HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Prevention in health and social care, HC 965

Tuesday 5 September 2023

Ordered by the House of Commons to be published on 5 September 2023.

Watch the meeting

Members present: Steve Brine (Chair); Paul Bristow; Chris Green; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 200 - 245

Witnesses

I: Dr Henry Burridge, Senior Lecturer, Imperial College, London; Helen Garrett, Principal Consultant, Building Research Establishment; Dr Jill Stewart, Associate Professor in Public Health, University of Greenwich; and David Finch, Associate Director, Healthy Lives Team, The Health Foundation.

Examination of witnesses

Witnesses: Dr Burridge, Helen Garrett, Dr Stewart and David Finch.

Q200 **Chair:** This is the first session, post summer recess, of the Health and Social Care Committee. We are in Committee Room 8 in the Palace of Westminster, in the House of Commons. Today is a public evidence session as part of our big inquiry into prevention in health and social care. There are 10 different workstreams, all available on our website if people are interested in seeing them. This is on healthy places. We are particularly interested in the relationship between housing and health. We are particularly interested in the cost of poor housing to the NHS and wider health costs, how where we live, work and play impacts on health and how we can change that to prevent ill health in the first place.

Our guests, whom we have kept waiting a little bit, are Dr Henry Burridge, a senior lecturer representing the Future Urban Ventilation Network at the Department of Civil and Environmental Engineering at Imperial College here in London; Helen Garrett, the principal consultant at the Building Research Establishment, the BRE; Dr Jill Stewart, associate professor in public health at the University of Greenwich, and David Finch, associate director of the Healthy Lives Team at the Health Foundation.

Do Members have any interests that they wish to declare before we get started?

Welcome, everybody. I really appreciate your interest in this inquiry and, in particular, in this workstream. I will open it up to Members, but to start on this point, Helen, research by your organisation, published just this year, said that the total cost of poor housing to the NHS is about £1.5 billion per year for England alone. This represents the first-year treatment cost to the NHS of leaving people in the poorest 15% of housing stock in England. You can obviously expand on that in your answer. It is a big ticket, which is one of the reasons why we are doing this workstream within the inquiry. How well recognised do you think the role of housing is in preventing poor health?

Helen Garrett: It has been increasingly recognised over the years. We have seen things like increased funding for disabled facilities grants that enable people to stay at home more healthily. I know that is not directly connected to the fabric of the dwelling, but the principles are the same—*they can keep people out of the hospital and reduce demand for health services and allow them to stay at home* longer, and that puts less pressure on our authorities.

Obviously, more recently, we had the very sad case of Awaab in Rochdale, which has put greater focus again on damp and mould in homes and the problems of disrepair. I don't think we all thought that someone could die of damp, but sadly that has happened. Credit to Government: they have put a lot of focus on the worst conditions of the

poor housing. A lot of those are preventable. It is good that there is greater public discussion around that.

It is fair to say that we have known of the links between housing and health for many years, right back to the times of the Victorians and the poor housing and impacts on health then. I am still not 100% sure that, as a society, we recognise that good health starts at home, so there is lots of work to be done.

Q201 **Chair:** And not least, of course, the original Health Secretary was the Health and Housing Secretary for a reason. David Finch from the Health Foundation, interestingly, you talk about the relationship between tenure and security of tenure and the aspects of poor housing that can then contribute to poor health. Obviously, there are the direct, in front of you impacts of poor housing, but the tenure issue is interesting around the stress caused by short tenures, and unsecured and unreliable tenures. Would you expand on that in answer to my question: how well recognised is the role of housing in preventing poor health?

David Finch: Some of the wider issues were recognised through the pandemic as well. People spent more time at home and some of those issues became very apparent.

One thing that we should always try to be aware of is that there are probably three main routes: quality, stability and security, and affordability. It is those three different routes through which health can be affected. There are also some quite clear interactions between those elements. Particularly on stability—you mentioned tenure—it is about an increase in the number of people or households now living in the private rented sector, where you tend to have shorter tenures and a faster turnover. Those homes tend to be of a lower quality as well, so you have almost a mix of all three issues, all three pressures, within the private rented sector.

That is a particular issue because part of that increase has been families with children who are unable to afford to become homeowners and who, with limited social housing, are now living in the private rented sector, which has not particularly been designed to meet those families' needs. Some of our work has shown that children who move more frequently through their childhood are more associated, or at least their parents, with having poorer health. That tends to be very much focused in the private rented sector.

Some of the issues come through when thinking about affordability pressures and the high cost of renting. The local housing allowance, which is the bit of universal credit that will cover private rental costs, was restored to a previous threshold during the pandemic, but since then, because we have had really fast increases in private rents, some IFS research has shown that something like 5% of things on the market are affordable and local housing allowance would actually cover them. That just adds to the different types of stresses and strains that families might

be facing. There is a risk that they will be in poorer-quality housing as well.

Q202 **Chair:** Members may wish to explore your point a bit more, which was well made, of the impact it can have on your physical and mental health if you move regularly during your younger years. We would love to see some evidence behind that.

As part of these very focused workstreams, we are interested in recommendations to Government. There is the much talked of but not yet debated here Renters (Reform) Bill. Does that have a positive impact on what you have just said?

