Think Housing First

Reducing health inequalities through access to good quality and affordable housing

2013 – 2015

Joint Policy and Planning Board (Housing)

Working with Partners across Kent

Kent Housing Group

The Voice of Housing in Kent

Contents

Foreword

Roger Gough

Chair of the Kent Health and Wellbeing Board

Improving health and reducing the health inequalities that still exist in different areas of Kent is at the heart of all of our collaborative work. We all have a role to play, whether we work at county or district level and whichever organisation we represent.

With responsibility for public health having moved from the NHS to Kent County Council in April 2013, we have an even greater opportunity to focus on the things that we can do to prevent illness and increase healthy life expectancy across the county. Local Government has long seen its housing role as a vital part of the health improvement agenda and the return of public health functions to Kent County Council gives us an opportunity to renew this tradition.

The relationship between poor housing and ill health is well documented. Poor housing can lead to an increased risk of cardiovascular and respiratory disease as well as to anxiety and depression. Problems such as damp, excess cold and structural defects also present hazards to health.

Housing colleagues are central to many health improvement issues including preventing falls, linking homeless households to GP services, the provision of accessible and safe green spaces and play areas and preventing unnecessary hospital admissions.

Professor Chris Bentley has been working with the Kent Health and Wellbeing Board to demonstrate a number of models to help us to understand and reduce the health inequalities gap in Kent. Think Housing First supports and complements Kent's Health Inequalities Action Plan, 'Mind the Gap' produced by Kent County Council in collaboration with district councils and a wide range of partners.

Think Housing First reflects the important role that housing has in the lives of the people of Kent and illustrates the breadth and range of initiatives that can be delivered across the public and private sector to play a part in reducing health inequalities.

John Littlemore

Chair of the Kent Joint Policy and Planning Board (Housing) (JPPB)

In March 1840, the Government was so concerned about sanitation and living conditions that it set up a Parliamentary Health Select Committee to report on the Health of Towns. Its findings revealed the scale of overcrowding, and the descriptions from health specialists drew a vivid picture of the extreme filth and disease that resulted in widespread death.

The links between health and housing remain very real today and it was for this reason that the Kent Joint Policy and Planning Board (Housing) (JPPB) was instigated, to better promote a strategic partnership between health, housing and social care.

Together with the Kent Housing Group, the JPPB was pleased to be invited by its health partners to develop this action plan, which focuses on how the housing sector can play its part in reducing health inequalities in Kent.

The condition and location of our homes can have a fundamental impact on our health. Yet the gap between the housing haves and have-nots is widening and there is a danger of it becoming entrenched for generations. We know there is a strong correlation between housing inequality and health inequality. Neighbourhoods and housing matter to health in many ways from homelessness, the physical attributes of housing failing to provide adequate, safe, dry, warm and not overcrowded accommodation to neighbourhoods with concentrated disadvantage, where services are overburdened, basic amenities in short supply and issues such as high crime, challenging schools and poor transport mar the life chances for many.

Think Housing First creates a framework and understanding of the role of the housing sector and provides the opportunities for sharing good ideas, support and resources to support the impact of our housing on health inequalities.

1. Introduction

About Think Housing First

It is a well known fact that housing is intrinsically linked to health inequalities. It is one of the many reasons for the existence of poorer health outcomes between different population groups. In short, without access to good quality and affordable housing, the chances of enjoying good health and a long life are hindered.

Think Housing First sets out the role of the housing sector; the relationship between health inequalities and housing; and what can be done in Kent in addition to current housing interventions under the action plan.

It is an action plan that very much builds on the good work already being undertaken in the overarching Kent health inequalities action plan **Mind the Gap** (2012-15) which takes account of all of the strands affecting population health outcomes. Think Housing First presents a more in-depth look at the housing strand in particular, to complement the efforts of Mind the Gap.

Local needs and priorities will of course be different in each district of Kent as health inequalities exist in varying degrees across the county, which is why each district is developing their own local health inequality plans. It is the intention that Think Housing First will be a reference point on the housing strand, recommending actions that can feed into emerging and future district plans, and delivered locally.

