities to those of the council and NHS. Simply put, cramped conditions and associated health issues were not always the top priorities for those households experiencing them. The number of offers of larger accommodation that had been turned down by overcrowded families was evidence of this. In a similar vein to the previous section, which stressed that the work of the caseworkers cannot necessarily guard against the negative impact that tenants may have on their own circumstances through their personal choices, households may simply not prioritise their own living conditions above other factors. These can include preference for a specific neighbourhood, a sense of “home” in a dwelling even if it is too small, proximity to friends, families and amenities, and other more specific considerations such as the right to buy the accommodation being offered.

In these cases there is an identifiable role to be played by the caseworker in making tenants fully aware of the potential negative impacts of living in overcrowded conditions. Indeed, it is important that families know about the health implications associated with being overcrowded. Whilst caseworkers already highlight such issues, it does not guarantee that households will prioritise overcrowding and it is clear that this is an area which requires further attention.

6. Key Findings (continued)

6.3 The importance of ensuring health issues are addressed

The project was initially to be supported by an additional two health practitioners that would provide specific support on health issues. However, a lack of funding meant they were not put in post at the start of the project and only now is a health outreach worker being assigned thanks to Central London Community Healthcare NHS Trust.

The health and overcrowding toolkit developed to support the project had proposed the following outputs to be measured by the health practitioners:

- No of health checks undertaken, including:
 - ⇒ No of new patient registrations at GP practices
 - ⇒ No of new patient registrations at Dental practices
 - ⇒ No of patients requiring input related to long term conditions
 - ⇒ No of patients with poor mental wellbeing
 - ⇒ No of patients with respiratory difficulties
 - ⇒ Referrals to the Stop Smoking Team
 - ⇒ Referrals to the Expert Patient Programme
 - ⇒ Referrals to the Health Trainer Programme
- No of health plans developed
- No of people with improved health after 4 month health plan
- Feedback from client satisfaction survey

However, this data has not been collected as there have been no employees in the health visitor posts. As such the project has been lacking the capacity to focus on improving the health of overcrowding households and in turn there exists an information gap surrounding the effects of interventions (including those of the caseworkers) on health. There is evidence that in some cases, such as through the Paddington Development Trust, health outreach workers have been working with the health and overcrowding caseworkers either by conducting joint visits or taking referrals to follow up. Whilst such practice is to be encouraged, the lack of dedicated health visitors in post in the first two quarters of the programme has prevented the systematic evaluation of its impact.

Given the prominence given to the health of overcrowded households in the joint council/PCT strategy for tackling health inequalities, Members were disappointed that such an important part of the project had not been implemented from the start. The success of the project was reliant on effective integrated interventions and this was only just starting to be achieved through the recruitment of a health visitor.

Now that a health practitioner is in place it will be important to track and monitor progress according to the outputs listed above. The conducting of a four month follow up to gauge impacts and developments will be particularly vital in evaluating the effectiveness of the interventions. With a limited resource (one health worker rather than two) there will need to be an appropriate mechanism in place for allocating visits. In most likelihood, the greater capacity in the casework team may mean that an initial assessment is conducted by a caseworker and those identified as most in need of health services and advice are followed up with a dedicated health visit.

6. Key Findings (continued)

6.4 The need for rigorous evaluation

The best evidence to date of beneficial impacts from the project derives from the anecdotal feedback received from the tenants and quarterly case studies reported by the caseworkers. The personal interest caseworkers took in these families' circumstances and the interventions they offered (such as space saving solutions, repairs and alterations, managing tenant expectations of being re-housed and referrals to health and other services) may well have had beneficial impact on tenants' physical and mental wellbeing. However, as in the Camden pilot, it is extremely difficult to quantify this from the output data available.

The original toolkit included a mechanism for evaluating health benefits from the number of health action plans developed by the health practitioners and the follow up assessments of the health goals attained after four months. Together with the feedback received from satisfaction surveys, this could still be a useful tool to illustrate health improvement or decline.

Another option would be follow-up surveys by the caseworkers, to ascertain how many of their recommendations and referrals to ancillary services had actually been taken up by the tenants and what difference those had made to the tenant's health and wellbeing. Alternatively, caseworkers might follow-up with households after they are re-housed to assess the effect on health of moving to larger dwellings. It should, however, be taken into consideration that such longitudinal approaches to assessing impact would potentially divert caseworker capacity from outreach to additional families.