David Finch: It does. The long awaited part of it is that there is something in there about trying to increase the length of tenure that people have, and also prevent some no-fault evictions that are currently allowed, so it would help prevent more people from becoming homeless. It goes some way, but as ever there is more to go. I would say that probably the big gap is the need to bring the decent homes standard in to be applied to the private rented sector. It is mentioned in the consultation paper but not in the actual Bill.

Q203 **Chair:** Dr Burridge, to give you an early feel of the ball, given your work at Imperial, through covid in particular, how well recognised is poor housing in preventing ill health?

Dr Burridge: It has been increasingly so. There have been some very well-publicised examples, and covid itself raised awareness more broadly. In my mind, housing is challenging because you have the facet of the place itself. Is the place appropriately facilitated to be healthy, right from adequate heating and places to dry washing, through to kitchen and bathroom extractors as well as ventilation more broadly throughout the place? Then there is the case of usage. Are the people living in the space aware of how to use their place for it to be healthy? Unless we get those two things right, we will struggle to address the fundamental issues.

Q204 **Chair:** Thank you. Finally, Dr Stewart, we have heard from your fellow panellists that this is an issue rising up the agenda. Would you concur?

Dr Stewart: Absolutely. I agree with and support what my colleagues here have said. Housing has really gained traction in public health debates in recent years. There is still a long way to go. We have known about the links between housing and health for many years; there is a growing body of evidence. What we are less clear on is how to act on that and put it into practice at the frontline. The work from the BRE in particular has provided enormous impetus and evidence to us about people understanding the costs if we do not address housing as a social determinant of health. I think that is key.

How do we see housing? There has been a lot of change. Organisations now tend to focus more on housing as a social determinant of health and as a home. We obviously have a tension with the property market and

how that contributes to health debates. Certainly, since Marmot and in the current public health agenda that we have, public health has taken much more of an interest in housing and health and its importance in physical and mental health. The thing that perhaps is less said is about people's general quality of life and enjoyment of their life; whether they have space to live and develop as children and whether housing is suitable across the life course. That is where the current public health agenda has really helped in giving a life-course approach to housing.

There is also geography in housing and health debates. We find different issues in different parts of the country. The tenure issue is key and how we intervene in relation to that, whether it is privately rented, socially rented or owner occupied. Obviously, there are different interventions available across those areas.

It is important to get housing right in the first place, in a good, planned environment, which helps address inequalities from the start, with a good, well thought-through environment. The Town and Country Planning Association has done some really good work in that area. The other issue is housing that has already been built that is poor and what we are going to do about that. There is a growing issue of families living in temporary accommodation and what that means for physical and mental health across the life course. There are multiple issues to think about, but they are all very interrelated. We need to think, if we act in one area, about the effect it has on housing across another policy area.

Chair: That is the purpose of this inquiry—to try to see that all these different things are interdependent in the prevention of ill health. I am going to open it up to colleagues now. Try to keep your answers short, but also try to think about what we are going to say to Ministers. That is what we are about. We are about changing policy to help prevent ill health.

Q205 **Taiwo Owatemi:** I am particularly interested in permitted development rights and the fact that the Government want to be able to transform non-residential homes into homes for families and for people to be able to live in. Helen, what lessons have we learnt from the current PDR developments that we have seen?

Helen Garrett: I am not an expert on new homes and construction types. All I can do is reiterate what my colleagues have said. If we get it right from the off, we are going to save ourselves problems down the line. There are lots of schemes like the BRE house mark and other recommendations. We had lifetime homes ideas as well, and perhaps have not followed those through. If we get the building correct in terms of space and the way people will interact with housing, we save ourselves a lot of problems down the line. A lot of the hazards we have in our homes today are sometimes down to poor design from the off, such as inadequate lighting and that kind of thing—noise without adequate sound insulation and poorly designed kitchens or poor conversions where people convert their home and have been allowed to do things that become

unsafe housing. It is important we get it right from the off because we save ourselves millions of pounds further down the line.

There has been lots of research that we have undertaken. Organisations like the Centre for Ageing Better have said that if you invest in accessible housing, for example, it will pay dividends. That is having level access and abiding by the requirements of part M. If we do that now, there is a cost saving down the line.

Q206 **Taiwo Owatemi:** I have actually been to one of the developments, Vantage House. Walking into the development, you can see that there is poor ventilation. There is a lot of noise. The quality of life for children living in the development is not as good as we want it to be for children in our country. David, what is the long-term impact of that on their physical and mental health, and how much is it actually costing the NHS in the long term?

David Finch: I don’t have the figure for the long-term impacts. I would refer to the one from Helen about the £1.4 billion a year to the NHS. There was a study of some business buildings that were turned into accommodation, where I think only around a fifth were meeting national space standards. It just reinforces that the quality was not there in that instance. There is obviously the importance of getting it right in the first place.

There are some clear impacts on child health. The direct impacts on child health are things like respiratory conditions potentially if there is damp or bad ventilation. There is also a potential impact on children’s education that can then lead to ultimately poorer prospects in the future which can be associated with poorer health. It is really important to get the quality right and make sure you are not creating long-term costs, which may be to the NHS but, if it is affecting education and someone’s earnings ability, it is ultimately affecting the economy as well.

Q207 **Taiwo Owatemi:** Dr Burridge, do you want to add anything to the two comments made?