Think Housing First also complements the Housing Renewal theme of the **Kent and Medway Housing Strategy** (2012-15) which tasks the JPPB to 'promote with the Health and Wellbeing Board the importance of housing conditions to quality of life and health outcomes and establish stronger links and closer working relationships with health agencies'. This action plan is testament to the joint effort being made between housing and health to deliver a more targeted and focused approach to the health outcomes of the Kent population.

Why housing is important

Many of the people that the housing sector work with will be those who are living in deprivation, are hard to reach, and most affected by health inequalities. This is why the housing sector is well placed to contribute towards reducing the disparities in health.

Reducing health inequalities through housing can also bring economic gains to health care budgets. It is estimated that poor housing costs the NHS at least £600million per year[i], but by spending relatively modest sums through housing can give real cost benefits to health.

Vision

The vision is to raise the profile of 'thinking about housing first' in addressing health inequalities in Kent. In doing so the aims are:

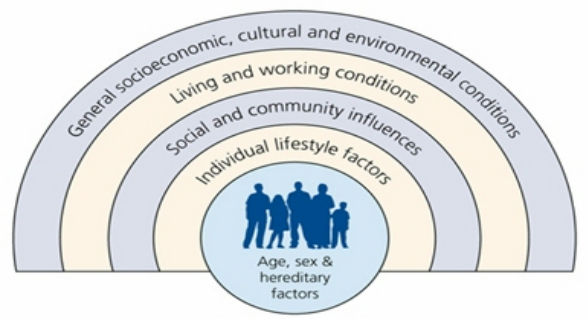
- To take advantage of the new opportunities, driven by the recent health reforms, for housing to strengthen collaboration and engagement with health
- To maximise the contribution of housing in improving people's health and wellbeing
- To raise awareness to health colleagues of the role of the housing sector
- To reliably inform commissioning priorities and decisions, by demonstrating how investing in housing can save in health bills

2. Background

What are health inequalities?

Health inequalities are disparities in health outcomes between individuals or groups. They arise from differences in social and economic conditions that influence people's health behaviours and lifestyle choices, their risk of illness and actions taken to deal with illness when it occurs. Those differences are not inevitable and are therefore considered unfair and avoidable.

In general, having a higher socio-economic position will make you more likely to enjoy good health, including mental health, and a longer life (the social gradient of health). Determinants that impact on health inequalities include lifestyle, access to services, and socio-economic and environmental factors such as educational attainment, employment status, income levels, and **housing**. Addressing the determinants of health, such as housing, is one of the crucial elements in reducing health inequalities.



Dahlgren and Whitehead (1991)

The Marmot Review

The Marmot Review (Fair Society, Healthy Lives, 2010) proposed an evidence-based national strategy to reduce health inequalities. It recognises that disadvantage starts before birth and accumulates throughout life and action must be universal with a scale of intensity proportionate to the level of disadvantage. The policy objectives proposed to reduce health inequalities are:

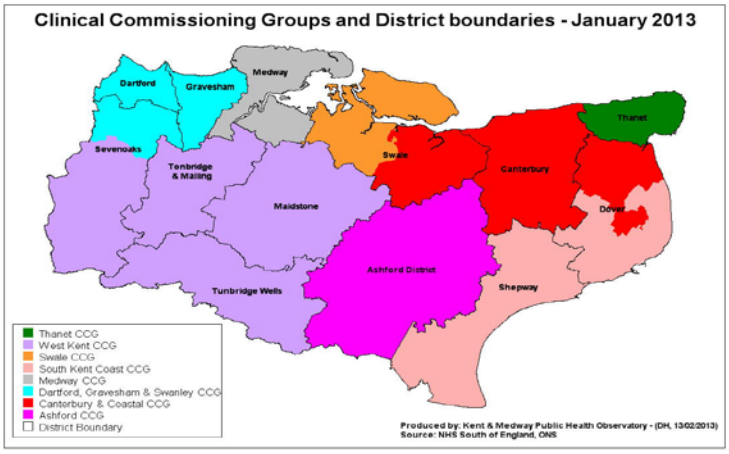
1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

Health inequalities in Kent

Kent is ranked 102 out of 152 authorities in the English Indices of Deprivation (2010) making it within England's least deprived third of authorities (a rank of 1 being the most deprived). Still there are significant areas in Kent that fall within the 20% most deprived in England.

