Linking energy efficiency and health: inter-agency working to deliver change

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1 - SYNOPSIS

A look at partnerships between local authorities and health authorities in the UK and an exploration of the advantages and the barriers of cross-sectoral working.

2 - ABSTRACT

This paper looks at the development of new partnerships between energy conservation authorities and health authorities in the UK and explores in particular the barriers to funding energy efficiency measures for agencies not normally associated with direct works on residential properties. A discussion of the effectiveness and efficiency of different approaches to cross-agency working is included.

The paper will review the few local initiatives in the UK that have already taken place on improving energy efficiency of housing specifically to reduce ill health. These include schemes where training has been provided for health visitors and referral schemes have been initiated where insulation measures can be 'prescribed' by the GP (family doctor).

Conclusions drawn are relevant not only to partnerships for health and energy efficiency authorities, but also to getting other authorities involved in working partnerships.

3 - INTRODUCTION

The results of research carried out by the Association for the Conservation of Energy and Projects in Partnership are described in this paper. The study's aim was to identify and review local initiatives that are seeking to improve the energy efficiency of homes. It has identified the barriers encountered in this approach, particularly the difficulties of cross-sectoral funding and working, and how they can be overcome.

The paper begins with a brief background on the problems of fuel poverty and the health effects of poor housing. It then goes on to discuss the role that health authorities can play in improving housing and the benefits of doing so. Some results from the study are reported in the form of case studies and finally conclusions are drawn about barriers to cross-sectoral working and suggestions are made for ways of overcoming these barriers.

4 - FUEL POVERTY

The poor suffer from worse health than the rich in every country in the world (Smith 1990). The Black report (Black 1987) showed marked differences in mortality rate between social classes and concluded that 'much evidence in inequalities in health can be adequately understood in terms of specific features of the socio-economic environment'.

Fuel poverty was first identified as an issue for public concern in the UK after the oil price shock in the early 1970s. It is defined as 'the inability to afford adequate warmth because of the energy inefficiency of the dwelling' (Boardman 1991). Thus fuel poverty differs from general poverty in that it cannot be solved merely through increasing income, but requires investment in improving the energy efficiency of the home.

In the UK the average expenditure on fuel is around 8% of disposable income. Around 7 million households need to spend more than 10% in order to achieve minimum heating standards (i.e. 18°C in the living room and 16°C in all other rooms) – these are the fuel poor. This differs significantly between tenures, with private tenants needing to spend an average of 16.7% of disposable income compared to 7.7% for owner occupiers. Many do not spend enough to reach even the minimum standard and instead live in cold damp homes.

5 - ENERGY EFFICIENCY

Energy efficiency of houses in the UK is measured on a scale of 1 to 100 (the higher the number, the more efficient the house), called the SAP rating. In England, the average is 35 whilst houses conforming to the 1995 building regulations typically have ratings of 70 or more. At average winter temperatures, 95% of households in homes with SAP ratings of 20 or less fail to meet minimum health-based heating standards. In England alone there are 2.85 million such households.

This fuel poverty burden is felt most by the vulnerable – especially the elderly and the poor. 22% (940,000) of pensioner households in England have houses with SAP ratings less than 20 – compared with 13% in the rest of the population. 69% of all elderly people who are private tenants live in dwellings with SAP ratings of less than 20. 460,000 English households with an income less than £4,500[1] live in a house with a SAP rating less than 10. At average winter temperatures, 66% of people who get more than 75% of their income from state benefits fail to meet the minimum health-based heating standard. These percentages are 76% for households with income under £4,500 and over 80% for private rented households. As a result, poor housing is a major factor in causing and exacerbating health inequalities (Joint Statement on Housing 1998)

In addition to this, evidence gathered by a health authority in Birmingham has shown that those most at risk are the least likely to complain or to claim grants that are available – these are the elderly and ethnic minorities often living in private rented properties (Williams 1999).

6 - COLD HOMES AND ILL HEALTH

The relationship between health and housing has also long been recognised and there is considerable literature examining the links with health of both cold houses and damp houses (see for example, Henwood 1997). Cold homes have repeatedly been linked to ill health and early deaths particularly in winter. There are an estimated 30,000 excess winter deaths each year in the UK (House of Commons 1997); this figure often rises when there is an influenza epidemic. This is an increase of 30% on the rest of the year. Other countries, like Norway and Sweden, see far smaller increases (around 10%) despite having colder winters. A recent article in the British Medical Journal (14/2/98) concluded that the situation in the UK was worse than that in Siberia.