Dr Burridge: Only that I think we need to understand these things more clearly and increasingly gather evidence. There are some relatively low-cost interventions in tools to better educate landlords on the benefits of keeping a well-maintained property—it is their asset at the end of the day—and crucially informing residents how to spot things like early signs of mould and what they, as residents, can do to mitigate them and where to go if those mitigations do not work. I can imagine there being a whole series of pamphlets. What if somebody in your house vapes? What should you do to mitigate the impact on your children and the like? These are relatively low-cost interventions that, if done well, can only have a positive benefit. In the meantime, we can be finding deeper evidence to support much more costly interventions that will also be needed in the longer term.

Q208 **Taiwo Owatemi:** Vantage House is an office space. Although it has been sectioned out, noise, smoke and any of that affects everybody on the floor because it was not essentially created for that purpose or that use.

Lastly, I want to move to social prescribing. I know that some of my colleagues will focus on some of the points made in much more detail. Dr Stewart, I want to turn to the cost and impact that social prescribing can have in improving the quality of housing for families. For example, I know that certain hospitals in Liverpool are piloting being able to give families extra support if they have a problem with heating, to address asthma and other respiratory-related conditions. Other areas are looking into allowing GPs to prescribe heating vouchers, again to address respiratory conditions in adult healthcare. What is the advantage of that? In particular, how can we support GPs who are finding it difficult, to encourage them to socially prescribe and take it on more?

Dr Stewart: That is a very interesting question. The main benefit is bringing the health and housing sectors together. If somebody presents with a respiratory disease or disorder, it may well be related to cold, damp housing and a lack of heating. It is another way of identifying poor housing where an intervention could help. It would help GPs to work more closely with local authorities, which can only be of benefit.

As I understand, it works very well in some areas but not in others. It would be beneficial to roll it out more widely. Obviously, GPs or prescribers would need more resources to be able to do that. As I understand it, where it is in place it is working very well. The main thing is the organisations working more effectively together and more people making referrals. As we heard earlier, we are all far more aware of what can happen when vulnerable people with children are living in damp and mouldy housing. The interventions can be challenging around cold homes and fuel poverty, as we know. The more people who are working together and able to identify and prescribe remedies from other service providers, the more helpful it would be.

Q209 **James Morris:** Helen, the Chair referred to the BRE estimate that the cost of poor housing to the NHS is £1.4 billion a year. Do you know what proportion of that £1.4 billion would be the cost of mental health care?

Helen Garrett: More research is needed in that area. In our research we have looked at the initial treatment cost to the NHS in hospitals and some very short-term care, because the public health data is there. We do not have the data in that very important area. You are absolutely right that it is one of the areas where mental health and wellbeing is one of the consequences of poor housing and the feeling of isolation. The data is not there at the moment, so more research is definitely needed.

Q210 **James Morris:** David, in some of the work that you have been doing is there evidence of a link between poor housing and mental health at a variegated level according to tenure? Is there evidence about that?

David Finch: It is always quite hard to get to a precise causal impact because of the big interactions that go on. There is housing and health, but often the reason for your poor housing might be related to income or the job that you do or do not have. It can be quite hard to completely unpick it all.

What we do have are some clear associations between things like overcrowding and psychological distress, for example, or the tenure point that we mentioned earlier. Often, these are worse where you have more than one housing problem. It is not just the overcrowding and the home being at a non-decent standard; it is the fact that it is both at the same time that is worse. Even when you control for some other factors, there is still that overriding strong association. If you have a poorer-quality home, you are more likely to have poorer health.

Q211 **James Morris:** Dr Burridge, thinking about quality of housing and the work that you have done around ventilation, is there evidence of links between that and particular mental health conditions?

Dr Burridge: No, there is no research specifically on that which I am aware of. We are very well aware of the links between ventilation and noise, be that through either installed ventilation systems or opening windows in noisy environments. There are evidence links between noise and mental health, but there isn't an inherent connection that has been evidenced per se.

Q212 **James Morris:** Dr Stewart, on the public health link, is mental health thought of as being a core part of the concern about poor housing quality? Is that something that you think is getting sufficient attention?

Dr Stewart: I always hope that it would attract more attention, but there is certainly lots of evidence of the links between poor housing and mental health. As our colleagues have said, it is around conditions and management of housing stock as well as tenure, and if people feel they can stay somewhere. Short-term tenure is a crucial issue for people's mental health. There is the thing about the sense of home. Do people feel invested in an area? Do they know they can stay for more than a six-month tenancy, for example? The whole rent reform debate is crucial to mental health.

I don't think there is evidence to directly link the effects, but there is certainly a lot of anecdotal evidence. We have strong evidence of mental health in relation to issues such as damp and mould and how that makes people feel about overcrowding. We have had the evidence for years and years. There is the lack of privacy and lack of space in multiple occupied places, and the issue around mental health from sharing facilities, perhaps with strangers. For example, there are massive health effects associated with sharing a kitchen or a bathroom that we know from evidence.

There are multiple areas. They are obviously compounded by poverty and inequality. Many people suffer multiple health issues there. If those issues happen together, they present worse mental health outcomes. Many physical characteristics of properties can give rise to mental health effects in people living there. Loneliness and isolation is another one. It is very hard to understand by evidence, but we certainly know that there are multiple issues for people who are confined to their home for longer, for a range of reasons.