Overall Kent has a good standard of health but there are pockets of considerable areas of poorer health and life expectancy. For example, a man living in a deprived area in Kent will live on average 8.2 years less, and a woman living in a deprived area will live on average 4.5 years less.[ii]

Public health in Kent



The Health and Social Care Act 2013 established the creation of Health and Wellbeing Boards with effect from April 2013. This essentially moved public health services into the responsibility of upper tier local authorities to enable closer working between health and local government.

The **Kent Health and Wellbeing Board** has oversight of all health care and public health activity in Kent. It also provides advice and information to the seven Clinical Commissioning Groups (CCGs) across Kent that have responsibility for commissioning services to improve the health and wellbeing for their local areas. Medway, as a Unitary authority has one CCG. The CCGs work with local Health and Wellbeing Boards reflecting the same geography to help determine their local health and care priorities.

- **Thanet CCG**
- **West Kent CCG**
- **Swale CCG**
- **South Kent Coast CCG**
- **Medway CCG**
- **Dartford, Gravesham & Swanley CCG**
- **Canterbury & Coastal CCG**
- **Ashford CCG**

The Kent health inequalities action plan **Mind the Gap** (2012-15) sets out how Kent will tackle health inequalities. This is informed by the **Joint Strategic Needs Assessment (JSNA)** which analyses the health and wellbeing of the Kent community and the strategic direction of service delivery. Each local district in Kent is also developing their own health inequality plans to address local need.

3. The role of the housing sector

The housing sector encompasses a range of organisations including local housing authorities, housing associations (registered providers) and the voluntary sector. They carry out a wide variety of interventions that enable people to access suitable housing, help them to sustain their housing, and ensure it is of a decent standard thereby contributing towards good health.

Homelessness

Homelessness advice and assistance

Local housing authorities have a legal duty to secure accommodation for homeless people and people threatened with homelessness if they are eligible for assistance, not intentionally homeless, have a local connection and are in priority need, which includes people who are:

- Pregnant (and people who live with them)
- Responsible for dependent children
- Made homeless by fire, flood or disaster
- Vulnerable due to old age, mental illness, physical disability or other special reason
- Vulnerable due to time spent in care, in custody or in the HM Forces
- Vulnerable due to fleeing their home because of violence or threats of violence
- Aged 16 or 17 (unless the young person is a 'child in need', 'looked after' or a 'relevant child') and care leavers under the age of 21

Housing Options teams will give advice and assistance to homeless people and those seeking accommodation. At least every five years local housing authorities also carry out a review of homelessness in their district and publish a strategy for preventing homelessness.

Joint homeless protocols

Local housing authorities and other partner agencies have signed up to a set of joint working **homeless protocols**. Developed by the JPPB, these protocols ensure a consistency of working between partner agencies across Kent in the prevention of homelessness.

Housing related support

Housing related support helps vulnerable people live independently, sustain their accommodation, and prevent the problems that can cause homelessness. Services can be accommodation based, floating support, Home Improvement Agency and handyperson services and community alarms.

Affordable housing provision

Supply of housing

Registered providers, who are housing associations and local housing authorities with retained stock, are the suppliers of social housing. Local housing authorities work with registered providers and developers to enable the provision of new affordable housing based on the vision and plans for current and future housing need set out in their housing strategies. Local planning authorities create local planning policy and determine what development takes place on all tenures of housing.