The 1991 English House Condition Survey confirms that many of the poorest quality homes are occupied by people who are likely to be especially vulnerable to the cold, and recognises that 'cold homes represent the primary health risk in buildings' (Department of the Environment 1996).

In colder temperatures, blood pressure increases and the risk of heart attacks and strokes rises dramatically. As a result, most of the excess winter deaths are caused by heart attacks, strokes and respiratory illness, with just a handful caused by hypothermia. The majority of these excess deaths occur amongst older people, particularly those with lower incomes and poorer housing conditions. In addition, cold houses are often damp, resulting in ill health through the presence of mould and dust mites, both of which are associated with a range of respiratory and allergic conditions.

With so much ill health caused by cold homes, an additional burden inevitably falls on the health service. The Watt Committee has estimated that treating cold related illness costs the NHS £1 billion every year (see, for example, Boardman 1991). This spreads the impact of cold homes from those directly affected to those people awaiting routine operations that are cancelled during the winter. This figure does not include allergic conditions such as asthma, which is placing an ever-increasing burden on the health service.

7 - FUEL POVERTY IN EUROPE

Elsewhere in Europe, fuel poverty is less of an issue. A study by the Policy Studies Institute (Whyley and Callender 1997) concluded that only Ireland considered the problem on a similar scale to the UK. Although there is evidence for fuel poverty in the other two countries included in the study (the Netherlands and Germany), it is amongst a far smaller proportion of the population. The report states that

'The proportions of households in the UK and Ireland unable to afford to keep their home adequately warm is startling in comparison with Germany and the Netherlands. Virtually all Dutch and German households can afford to heat their homes adequately, but around a tenth of households in UK and Ireland cannot'.

Nevertheless, there are still lessons to be learned from this approach for those countries that do have a problem with fuel poverty, on whatever scale. For those countries with lower levels of fuel poverty those who do suffer may not be acknowledged and the identification of those in need may be more difficult. In these cases, a partnership with health authorities will ensure that those who do live in homes that are affecting their health are identified. Involving the health authority does have advantages, as outlined below, and many of the lessons learned from working in partnership with the health authority are valid for other countries, especially Eastern Europe where there is a similarly poor housing stock.

In addition, all aspects of poor housing and environments will have an adverse impact on health, not just the issue of energy efficiency. The development of such a partnership approach can facilitate general housing improvements and consequent health benefits. These results are thus applicable to other forms of pollution which have adverse health impacts. For example, partnerships between local authorities and health authorities will also aid the formation of local transport policies.

8 - ROLE OF HEALTH TRUSTS

Health trusts and health professionals have a high level of contact with the public, particularly with the groups vulnerable to poor housing such as the elderly, people with disabilities and young children. Because of this they can play a number of important roles in energy efficiency programmes (NEA 1998). These include:

8.1. Information provider

Because of the good contacts with vulnerable groups, health professionals have a major opportunity to provide the public with information such as general advice on energy efficiency and details of grants or other assistance that is available. This can be done through hospitals, health centres, doctor's surgeries, midwives and other health visitors.

This can be extremely cost-effective where health professionals are already making home visits. These professionals are trusted by the elderly, who are more likely to believe the information than if it was coming from a stranger or was utility-sponsored, for example.

8.2. Influencing local policies and deliveries

Health professionals can influence policy decisions. For example, if they are involved in the design of a programme of energy efficiency they can encourage targeting of those most likely to be suffering from ill health. Home visitors and GPs are vital for identifying those most at need.

8.3. Provision of resources

A handful of health trusts have invested in energy efficiency improvements in peoples' homes as an alternative to long term treatment.

Some schemes have shown how investing in housing may provide a more cost-effective solution to the treatment of the illness than conventional care. A scheme in Cornwall, for example, has shown that improving the homes of children who are asthma sufferers has resulted in fewer hospital admissions, lower medication and GP costs and fewer days off school due to ill health.

Where there is the option of improving the home, health trusts can provide a more appropriate service depending on the patient's need by identifying and solving root causes of medical problems such as damp housing.