Q213 **James Morris:** I have a quick, follow-up question for David Finch. I think you mentioned the impact on children and the family of frequently moving around. Do we have evidence about the long-term impact on children, things like educational attainment and other characteristics of mental health among children as an impact of that?

David Finch: I will have to refer back and see what we can provide. Often, we make links between different bits of evidence, essentially. We definitely have evidence on the frequency of moves and which children are—

Q214 **James Morris:** I was thinking about children in care, for example. That is an area where we know a lot about the impact of frequent moving on attainment and life outcomes. Is there the same general evidence about the impact? It would be interesting to see whether there was.

David Finch: I can share what we have with the Committee. Often, it is piecing bits of evidence together. We do not have one study that tells us everything, but we know the bits at each point of the mechanism, effectively.

Q215 **Dr Johnson:** I should declare that I was Public Health Minister very briefly last year.

I want to pick up the question about moving around. I am very interested in the children of our military personnel, who always have to move around with their parent who is serving in our armed forces. Does your evidence suggest that it is the moving that is harmful, or is it part of being within a wider unstable social or family circumstance? Do you have any evidence that it is causing harm to the children of military families?

David Finch: Not specifically military families. The types of survey data we are using probably don't have military families within them because of difficulties in collecting their data.

Q216 **Dr Johnson:** How do you know that it is the move and not a generally unstable life that is causing the issue?

David Finch: It is looking at a cohort study that tracks children or families over quite a period of time. You can effectively count how many times those families have moved by the time the child has reached a certain age, and then associate that with other types of outcomes.

There is definitely a world in which you could move a lot but, because your general environment is very stable and supportive, potentially it has less effect on you. The fact that you are moving frequently as well will be associated with other characteristics. What we have not done is completely unpick all the different elements of that. The fact that they are moving is to some extent—

Q217 **Dr Johnson:** It doesn't seem that you have unpicked whether it is the move that is causing the harm or the frequent moves as reflective of the different social issues that cause the harm.

David Finch: That is right. The bit I am referring to has not completely unpicked that, although we will have controlled for some other characteristics which will get at things like income and so on. The two will be closely entwined because, if you are moving frequently, it is going to be suggestive, as you are saying, of some kind of broader insecurity as well.

Chair: Very interesting. Thank you.

Q218 **Mrs Hamilton:** Could I start by following on a little bit from where Caroline left off? David, you have talked about the problems with people living in homes and moving around quite a bit. With the large increase of HMOs and exempt accommodation in certain parts of the country, can you see a link between this and the growth of poor housing and mental health in that area?

David Finch: Sorry; the link between—

Q219 **Mrs Hamilton:** The link between the increase in HMOs, exempt accommodation and poor health and mental health in this sector. You might not be the right person; somebody else may want to come in. Does anybody understand the sector that I am talking about? It is a specific sector that has absolutely blown up since 2018.

David Finch: The HMOs?

Q220 **Mrs Hamilton:** Yes. Has that had an impact on the health of our residents in this country since that time?

Dr Stewart: There is some research in this area, yes. A colleague, Dr Caroline Barratt, has done some research in the area around mental health in HMOs in deprived seaside towns, but there is some evidence from other sources as well. Houses in multiple occupation represent some of the poorest housing conditions we see. Many tenants have very little control over their lives or the ability to get repairs done or any management issues and so on. There is the issue about sharing accommodation, as I mentioned before, with people that you do not know—strangers. There are a lot of transient populations moving around. This presents one of the most challenging areas in housing stock as well. We know that children are living in HMOs.

There are possible interventions, but they can be very time-consuming. It can be hard at times to understand who the landlord is or the person to get necessary works done. It presents the most challenging part of accommodation that we have to deal with. We are also dealing with some challenging tenants as well at times.

Q221 **Mrs Hamilton:** I would carry on, but I am sure that other people may want to take up that point. I have different questions. My questions are for Dr Henry Burridge and Helen Garrett.

Several recent cases have highlighted the issue of a landlord's obligation to fix a repair and hazards in properties that can damage tenants' health. One of you highlighted the young man who died from respiratory problems due to mould. My question is simple. Do you feel that the law is strong enough regarding landlords improving rental property? Dr Burridge?

Dr Burridge: I am not an expert in this matter. All I could say is that there is obviously an issue. I do not know whether the issue is in the strength of the law itself or the ability to enforce the law. In my field we often have lots of regulation, and it is a question of how that is actually enforced. I don't know where the issue lies in this case.

Helen Garrett: I concur with that. The tragic death in Rochdale was due to chronic disrepair and neglect by a social landlord. In theory, it was very preventable. As you say, the law is available and social landlords should be proactive around this. I am not sure if it was a failing of the legislation or just poor housing management.

Q222 **Mrs Hamilton:** Do you feel there should be better policing in this area? If so, and you wanted to get a point across to Government, what would that point be re the policing aspect?

Helen Garrett: I have colleagues who work with local authorities that are trying to identify particularly poor private rented accommodation. It is a huge challenge because a lot of the poorest housing goes under the radar, like the HMOs and so forth. What they tell us is that they do not have the time or the resources. There are challenges. Where does this poor housing exist in the first place? They do not have the data to be able to find the poorest housing. Secondly, do they have the resources and enough skillsets to be able to do the local enforcement that needs to be done? Resources have been mentioned to us as a big issue.

Q223 **Mrs Hamilton:** Could I move to Dr Jill Stewart?