Housing allocation schemes

Local housing authorities work closely with housing associations to allocate social housing in their areas to local people in housing need using the choice based lettings service, **Kent Homechoice**. In allocating social housing, reasonable preference must be given to people:

- Who are homeless (within the meaning of Part 7 of the Housing Act 1996)
- Owed a duty by any housing authority under s190(2), 193(2) or 195(2) of the 1996 Act (or under section 65(2) or 68(2) of the Housing Act 1985) or who are occupying accommodation secured by any housing authority under s192(3)
- Occupying insanitary, overcrowded or living in unsatisfactory housing conditions
- Needing to move on medical, welfare, and disability grounds
- Needing to move to a particular locality, where failure to do so would cause hardship

Local housing authorities can on occasion also facilitate a move through the **Kent Agency Assessment**, which is a way for health and social care agencies to refer service users with housing related health and/or support needs for help accessing suitable accommodation.

Private Sector Housing

Local housing authorities have a duty to review housing conditions in their district and to take enforcement action where hazards are identified in the home. The main hazards identified in private owned housing are cold, dampness, falls, and fire safety. Local authorities have identified a number of methods of dealing with poor quality housing through the implementation of initiatives to enhanced enforcement action.

Housing, Health and Safety Rating System (HHSRS)

The HHSRS is a risk assessment tool that is used to assess potential risks to the health and safety of occupants in all tenures and covers 29 potential hazards in the home. Most local authority activity is focused on design with the private rented sector as this sector often has the poorest housing conditions and often the most vulnerable members of the community. The local housing authority has a duty to take enforcement action where a serious hazard exists (category 1).

Green Deal

In Kent, the Green Deal Partnership (KMGDP) supports residents to take advantage of this initiative. Green Deal allows households to make energy saving improvements to their home without paying the costs upfront. A loan for the improvements is taken out and then paid back though the electricity bill. The amount paid back should be no more than the typical household will save on heating bills as most improvements will mean less energy is being used.

Extra support may be available from the Energy Company Obligation (ECO) which is an energy efficiency programme working alongside Green Deal, for those households where the savings will not be achieved to make them better off.

Accreditation schemes

Most local housing authorities in Kent have landlord accreditation schemes. These are designed to improve the quality of the private rented sector by recognising well maintained and managed properties through awarding accreditation and benefits to the landlord (e.g. discounts on local services). These schemes also enable prospective tenants to identify good quality homes.

Licensing

Local housing authorities are required to operate mandatory licensing schemes for Houses in Multiple Occupation (HMOs) which have three or more storeys and are occupied by five or more persons forming two or more households. The licence ensures that the HMO is managed appropriately by a fit and proper person, and it is suitable for occupation by a specified maximum number of people. The local authority can take over the management of the HMO if it is unable to grant a licence.

Discretionary licensing schemes can also be designated. There are two types:

- Additional licensing – where an authority can require other types of HMOs to licence that fall outside of the mandatory scheme mentioned above. This can occur where there is evidence that there is a significant proportion of HMOs that are not being managed effectively, creating one or more problems to the residents or the community
- Selective licensing – these schemes can be designated in areas experiencing low housing demand and/or suffering from anti-social behaviour. This covers all private rented housing in the selected area

A selective licensing scheme has been put in place for the two most deprived areas in Kent, Cliftonville West and Margate Central in Thanet.

Safe and accessible housing

Disabled Facilities Grants (DFG)

DFGs are a mandatory grant that local housing authorities administer to improve the homes of disabled adults and children. The grants are means tested (apart from in children's cases) and can cover works that help to reduce hazards that lead to falls in the home such as the provision of stair lifts, replacing baths with level access showers, ramps or safer access.

This is a limited amount of funding and some districts have long waiting lists with applicants waiting a considerable time for the works to be carried out. Some local housing authorities do offer discretionary grants or loans that cover adaptations for falls prevention but they are usually based on limited eligibility criteria.

Changes to the funding regime are planned from 2015-16 where DFGs will be included in the new Integration Transformation Fund. This will be administered by top-tier local authorities (Kent County Council) as opposed to lower tier local authorities, as a single pooled budget for health and social care.