9 - CASE STUDIES

9.1. Cornwall and Isles of Scilly scheme

In 1995, the Cornwall and Isles of Scilly Health Authority made a grant of £300,000 available to district councils in their area so that they could install central heating and insulation measures in selected homes where children were suffering from asthma.

The project was started as a Health Authority initiative when a budget surplus was identified and they identified this as a cost-effective use of money. The Health Authority was convinced that the poor health of the children selected was directly connected to the cold, damp homes they lived in.

101 homes were improved, which housed a total of 108 children suffering from asthma. Interim results show the scheme was a success (Somerville and Mackenzie 1997). A follow up study was conducted on 28 children which found that asthma symptoms had improved and the children had had less time off school as a result of their asthma. (On average the children concerned had 4.1 days off in the three months before the investment and 0.6 days in the three months after.)

Further evaluation is currently taking place now all measures have been installed and the follow up study completed. The Health Authority has been monitoring the project closely, as this was a new venture for them and indeed the first in the country. The use of the money has thus been carefully evaluated. Such figures are vital if this scheme is to be replicated. Indeed, virtually every other scheme that has gone ahead has made use of the figures from this scheme.

9.2. 'Beat the Cold', North Staffordshire

This group was formed in 1986 by a group of health professionals, some local fuel companies, installers and local authorities. It was an informal and voluntary group for about 8 years before it received any funding. The aim of the group is to help vulnerable groups in North Staffordshire to achieve affordable warmth and reduce illness due to cold homes by giving them advice on energy efficiency and information about grants that are available to help them.

In 1994, NEA (a fuel poverty charity) and the Health Promotion unit at the local health authority contributed £13,000 and £15,000 respectively towards running the project. The funding over subsequent years has come from a variety of sources, with several grants from the Health Promotion unit, MANWEB (the local electricity utility) and British Gas.

As well as giving advice on available grants, Beat the Cold has also run several training sessions for health visitors and local authority staff. This has included health visitors, practice managers, home carers, handipersons, social workers, officers involved with student accommodation and housing officers. Over 50 individuals have now been trained under the scheme with plans for further such sessions.

Lessons learned
The existing infrastructure in the health service is a major barrier to investment in preventative measures - success is measured on reduction in waiting lists and other measurables. It is really a question of politics, not just cost effectiveness – if prevention of ill health through improvement of housing were a recorded target for health authorities, all would tackle the issue.

The health authority was a bit disappointed that this scheme hadn't done more to promote itself to them by trying to quantify the benefits. It seemed unlikely that the health authority would be investing further resources into this scheme. They would also have liked to see GP referrals and grants as they believe this would have more of an effect than advice alone. A total of 15-20 hospital admissions need to be prevented in order for the health authority to see a positive return on its investment. Beat the Cold believes that they have probably achieved this, as the take-up rate of insulation measures has been high. There is anecdotal evidence for an increase in affordable warmth, but no figures to back this up.

Some health visitors are more pro-active than others and will campaign on a variety of issues and learn benefits they can access for their clients – these are the types who need to be targeted for receiving energy efficiency advice training.

There is a battle between the medical model and social model of health. The medical model requires immediate results - GPs were convinced of the benefits of this scheme and were pleased with results of displays and advice sessions in their surgeries, but still said that if given the money they would spend it on operations because their success is measured in these terms.

9.3. 'SNUG' scheme, Birmingham
This GP referral programme for the elderly was started as a result of a growing waiting list for 'minor works grants' for home improvements. Some research was done by the health authority under the Healthy Birmingham Programme and the elderly were identified as most at risk and the least likely to complain or apply for grants (Williams 1999).

The scheme was set up by the Urban Renewal division of the City Council, with help from the Family Health Service. A bid to the health authority for a one-off grant programme gave the scheme £150,000.

Under the programme, GPs can refer elderly patients on health grounds. A person-specification was written for the GPs to help identify those eligible for the scheme. This stated that the grants were not just about wellbeing, but whether the work could be prescribed as an alternative to medicine or treatment. An estimated 3 days in hospital needs to be avoided per patient in order to make the home improvements worthwhile.