Dr Stewart: There are multiple issues. As we know, the private rental sector has become more complex. It has grown substantially. A lot of people who would traditionally have been housed in social housing are now living in the privately rented sector. That presents us with multiple challenges, one of them being the regulatory workforce—environmental health officers and their colleagues working in local authority housing teams, housing enforcement teams and private sector housing regulation

teams. We know that the workforce are not sufficient to keep up to date with the challenges faced. There is a lot of interest in that at the moment as well. There are major problems.

There is plenty of law. Much of it is under review, as I am sure you will all be aware. There is the decent homes standard and the housing health and safety rating system. We are currently waiting for decisions on that, but we certainly need to focus on who is going to deliver on it and how that is going to happen. There are some real challenges in that area because it is a complex field and requires careful and well thought-through planning and training academically, and practice experience.

Q224 **Mrs Hamilton:** This is my final question. Owner-occupiers can face increased hazards. As someone who headed up social care for a number of years in my area, the issue I found was that if you were a council tenant it was far easier, even though very difficult, to get adaptations done. If you were a homeowner, sometimes, especially if things were means-tested, it was virtually impossible if you did not meet certain criteria. Sometimes people die before getting adaptations, or they may not even be eligible, as I said. Do you believe there is enough support for older owner-occupiers to ensure that their homes remain safe? I will start with Dr Jill, then ask Henry Burridge and finally Helen Garrett. I will then pass back to the Chair because I know others want to push a bit further.

Dr Stewart: Again, it is a really important question. We have a growing older population and more people living into extreme old age. With that comes the need for housing that is suitable and in a good state of repair. That is one thing. It also has to be able to be adapted for changing needs as people enter older age. There are a few different issues going on. We know that people tend to want to stay in their own home for as long as possible independently. We know the costs of people moving into residential care homes, and most people want to stay in their own home. There is multiple research in that area about what could be done.

To keep it brief, there have been grants in the past to support people living in their own home. These have tended to shift to loans, and if they are offered at all—it is discretionary—they are for repairs, keeping the house maintained and repaired. The other thing is adapting—home adaptation—which is different; for example, someone might need a grab rail or a ramp or stairlift. It is fairly small scale, so that they can use their home as designed. The bigger issue might be a disabled facilities grant, but in order to access that a person needs to be registrable as disabled. Many people would not be eligible for it. There are lots of opportunities but, again, we are not sure how it looks across the country for discretionary opportunities for owner-occupiers.

Q225 **Mrs Hamilton:** Do you feel that people actually understand about all those different grants that you have just talked about?

Dr Stewart: We could do with much more information about them, what is available and how to access them. They need to be part of a package

and not just a grant around the house. Somebody who is entering older age will have different healthcare needs and maybe we need to think much more carefully about the personalisation of services so that the services meet the person's need, and the person does not have to fit the services that are available. There are some really good examples where that is working well across the country.

Q226 **Mrs Hamilton:** Thank you for that. Dr Burridge?

Dr Burridge: I simply defer to Dr Stewart's expertise.

Helen Garrett: I totally agree with everything Dr Stewart has said. The homeowner and the problems with hazards in those homes are really the elephant in the room. If you had an environmental health officer who saw hazards in a homeowner's home that were a danger to them or to visitors, you would not enforce anything. The trick is trying to get in the door and recognising those problems. Ideally, you want the sort of hand-holding, holistic approach that Jill mentioned.

There is one case study we became aware of at BRE. I will not go on too long because I know that your time is precious, but it involved a couple. They had not heard about disabled facilities, but the health visitor mentioned them. They went to Aster Living, which helped them to talk through the DFGs. At the same time, they looked at their old gas fire and thought, "That doesn't look right." It was actually giving out carbon monoxide, so they arranged for the local handyman services to come in. They had a little bit of savings themselves; they also went to a local charity. They installed a new heating system, which probably saved their lives. It was done by getting in the door, having that hand-holding service and, as Jill said, making a package to reflect the person's need.

The challenge is getting in the door, educating the people—because they may not know about risk in the first place—and, as I said, having that holistic, hand-holding approach.

Q227 **Mrs Hamilton:** I was not going to ask this, but it is my final point and will help to tie things up. For me, there are too many different areas people can go to in order to get funding. Older people are very proud. They don't like asking for things and prefer not to if they don't have to. If some of this was combined, do you think it would make it far easier for people to access what they need to help with their health going forward?

Helen Garrett: Absolutely. It is like a one-stop strategy, isn't it? You go in the door of one organisation and, as Jill said, ideally you want integration at local level between housing, health and the professionals there. There are some case studies where it works very well. The Local Government Association has good case studies where there is joined-up thinking between housing and health professionals. We talk about data at BRE, but at the end of the day it is about the people behind that data. We produce big numbers, but you make a lot of difference on the doorstep.

Mrs Hamilton: Fantastic. Thank you for that.

Q228 **Paul Bristow:** Following on from Paulette's excellent questions, I want to talk a bit about what has become known as Awaab's law. The young lad who very tragically died was called Awaab Ishak. He died because of excessive mould in his property. It was a housing association property. Awaab's law will ensure that social landlords have to fix mould and damage like that under strict time limits, but the Health Foundation report says that the lion's share of the problem is actually in the private rental market. The Government are looking to legislate through the Renters (Reform) Bill and other things. Dr Stewart, are you the right person to ask? In your mind, how easy would it be to apply this to the private rental sector?