Housing Assistance

Some local housing authorities offer discretionary grants and/or loans to help households improve their home. The help is often targeted at low income households for making homes warmer, cutting fuel bills and/or to reduce hazards in the home that can, for example, lead to a fall or fire.

Private sector housing teams are also often involved in cases of vulnerable households who hoard and usually as a result of hoarding are living in poor, unsafe conditions. Local housing authorities have statutory powers under Public Health legislation in certain cases to take action. In most cases officers work alongside agencies such as GPs, Social Services, Kent Fire & Rescue Service and Home Improvement Agencies to gain the trust of the household and work with them to help improve their living conditions.

Home Improvement Agencies (HIA)

HIAs assist applicants with their DFG application and submit this to their local housing authority for approval. They help older, disabled and more vulnerable people repair or adapt their homes; run handy person, affordable decorating and gardening services; and signpost and refer to other services.

HIAs also deliver the Winter Intervention Support Kent (WISK) programme in partnership with Kent County Council and Age UK. Their role includes visiting people over 75 years with an underlying cardiac or respiratory condition to assess what support and assistance is needed to and then delivering a range of interventions to prevent excess winter deaths.

Referral schemes

Your Home Your Health

Your Home Your Health was designed in partnership with health, social care and housing and has been piloted in Thanet as a multi-agency referral scheme between housing, health and social care. When households are visited, a form is used to collect in-depth information about the condition of the property, security, health of the household, and their access to services. The data is collated and referrals are then made to partner agencies.

HELP

HELP is a referral system used by Ashford and Swale through Kent Homechoice that enables referrals to be made to various agencies and monitored. Referrals are made to advisory, employment and training, financial, housing, support, and health services.

4. How housing impacts on health inequalities

The social gradient of health means that the lower a person is on the socio-economic scale, the higher the chances they will smoke, lack physical activity, have poor nutrition, drink too much alcohol and misuse substances. These health behaviours contribute to the development of chronic illness leading to an earlier death.

Health inequalities can be compounded by the type of housing (or lack of housing) and communities in which people live. The people most vulnerable are those who are homeless; or living in poor quality or stressful housing conditions; or living in neighbourhoods that discourage a healthy lifestyle; or living in relative poverty with expensive housing and high living costs. Such disadvantages influence health behaviours, but they also influence the risk of developing illness and having accidents in the home, and the action taken on health problems when they arise.

In 2011, the Health Inequalities National Support Team produced 'Housing and Health'[iii], an evidence based workbook, which is a useful reference point to demonstrate the robust links between the key housing factors affecting health. These are expanded in the sections below with recommendations for further action.

Mental health and wellbeing

It is important to recognise that as well as disadvantages in housing having an impact on physical health and life chances, they also have an influence on mental health and wellbeing. Resilience levels will deteriorate and place a person at risk of poorer mental health, such as depression and anxiety, or exacerbate existing mental health conditions, if they are homeless or living in stressful housing conditions. The impact on mental health is a recurring theme throughout the issues covered.

Objective 1: Reduce the negative impact of homelessness on health

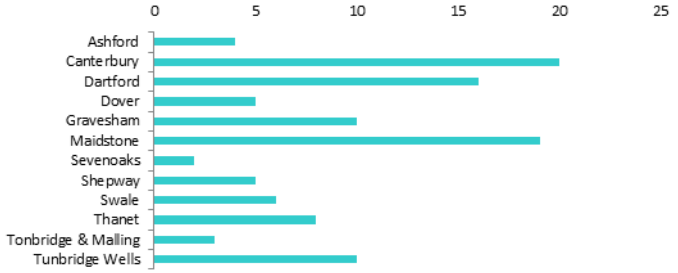
Rough sleeping

Rough sleepers experience significant health inequalities. They have higher rates than the general population of hepatitis, hypothermia, pneumonia, respiratory disease, tuberculosis, poor condition of teeth, skin conditions, infection, poorer mental health, greater prevalence of smoking, alcohol and substance misuse, and injuries following violence. The average death of a rough sleeper is 47 years, which is on average 30 years before the general population[iv].