Most GPs in the area responded, with 45 GPs having made a total of just over 100 referrals. Some further recommendations were made which were passed on to other grants programmes (particularly disability grants).

The recipients of the measures have been very pleased with the results, and the programme manager reported a record number of thank you letters. These were copied to the GPs who had referred them, in order to reinforce the message.

The health outcomes of these works are in the process of being measured. The importance of such figures is understood by the programme manager. A letter has been written to GPs who made referrals and the more active ones have also been asked to sign a petition to get renewed funding. About 10% of GPs have responded so far and the remainder will be followed up in due course. Although actual figures on cost-effectiveness may not result from such a survey, comments from GPs are also valuable.

Lessons learned
Social services are client-oriented not strategic planners, thus problems arise with working methods related to this. However, one of the primary aims of the programme was to improve linkages with GPs. This was achieved and the improved relationship has been used for other purposes – for example, they are now working together to research the impact of housing estate improvements on asthma.

9.4. 'Improved Health and Housing', The Wrekin council

The Wrekin was awarded £50,000 under a government grant programme in 1997 to run an 'Improved Health & Housing' scheme, which links health and energy efficiency. The aim of the scheme is to accelerate the rate of installation of energy efficiency measures by increasing awareness of energy efficiency issues amongst health care professionals. The scheme builds on existing work by the Wrekin Health Partnership - a multi-agency forum.

The first part of the project involved undertaking a study to establish levels of awareness amongst health professionals of energy efficiency issues. The aim of this research was to identify specific concerns and barriers to the adoption of a more proactive approach. The study, which was conducted by a local energy advice centre in conjunction with the health authority, found that:

- There is a general lack of awareness of energy efficiency issues amongst health care professionals;
- There is an appreciation of the benefits of linking the two issues;
- Professionals feel that patients would benefit greatly from energy efficiency advice and assistance;
- The level of ability to help patients varies - district nurses and health visitors are in the best position;
- An information pack and training was needed.

In response to the research findings, the next stage involved developing an energy/health information pack for GPs/health care workers, to help them assist those at risk from cold homes. The pack is intended to enable the health workers to act as a referral mechanism to signpost patients in the right direction for further advice and help with energy efficiency issues. A series of presentations was held for health care workers to launch the pack, with the additional aim of encouraging them to invest in energy efficiency themselves. In addition, three levels of training in energy efficiency were offered to health professionals and a scheme to train hospital staff in energy efficiency has now been started.

The Health Authority provided £13,500 to fund a series of pilot energy efficiency grants, through which insulation is provided to low income, vulnerable people whose health would benefit from the work. The lead officer in the primary health care team is responsible for identifying patients whose health would be directly improved by an agreed package of energy efficiency measures (including insulation and off-peak water heating timers) as well as extractor fans to reduce condensation in the home. The maximum grant per household is £500, with patients on income related benefits asked to contribute just £10. Those not in receipt of benefits are asked to contribute 20% of the cost. Furthermore, the Wrekin Council is ringfencing £25,000 from its home repair assistance budget for providing grants in this area

The scheme aimed to achieve 220 loft insulations and 70 cavity wall insulations in the first year, as well as a range of other measures. In addition, 14 houses have been insulated using the health authority grant.

Lessons learned

It is vital to get all the parties on board at the earliest possible stage. (This scheme benefited from the fact that the Wrekin Health Partnership had been up and running for some time before the grant bid was put together.)

The multi-disciplinary approach can be effective, but perseverance is necessary to get the co-operation of professionals from outside the housing sector.

9.5 Eastleigh Borough Council

In 1997, Eastleigh Borough Council received a Government-funded grant of £53,700 to run a scheme highlighting the links between health and energy efficiency in the home. The scheme is run in conjunction with two other local authorities and the two local health trusts. The Health Trust has provided £15,000 of in-kind support to the scheme.

The aim of the scheme is to use health visitors to target and encourage a limited number of vulnerable households to apply for a grant to cover 90% of the cost of energy efficiency measures in their homes. It was anticipated that health visitors would also use the links between health and energy efficiency to make all their clients aware of the general benefits of energy efficiency and refer them to sources of other energy efficiency advice.