Dr Stewart: The private rented sector is generally older housing stock. Therefore, it can be more challenging to retrofit. We need to understand who the landlord is—I use that term widely—and who is responsible, and then ask the landlord to carry out the relevant works, which might be extensive. First, we would have to understand the causes of damp and mould from the construction and to identify any deficiencies and how to remedy them. The process would be to serve a notice requiring the landlord to do the works. Then there would be time allowed for full compliance. It may or may not be complied with, so there might be an additional time delay if there was a court case, a tribunal or something of that nature.

We already have the housing health and safety rating system. We have statutory nuisance provisions that allow us to enforce on that, but, ironically, it can be quite challenging to prove what we have to in cases of damp and mould in order to issue notices. It is one of those ironies where we do not always have as much data as we need. The housing health and safety rating system is under review, as we know. Hopefully, it will be easier with the revised system once it is in place.

Q229 **Paul Bristow:** You said in your answer to Paulette's questions that this is a complex issue and a complex area. Why is it so complex? Why can't we have a simple system where people are able to live in decent homes? Isn't it the case that if we pulled out of existing regulations and made it much more streamlined and much clearer, solutions could be found and these problems could be overcome?

Dr Stewart: It is a difficult question.

Q230 **Paul Bristow:** Are we asking landlords to do too much? Are we asking them to do the wrong things, when in fact what we actually want is landlords to provide decent homes for their tenants? Are we asking them to do too much or too little?

Dr Stewart: I think it is the right amount. The problem is one of enforcement and compliance. The landlord sector is very varied. We have a whole range of landlords. Some are very good and some are not so good. We need to be able to ensure that the regulatory framework that we have in place works for everyone—for the landlord, for the tenant and

for the local authority. There is plenty of legislation, but it can be challenging to apply, for a complex range of reasons.

Q231 **Paul Bristow:** Perhaps I can put a similar question to David. Why is it straightforward to ask social housing providers to do this within strict limits, but not straightforward to ask the private rented sector to do the same?

David Finch: Dr Stewart covered some of these things. It might seem straightforward to us when it is the social housing sector, but there are still problems of enforcement and quality there as well. Some of it comes down to the enforcement issue. We have had some discussions where it can be hard for tenants to make their problems heard even by the social landlord. That is looking just at the social rented sector. The big difference is that you have fewer—

Q232 **Paul Bristow:** Why is that? Are they useless? Why aren't they responding to simple needs: "I don't need mould in my flat"? If a tenant comes to me, as the Member of Parliament for Peterborough, and says that their house or flat is in a state of disrepair and it is affecting the health of their children, I go bananas. Within 24 hours, the housing association is around there cleaning and solving the problem. Why is that not routine, in your mind?

David Finch: Partly, it is about voice and agency. They almost need someone to champion their cause to get it dealt with at the time. I think that—

Q233 **Paul Bristow:** I'm sorry, I know I am interrupting. Why is that not a matter of course, in your mind? Why does it take someone like a Member of Parliament who has the agency to be able to force social landlords to do that? That is their job, surely.

David Finch: It is a really good question. Some of it comes down to resource, ultimately, and trying to manage cases at that level. It is about having genuine one-to-one relationships between the tenant and whoever is their main contact point in the housing association. It is easier to engage with social landlords because there are fewer of them and they tend to be quite big organisations. That is one big challenge with the private rented sector.

Q234 **Paul Bristow:** It is easier to engage with social landlords.

David Finch: For the Government to legislate. Because you are going through fewer routes, essentially, whereas there are lots of small private landlords, which makes it harder to do. Often it is hard to keep track of who is or is not a landlord.

One advantage in the private rented sector, although we think that it is a disadvantage for health, is that you have more points of churn and change. Things like regulations around electrical standards are being brought in, where certificates are needed before a tenancy changes

hands, so there is a point of change at which you could get in, essentially, or enforce a standard to be met. Potentially, if it is an older property, some quite large-scale changes may be needed.

Q235 **Paul Bristow:** Some local authorities have put together licensing regimes where landlords have to license themselves for various different reasons. One of those might be providing decent homes. What role do you think licensing regimes have in improving the quality of housing for health? Have you done any work or study on the effectiveness of those when it comes to the maintenance of healthy homes?

David Finch: Others may have something to add on this question. What it provides is a lever or mechanism by which you know who the landlords are and have a point of contact at which you can start to enforce things. It then comes down to whether you have all the landlords on your register licensed and whether you can then enforce the quality that you want with them.

Paul Bristow: That sounds like a jolly good idea to me. Helen, you are from BRE, so obviously, you are looking at the technology and how easy it is to do all of this. How easy do you think it is to make the vast majority of homes in the UK, especially in the private rental sector, free from hazards?

Helen Garrett: It is inexpensive in some cases. I have a figure here. About 10% of poor housing can be mitigated for under £350 and about 50% for a few thousand pounds. Some hazards, such as falls from the stairs, can be mitigated quite effectively by putting in new balustrades, handrails and so on.