The transient nature of rough sleeping and a lack of an address make it difficult for rough sleepers to register with GPs and receive primary health care services. Rough sleepers will instead access secondary acute health care services, such as A&E, for non-emergency health problems and again when conditions have worsened and reached crisis point. It is also more difficult to achieve a continuation of care once rough sleepers have been discharged from hospital. 70% of rough sleepers are discharged back onto the street without their housing or on-going care needs being properly addressed[v].

Because of barriers to accessing primary health care services, an overreliance on acute health care services costs more to health budgets than the general population. It is estimated that rough sleepers use acute health care services four times more than the general population and use inpatient health care services eight times more, staying in hospital three times longer at a cost of around £85.6million per year[vi].

The Kent picture – rough sleeping[vii]



It was estimated that on a single night in Kent in 2012, there were 108 people sleeping rough. Canterbury and Maidstone had the highest levels of rough sleeping. Although, this is a snapshot on a given night and could fall short of the numbers that local agencies working with rough sleepers record over the year

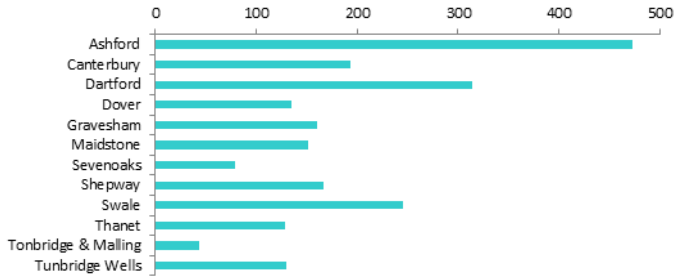
Homeless households in temporary accommodation

Homelessness can also be hidden from view in the form of sofa surfing or squatting and living in temporary accommodation such as hostels, bed & breakfast and other types of short term leased accommodation. The stress, insecurity and expense of being homeless and living in costly temporary accommodation can impact on health. 49% of a survey of households living in temporary accommodation said their health had suffered due to living in temporary accommodation. More than half (56%) said they were suffering from depression[viii].

Homeless households in temporary accommodation moving from one address to another can lose touch with primary healthcare services such as GPs, and so access secondary health services when problems become worse. As a consequence, children living in temporary accommodation are more likely to miss out on immunisations, which can have serious implications for their future health. And, children are at greater risk of infection, skin disorders, and experiencing difficulties at school whilst living in unsettled accommodation[ix].

Due to a lack of supply of available affordable social and private rented accommodation, people stay in temporary accommodation for longer periods than they should, exacerbating their health conditions. The impact of the welfare reforms could see the availability of temporary accommodation being further squeezed due to households migrating from more expensive areas, such London, in search of cheaper accommodation in Kent.

The Kent picture – Homeless households in temporary accommodation[x]



In 2012, there were 1,015 households accepted as homeless and in priority need in Kent. Of the households who asked for assistance, a total of 2,220 were placed by local housing authorities in temporary accommodation in Kent. Ashford and Dartford had the highest number of households in temporary accommodation

Recommendations

1a Improve access and registration with GPs for rough sleepers
1b Take primary health care services to where rough sleepers are
1c Make plans for accommodation for rough sleepers upon hospital admission
1d Raise awareness of health, housing and support services available to rough sleepers
1e Link homeless households in temporary accommodation to GPs
1f Improve identification of people in housing need who have mental health problems
1g Raise awareness of resources for promoting healthy mental wellbeing