Yet another possibility would be to develop a cost avoidance model on a similar basis to that used for Westminster's Family Recovery Project, which invests in targeted interventions in problem families in order to save money by avoiding the larger costs to society, such as crime and child protection. To what degree this is taken forward by the Health and Overcrowding Project will depend on how long it is expected to run, but it would undoubtedly be a useful evaluation tool in assessing the financial cost and benefits of the interventions. The good practice in New Zealand mentioned previously, measured a significant reduction in hospital admissions and it would be possible for caseworkers or health visitors to record the number of hospitalisations in households prior to and after intervention. Allocating an average cost for hospital admission or GP visit would then facilitate an early assessment of whether interventions were making a noticeable impact.

There have been relatively few projects which have focused on mitigating the adverse effects of overcrowding as councils' priorities generally rest with re-housing those that are most severely overcrowded. As the Overcrowding and Health, Mental Well-being Impact Assessment (MWIA) (Abrams et al., 2010:20) states,

“There is limited literature available looking at the impact of interventions which aim to improve housing conditions without moving families into larger accommodation therefore it is important that this project is evaluated and ideally published to improve the literature base”.

6. Key Findings (continued)

This scrutiny investigation fully supports this finding. In an era when councils and partners are facing increased financial pressures it becomes all the more important that projects are evidence-based and able to justify their funding through comprehensive assessments.

6.5 The challenge of reduced resources

The current financial climate has already led to the withdrawal of Local Area Agreement funding which means the three caseworkers are only due to be in post until the end of March 2011. As mentioned above, if non-statutory schemes are to continue they face increased pressure to evidence what value they add.

Although the council's primary commitment is on re-housing the most severely overcrowded families by 2013-14, the long waiting lists, especially for those households that do not fall into the severe category, means there is a place for intervention particularly where health could be improved. With the announcement in the Public Health White Paper *Healthy Lives, Healthy People* in November 2010 that councils will take the lead on promoting public health, serious consideration should be given to how schemes such as the Health and Overcrowding Project can contribute towards wider goals. Certainly the project would appear to complement the proposal for a health premium whereby councils are rewarded for reducing health inequality in the most deprived areas. Therefore if current funding is due to expire in April 2011 caution should be exercised in making any quick decisions to end the project pending completion of the evaluation.

The concept of building a Big Society is a central component of the coalition government's agenda. An option to consider in relation to the Health and Overcrowding Project is whether there is a role for the voluntary and community sector in the future. One example in the field of child protection is CSV's Volunteers in Child Protection (ViCP) programme which has been piloted in Bromley and Sunderland. As part of this, volunteers who are trained and monitored by a project manager employed by CSV, are matched by a social worker with particular families. The volunteers then provide additional support and findings have shown that families often engage more easily with them due to their informal role. If funding for the Health and Overcrowding Project is limited or expires entirely, it might be worth exploring use of such trained volunteers to conduct initial visits to identify families for referral to health and other community services.

7. Recommendations

1. That work continues to develop an integrated approach with partners and that thought be given to how the effectiveness of these links can be evaluated and monitored. For example, by moving beyond simply measuring the number of referrals.
2. That a mechanism be put in place to record the time taken for repairs to be carried out once a problem has been reported. Additionally that reducing the time between reporting a problem and carrying out the works is made a priority.
3. That thought be given to how best caseworkers can report and record instances where barriers are encountered. This may be in terms of households inadvertently worsening their own situation or linkages with partner organisations.
4. That particular effort be taken in making households fully aware of the negative effects associated with overcrowding, so they are mindful of these when considering offers of larger accommodation.
5. That emphasis is placed on evaluating the health impacts of the project particularly through progress measured in the four month health plan. Additionally that an appropriate system be put in place to ensure households with high health needs are referred to and picked up by the health practitioner.
6. That consideration is given to having caseworkers do a follow-up survey to assess impacts on health and/or households be surveyed once they have been re-housed to gauge whether their health has improved.
7. That consideration is given to developing a cost-avoidance model to demonstrate the impact of the project. One potential area to explore is whether interventions reduce the number of hospital admissions and GP visits.
8. Ideally that an evaluation of the project be published after the end of the financial year 2010/11.
9. That consideration is given to how the Health and Overcrowding Project may form part of the council's increased role as the local leader on promoting public health.
10. That the potential for volunteers to contribute to the project by carrying out visits and assessments (particularly if funding is not available) be investigated.