The cost of retrofitting homes to deal with dampness depends on the cause. Most dampness is caused by disrepair, as opposed to household behaviour. That is one of the things Jill was referring to. There is often a complex interaction between disrepair and household use. To mitigate category 1 damp in the private rented sector, you are talking about £6,000 a dwelling, on average. For some landlords, that could be a sum of money they are not willing or able to part with. If you are thinking about retrofitting homes, a third of the stock in the private sector was built pre-1919. We know that it is going to cost at least £6,000 to bring it up to a decent energy efficiency rating.

Q236 **Paul Bristow:** I have one final question. The wording on your website is "science-led solutions to built environment challenges". That sounds good. Putting myself in the position of the landlord for a second, I was disappointed by how difficult it might be sometimes, especially in the middle of an energy crisis, for a landlord not to force but to make sure that his tenant, who may be struggling with household bills, is using enough heat to prevent mould. The landlord could be doing everything they possibly can to try to keep a decent environment, but the tenant may not be doing everything they can, because of circumstances and because they are struggling financially, to prevent the reappearance of

mould.

Helen Garrett: Under the MEES regulations, from September this year landlords should not be letting out properties below a band E. They have an exemption if they cannot afford to spend more than £3,500, which may not be enough in many cases.

It is not the landlord’s fault, but it is a big problem for us as a society, isn’t it? We are going to have a greater health issue because, with the cost of living crisis and rising energy bills, there will be people living in properties that have a decent energy efficiency rating but they cannot afford to pay the bills. As you say, one of the risks of that is cold air hitting surfaces and causing damp and condensation. There can still be education around that; regular washing of walls, and products that enable damp and mould growth to be alleviated. There are still proactive things that we can do through education and, obviously, financial assistance to overcome that problem, even though the landlord may say, “It’s not my problem.” There needs to be a conversation.

Q237 **Rachael Maskell:** This is really interesting evidence. Thank you all for your responses so far. It seems that we need one controlling mind over the system and, at the moment, there are too many. It also seems that there is a lot of confusion about the objective and that health is not a prime factor in that.

Helen, I want to start with you and ask about the issue of densification. We have gone through cycles of building high and then determining that that is not positive and coming down. Now we are again seeing more densification. What is the impact of building high on communities, on loneliness and on individuals? Do we have a strong and robust enough evidence base to ensure that we are directing Government policy well in this area?

Helen Garrett: That is not my field of expertise. I can certainly ask wider BRE to see what research may have been done in that area.

Q238 **Rachael Maskell:** Does anyone have expertise in that area? The answer is no, so we will come back to your colleague. That would be really helpful. I appreciate that.

I want to ask a question about levers for bringing in change. We have this whole regime of mechanisms. We have heard about the lack of voice and agency. Clearly, it is not a proactive approach, particularly around the multiple challenges that we see. I am regularly contacted by constituents about antisocial behaviour noise and the impact that has on their mental health. Neighbours with substance misuse or mental health issues are a classic example, but we know that building mixed communities is a way of building stronger communities. I will start with Jill, if I may. What are the levers that we need to ensure that we have enforcement around creating safe environments for people to live in, when mitigating against the multiple risks that we are increasingly seeing?

Dr Stewart: Is your question about antisocial behaviour—

Q239 **Rachael Maskell:** My question is about the levers that we need to ensure that those risks are dealt with. The framework at the moment is clearly not sufficient.

Dr Stewart: There are lots of possibilities in place, one being the licensing regime we have just started to hear about. There are three sets of licensing: mandatory licensing for HMOs, additional licensing, also for HMOs, and selective licensing. There is some research around selective licensing, which is where either the whole or part of a local authority area addresses its private sector housing stock through a licensing regime and can apply conditions. One of the benefits we know of from evidence is that it can have effects on antisocial behaviour by helping to provide some cohesion to the area. That is one wider geographical intervention that we have at the moment.

There is provision under statutory nuisance legislation around noise. However, it can be hard to prove, which is where many of the frustrations come in. We would have to be certain that the relevant criteria were met, and that a nuisance was actually in place before issuing a notice and then enforcing on it. The person alleging the nuisance may not wish to wait a period of time before the notice can be enforced.

There are provisions around antisocial behaviour as well. With a partnership approach, local authorities, police and many other organisations and agencies can intervene with some success, but obviously it tends to be reactive.

Q240 **Rachael Maskell:** What additional measures would you want to see in place to ensure that we maintain good environments for tenants?

Dr Stewart: I suppose it comes back to where we started with this: having good, well-designed environments in the first place, with appropriate supports across all policy areas—education, social services, policing and planning—so that we create environments that help to develop the citizens of the future, if you like.

Q241 **Rachael Maskell:** Henry, can I ask you the same question, particularly if we think about some of the climate challenges that we are seeing? Some of those are around air quality, especially indoor air quality, but increasingly we are seeing challenges around heat. If we think about the future, given the rate at which the climate is heating up, that is going to present a major challenge around ensuring that people, particularly older people, are safe in their homes. What are the levers that you would ask Government to provide to ensure that we can have safe housing for tenants?

Dr Burridge: There is a balance when you talk about energy consumption, climate change and indoor air quality. There is at least a perception that the quickest way to save energy is to seal buildings. That puts residents at risk from indoor sources such as damp and mould. You

are right that climate change also brings the challenge associated with overheating and that elderly and vulnerable residents are most at risk. Off the top of my head, I cannot think of any particular levers that need to be implemented immediately.

Q242 **Rachael Maskell:** It is not working currently. We know that people are dying in their homes because of poor air quality and even heat, so surely we must say that there could be improvement.