Objective 2: Encourage people to live in homes with good air quality

Smoking

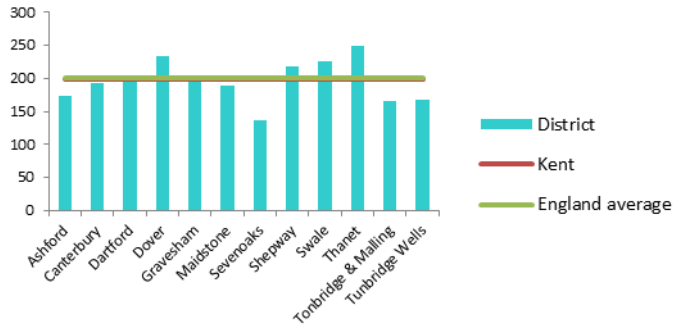
Smoking contributes to three main health problems; lung cancer, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Smoking during pregnancy increases the risk of low birth weights, miscarriage and perinatal death. Smoking after pregnancy increases the risk of sudden infant death syndrome. Second hand smoke can increase the risk of cancer, and, children exposed to second hand smoke are particularly susceptible to developing respiratory illness, impaired lung function and middle ear disease (glue ear).

29% of men and 26% of women in routine and manual occupations smoke compared to 14% of men and 12% of women in managerial and professional occupations[xi]. Smoking is the principle cause of the inequalities in death rates between the rich and poor and accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Estimates on the cost to the NHS of treating diseases cause by smoking ranges from £2.7billion to £5.2billion a year[xii].

Emotional stress, anxiety and smoking are linked with living in stressful housing. For example, living in poor quality housing, suffering anti-social behaviour, the inability to afford housing costs, and having insecurity of tenure are all stress factors that increase the chances of smoking.

The type of housing a person lives in can compound the effects of second hand smoke. Factors that can give rise to poor air quality within the home are a lack of ventilation and air cleaning, and living in accommodation without access to the outdoors to use (such as a garden or balcony) to prevent household members inhaling second hand smoke. Homes with high radon levels increase the risk of developing lung cancer, particularly among smokers. And, the risk of accidental injury and death because of a fire in the home is also heightened due to the careless disposal of cigarettes.

The Kent picture – Smoking related deaths[xiii]



Smoking related deaths in Kent in 2013 are not significantly different to the England average. Yet there are a higher number of deaths than the England average in East Kent. Smoking during pregnancy is also worse in Kent than the England average with 15.2% of mothers smoking in pregnancy compared to the England average of 13.3%

Tuberculosis

Tuberculosis is an airborne infection spread through coughing and sneezing. In most healthy people the immune system kills the bacteria and there are no further symptoms. But if the immune system cannot kill or contain the infection, it can spread to the lungs or other parts of the body turning into active tuberculosis. Left untreated, tuberculosis can be fatal.

Social risk factors that make certain people more vulnerable to developing active tuberculosis are those who lack consuming food rich in protein, vitamins and minerals; those who take drugs, smoke or abuse alcohol; and those with a lack of access to healthcare. These factors can weaken the immune system making the body less able to kill the infection.

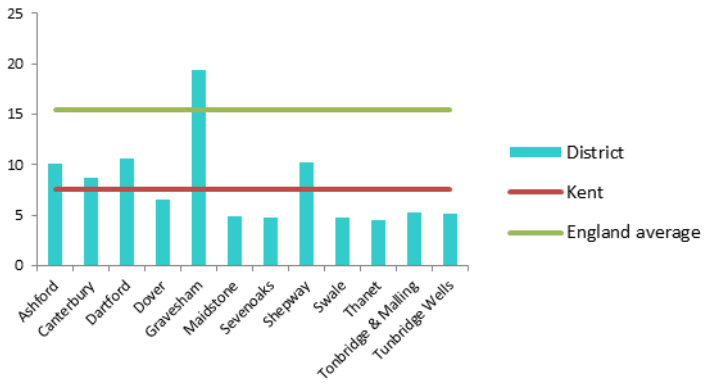
People who have tuberculosis are more likely to be homeless people and those living in poor housing, overcrowded housing and houses in multiple occupation (HMOs), where the infection can be spread more easily. Areas with higher rates of migration or established communities originating from countries with higher tuberculosis levels are also likely to experience higher rates of the infection.

Rates of tuberculosis have stabilised in the UK over the past few years following the increase in incidence from 1990 to 2005. However, despite efforts to improve tuberculosis prevention, treatment and control, it remains high compared to most other Western European countries.