The local energy advice centre arranged training sessions for all the region's health visitors. Different styles of training were tested. Those sessions added on to existing health visitors' meetings were the best attended. Training covered basic energy efficiency awareness, links with health issues and sources of grant funding. In addition, all health visitors in the South West Hampshire area have been provided with a comprehensive energy efficiency information pack.

Initially, the health visitors' line managers requested that publicity be delayed until the health visitors had identified householders to receive the grants. This was in order to avoid the health visitors being canvassed by their clients. However, health visitors have proved reluctant to recommend clients, and the scheme is now being publicised directly to householders. All residents who qualify for the scheme are now being mailed with information on the scheme. Take-up rates are still proving poor, and the authority suspects that the £20 householder contribution that is required may be the major barrier to uptake of this offer.

The scheme is being extended to include health/community workers such as district nurses, community health facilitators (who have a special responsibility for visiting the elderly), occupational therapists and social workers in the training programme, to allow them to promote energy efficiency to their client groups.

The energy advice centre estimates that all the health visitors in the region have now attended at least one training session. The scheme was aiming to achieve 200 loft and 140 cavity wall insulation installations in the first year. In fact, by March 1998, only 15 measures had been installed. The authority reports that the response from the health visitors has been very disappointing.

Lessons learned
In the context of hierarchical changes within health trusts, promotion of energy efficiency is not seen as a priority by the health visitors. Those attending training sessions were receptive to the aims of the scheme, but their response in terms of making referrals has been very disappointing. The local authority feels that greater involvement of the health visitors and their line managers in the formulation of the original submission for funding may have resulted in greater ownership of the project.

Health visitors' time is very precious, and training is best attended when it is incorporated into existing meetings.

Expecting even small contributions (of around £20) towards the cost of energy efficiency measures from fuel poor households seems to be a major barrier.

9.6. Training and Awareness Scheme, London Borough of Hammersmith & Fulham
The London Borough of Hammersmith & Fulham was awarded a grant of £50,000 under a national scheme in 1996, to set up a training programme for health workers in energy efficiency advice, to enable them to advise their clients on effective energy savings.

The project aimed to train some trainers within the local health authority in the provision of energy efficiency advice, and to produce a training module that, once delivered, could be used through the health authority's existing in-house training programmes.

An advisory group was set up at the start of the project, composed of representatives from the health authority, social services and the local care & repair agency. The local tenants and residents association and the local Action for Disabled groups were also invited, but were unable to attend. The purpose of the advisory group was to involve the sectors that were to be targeted for training at key stages of the project.

The second stage involved conducting research to establish existing levels of energy efficiency knowledge amongst primary care workers, to review any training in existence and to identify which groups of staff would benefit most from the training. The research was conducted by phone interviews with strategic and front-line staff.

The research found that all interviewees were familiar with the link between energy efficiency and some of their clients' problems. Interviewees were keen to increase their knowledge of this subject and particularly

wanted to help their clients access further information and grants. Some staff, such as social workers, are expected to take time to actively assist clients with problems - area wardens, for example, will make phone calls on a client's behalf to help them access a grant, whilst others, such as home helps, will refer clients to other agencies if they see a need.

None of the interviewees had previously received any training in energy efficiency. Front-line staff asked for training in general energy efficiency issues, including behavioural tips, how to deal with condensation, how to reduce fuel bills and how to access grants. They all wanted booklets for their own information with details of available grants.

Lessons learned
An advisory group with representatives from the health authority (and ideally including front-line staff) can help to give the project direction from the outset. In addition, a consultation process can ensure that the training is designed to suit the health workers' needs and that the promotional material is relevant to their clients.

Because there was no system for monitoring the impact of this training, there is no way of knowing whether the training module is still in use. Similarly, there is no information on whether the client advice has had any impact in terms of measures. To be able to assess the effectiveness of this type of scheme, it is essential that a monitoring system be built in from the outset.

10 - MEASURING SUCCESS

Results of each scheme can be measured in terms of the development of successful and ongoing partnerships, the numbers of health professionals 'on board', the amount of energy efficiency advice provided as a result of the scheme and the number of measures installed. Many of these are hard to quantify, and opinions of those involved have often been relied upon.

Every scheme has had some success, but all have also encountered barriers, which for some schemes have dramatically limited their results. The barriers can be roughly split into problems with the partnership approach, lack of evidence, resource constraints, lack of guidance and problems caused by the design of the scheme.