Dr Burridge: Yes. We know that ventilation is key to mitigating both of those opposing aspects, and that when we measure buildings a huge percentage of them do not adhere to current building regulations. My personal view is that a priority would be to see existing building regulations better enforced and assess the impact of making that change. Then we can quantify what further changes, if any, need to be made to the building regulations themselves.

Q243 **Rachael Maskell:** David, I will end with you if I may, with a similar question about the enforcement regime. What do we need in place? I thought that what you said about agency and voice was very powerful, because that is a major challenge for a population that is particularly disadvantaged in the first place and is then placed in some of the worst housing conditions. If those people then raise their voice, they could lose their home as well. Jill said that enforcement is quite reactive. What external proactive enforcement regimes could be introduced to protect the most vulnerable people and ensure that they have good health in their housing?

David Finch: I was almost thinking of this as being not so much about the enforcement side of it. Part of the problem is that there is a whole range of factors. Ideally, you would not be putting people into poor-quality homes in the first place. It definitely goes back to that. There should be different approaches for different sectors as well. That is probably an easier way. The social rented sector tends to be one of the best for quality, as it is easier to enforce some of those standards. I suppose it is partly about making sure that the funding is there and available for social landlords to make changes.

On the tenants' voice point, part of the Renters (Reform) Bill is around trying to ensure that there is a greater obligation to respond to that. There is probably something around social landlords offering open forums and more possibilities to engage and check on the quality of housing. The broader point is that different sectors need slightly different approaches. If you are talking about homeowners, you are more in the range of potential subsidies or incentives to try to get people to change and improve the stock.

There is also a broader point, which comes down to the complexity of some of this. We have talked about agency. Some of that is around wider pressures people may be under and experiencing. It can come down to things relating to their income or their work. It could be to do with

children and schools. There is a need not to think that there is ever going to be one single thing that can be done. Some of it is about alleviating some of the pressures that are making it hard for people to engage with these issues in the first place, and to have the time to make a difference.

Q244 **Rachael Maskell:** This is my very last question to you. Do you think that there is a malaise and reluctance in landlords, private or social, in responding to these needs, because of their resource base? Are they therefore pushing the problems down the road, as opposed to owning them and talking about the challenges that they face?

David Finch: There has definitely been a reduction in the resources that the social housing sector has available. Obviously, you have some quite significant cost pressures in the private rented sector, where landlords may be picking up on things.

I would probably point more to the fact that there is a general difficulty with people thinking longer term. Although there may be things that can be done in the shorter term to alleviate problems, a lot of the issues are about taking a very long-term approach to trying to address what are really long-standing problems. The decent homes standard was brought in in the early 2000s, but we have not yet got to the point where everyone is meeting it, and now it is probably out of date. That points to the need for thinking properly long term, across all the different actors in this space.

Q245 **Dr Johnson:** I want to ask some questions about housing density. We keep hearing that we need to have houses built more densely and that we need more houses. I want to ask about what effect that has on people's health. When houses are built more densely, they often have a much smaller downstairs footprint, without a downstairs loo or extra spaces for people who, if they are ageing, want to sleep downstairs, for example. We also see that, where they are building more flats, people have no outside space to dry clothes, which contributes to damp and mould. Is housing density bad for our health, Dr Burridge?

Dr Burridge: I am not an expert, so I will defer to someone else. I think that it is not inherently bad for our health. We have technologies and designs that can cope with providing dense living environments that are healthy. Would anyone else like to comment?

Dr Stewart: I don't know whether there is evidence per se. Obviously, lots of things have happened in history about how we design houses with space standards. We can think about the inside of the actual house or flat, but there is also the space outside that people have to use. It is a question that goes beyond the issue of space in itself.

We need to think about denser living environments, some of which are really successful and have been well designed. We have examples of that as well. We need to think more about what provision people living in high concentrations have and what demands they have for local services. That

is an issue as well. Are there enough school places, doctors and social services and everything else that we need to live a healthy life? It goes beyond the question of whether or not it is a dense development.

Dr Johnson: Yes. It just strikes me that if you have more people living in a more densely packed environment, you are going to get more noise, more traffic, more air pollution and more difficulties drying clothes outside and, therefore, more damp and mould, as well as more irritation and general annoyance from other people being around you and walking on the floor upstairs and making a noise when they come in late, or you are working nights or whatever. There are more challenges for houses when people age, particularly if you look at my rural constituency. We are building lots of small-footprint houses, which are a bit more difficult. People may retire to the area at 60, fit and healthy, but by the time they are 80 and have difficulty with stairs it becomes much more challenging. I am not really sure that we are meeting the requirements for that.

Chair: I was going to ask you a bit about planning, but we will talk to the Town and Country Planning Association about that at some point. A lot of the questions today have touched on that a little. I was struck by a quote from Chris Whitty, the chief medical officer, who said, "If you look back over the last 150 years, more has been done for public health by proper planning than almost any other intervention." That is quite an interesting point.

That is a tease ahead to where we go next on this particular workstream. For today, thank you to my colleagues, but most of all thank you, Dr Jill Stewart, Dr Henry Burridge, David Finch and Helen Garrett for giving evidence and talking about prevention of ill health and healthy places in particular. We will continue this in the coming weeks. Thanks very much for joining us.