11 - BARRIERS TO INVOLVEMENT

11.1. Partnership issues
Most schemes report that there are a number of barriers to smooth partnership working between the local authority and health authority/health trusts/GPs. These include:

- Different priorities for the different partners, and for the different departments in the local authority. For example, health authorities' priorities are focused on service provision rather than prevention of ill health, while the local authority is concerned with increasing energy efficiency and providing access to affordable warmth.
- A lack of history of working together is another barrier. The extent to which partners have worked together in the past varies from scheme to scheme, and the longer the partnership has been in place, the better the partnership usually works. This lack of experience of joint working can mean that the person planning the scheme does not have the right contacts at the other organisation, and therefore may not involve the most relevant people from the outset. This in turn can result in those people lacking a feeling of ownership in the project.
- Non contiguous boundaries between health authorities/NHS Trusts and local authorities do not facilitate a partnership approach. In addition, the authorities have different planning mechanisms, timetables, budget systems and targets.
- Several partners have reported that there is a degree of 'professional snobbery' between the authorities. In particular, the health professionals are often unwilling to commit to a local authority led project. When targeting GPs in particular, one reported that 'it is most effective if you make the GPs believe that the scheme is their idea'. In general, health visitors seem to be more receptive than GPs, probably because they

have first hand experience of their clients' living conditions and can therefore easily identify where ill health is caused by cold or damp living conditions. However, in general terms, GPs are more influential than health visitors. In particular, they will play a prominent role in the new Primary Care Groups[2], so gaining their commitment is very valuable to a project.

11.2. Lack of evidence

There is still no generally accepted robust piece of research that quantifies the link between poor housing and ill health. While local authorities seem generally happy to take action based on qualitative or anecdotal evidence, health authorities more often require quantitative evidence on the cost effectiveness of the approach before they can commit money, or in some cases time, to such a project. While there are a number of research projects that are being carried out, it is unclear whether they will provide the evidence required.

In addition, many schemes do not have a system for monitoring the effect of the measures on the patients' health and well being, so can offer little to the funders to prove that the money is well spent.

11.3. Resource constraints

Many local authorities that have tried to involve health professionals in training have reported that they are all incredibly busy and do not have much time to attend training on energy efficiency (EST, 1999). Anything that they perceive to be adding to their workload is unlikely to be well received.

11.4. Funding priorities

Although all health authorities spoken to during the course of this study agreed that investing in improving housing was very worthwhile, they found it hard to commit funding to it because the effects were very hard to measure. All decisions need to be taken on a cost-effectiveness basis, and in most cases there has been no attempt by the programme implementers to actually measure the health outcome of the investment. There is also some lack of communication - in some cases the health authority thought these figures were vital whilst the programme implementers thought that as long as it was obvious the programme was having some effect, it didn't need to be measured.

Another major problem is target setting by national Government. Targets are set mainly in terms of waiting lists and although GPs can see that improved housing helps in the long term, given a sum of money they would rather send as many people as possible to have hip replacements or other much needed operations. It is not necessarily because they believe that this is more cost-effective, but that their performance is measured in these terms.

11.5. Guidance

Many partners report that it would be helpful to have 'an example set by central government', or at least guidance on the desirability of this kind of approach. Because inter-departmental activities within central government are rare, there is no model to follow.

In the course of this study around 10 programmes have been discovered where the health authority is taking an active role. The people involved in most of these are unaware of the other programmes and are all developing in isolation. Some 'best practice' guidance is urgently needed in order to save time and avoid mistakes being repeated. Also a body of evidence for the health outcomes of such measures is slowly growing and the dissemination of this information is vital to persuade health authorities that there will be a positive health gain from investing in housing.

11.6. Scheme design

Finally, some schemes have floundered because they are complicated to run and the referral system requires a lot of paperwork. Schemes that are straightforward to administer are the most successful. Similarly, those that offer flexibility in terms of the measures that can be installed are the best received.

In addition, finite schemes will achieve little or nothing in the long term. Approaches have to be ongoing in order for partnerships to become established.

12 - OVERCOMING THE BARRIERS

12.1. Partnership working

It is vital that all key partners are involved in the scheme from the outset. For example, schemes targeting health visitors should include their managers. By involving the key players from the start, they are more likely to feel that they have ownership of the scheme and are thus more likely to be committed to the scheme's aims. In addition, through their involvement, aspects of the scheme can be designed to suit those targeted – for example, relevant training can be provided, in a format that suits.

Time is needed to set up a partnership and to get it working smoothly. It is better to delay the launch of a scheme until this is in place than to start a scheme without the key players on board.

Statutory joint consultative committees and joint care planning teams provide a central framework for co-ordinating strategy and service delivery. More recently, the Government's 'Health of the Nation' strategy and the newly set up 'Health Action Zones' are also a focus for working alliances.

There may also be a positive effect from the further re-organisation of the health service and the plan to bring health promotion into joint social planning. This would break the barriers between health and social funding.

12.2. Evidence

It is possible that some of the research currently being conducted will provide the evidence required. However, it is also possible that the health authorities will not be convinced that the methodology employed is sufficiently robust.

One health authority, working in partnership with the local authority and the local university, has designed a piece of research which it feels would provide the necessary evidence to prove and to quantify the link between housing and asthma. However, the research has not yet been carried out because funding has not yet been secured.

Incorporating monitoring systems into schemes can also provide some evidence of their success. For example, finding out how much advice has been provided as a result of the scheme, and whether the householders have acted on the advice, as well as monitoring the health impact of the measures, can all help to convince those providing the funding that the money is being well spent.

12.3. Resource issues

If the necessary evidence were available, health authorities and health professionals would be more likely to commit their resources, in terms of time and money, to this kind of approach. In addition, guidance from government (see below) to both health authorities and local authorities on the benefits of this approach would be likely to release more funds.

It is preferable to involve the relevant line managers in the scheme from the outset, to help ensure their full commitment. Forming an advisory group to oversee the project's design can help to achieve this.

It is also important to make provisions for the training to be designed in such a way that it is most relevant, and most convenient, for the maximum number of staff. Existing awareness of energy efficiency amongst this group varies. In a scheme in the London Borough of Hammersmith & Fulham, a survey was conducted amongst key strategic and frontline staff to find out what kind of training they would like and in what format they would like it delivered. The same survey also established what kind of materials the health workers felt would be most useful (EST 1999).

12.4. Guidance

Guidance from central government on the benefits of this kind of approach would help to convince all potential partners to get involved. In particular, recommending that existing grant sources are used to fund these kind of programmes, or that this approach is incorporated into Health Improvement Programmes, would be helpful.

Several partners also said that it would be helpful if central government were to 'set a good example' in terms of partnership working in this area.

12.5. Scheme design
By involving the key partners in the design of the scheme at the outset, problems can be minimised. In addition, it is best to pilot a scheme wherever possible to iron out any problems at the earliest opportunity.

13 - CONCLUSIONS

Partnership approaches can be effective in increasing access to healthy living environments. However, schemes need to be well thought out before they are launched. In particular, it is vital that the stakeholders have ownership of the project, and to achieve this, the key partners must be involved from the outset. This will help to ensure that the scheme doesn't add to workloads unnecessarily, and that training sessions are designed to fit in with existing schedules. It will also ensure that any referral scheme is designed in such a way that all those involved feel it is sensible and workable.

Partnerships take time to establish and particularly in the early years will often rely on one 'champion' working to keep the initiative going.

Local authorities are happier to take action based on anecdotal evidence, while health authorities require quantitative evidence. Conducting research that is designed by the health authority might provide this quantitative evidence and help to free up the necessary resources.

Any initiative needs to be ongoing, and hence an ongoing source of finance is required. A robust piece of research could provide the evidence that health authorities need to commit resources to this kind of approach. Good systems of monitoring for each scheme can also help to show that the money being spent is achieving results, and can thus help to secure continued funding. Finally, central guidance recommending that existing sources of funding can be spent on this kind of initiative, would be helpful.

14 - ACKNOWLEDGEMENTS

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15 – ENDNOTES

(1) £1 = approximately 1.5 Euro.
(2) From 1st April 1999, new NHS organisations called Primary Care Groups (PCGs) will come into operation. PCGs will bring together family doctors, nurses and social services they will develop the potential of primary care commissioning, without the disadvantages of individual funding. 481 PCGs will begin operation this year.

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