Although tuberculosis incidence levels are low, it can be a costly infection to treat. Uncomplicated cases usually require a six month course of antibiotics costing around £5,000. Left untreated or if the course of antibiotics is not completed, the tuberculosis is more likely to become complex or drug resistant, requiring more intensive and expensive treatment that can cost between £50,000 to £70,000 per case[xiv].

People who lead chaotic lives such as the homeless or those living in overcrowded and insecure housing may be less likely to know the symptoms of tuberculosis and/or seek assistance for early diagnosis. If they do, they may have a lower chance of completing the course of treatment because of their lifestyle.

The Kent picture – New cases of tuberculosis[xv]



Overall, the rate of tuberculosis in Kent in 2013 is significantly better than the England average. However, Gravesham experienced levels of tuberculosis that were significantly worse than the England average

Recommendations

2a Promote smoke free homes
2b Prevent accidental deaths due to fire caused by careless disposal of cigarettes
2c Provide information to at risk households on recognising the signs of tuberculosis

Objective 3: Ensure homes are warm, dry and free from hazards

Excess winter deaths

Excess winter deaths are the difference between the number of deaths during the four winter months (December to March) and the average number of deaths during the preceding months (August to November) to the following four months (April to July).

The main causes of mortality from excess winter deaths include cardiovascular disease, circulatory disease and respiratory disease. Being cold can also raise blood pressure and clotting which increases the risk of heart attack and stroke, exacerbate existing cardiovascular conditions, impair lung function, trigger bronchial-constriction in asthma and COPD, worsen the symptoms of arthritis and impair mobility.

Damp and cold housing is thought to be a significant contributor towards excess winter deaths, especially among older people over the age of 75 who are at the greatest risk and suffer the highest rates of mortality.

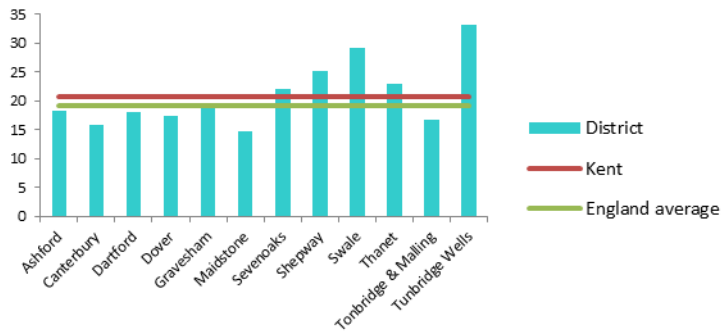
Damp housing can be caused by poor maintenance such as a leaky roof or from water from the ground getting into floors and walls. Condensation can also cause dampness and lead to black mould forming. This increases the risk of causing or exacerbating asthma and other respiratory illnesses due to the inhalation of the mould spores. Sometimes this is just a matter of education around how to prevent condensation but can require increased ventilation and heating.

Energy inefficient homes and fuel poverty are the primary factors of living in cold housing. Fuel poverty exists when a household has to spend more than 10% of its income on fuel to adequately heat the home (although this definition has been challenged by the Hills Poverty Review 2010 because it does not take account of rising fuel prices).

But relative deprivation is not necessarily associated with all excess winter deaths. Those who are most affected are some of the most affluent, such as single person households living in under-occupied larger homes and owner occupying asset rich and cash poor households. Fuel poverty is also prevalent in rural areas where households are less likely to be connected to mains gas and are reliant on more expensive fuels such as heating oils and solid fuel.

Age UK estimates that cold homes are costing the NHS in England £1.36billion every year[xvi]. Deaths caused by this are preventable through improving heating, insulation and addressing fuel poverty. The Kent Health and Affordable Warmth Strategy (KHAWS) (2013-15) is in place to work across partners in Kent to put in place programmes to reduce excess winter deaths; link affordable warmth measures to the falls prevention framework; increase awareness amongst households and professionals of the health risks associated with excess cold and the services available; and help disadvantaged groups access all the benefits and services available to them.

The Kent picture – Excess winter deaths[xvii]



In Kent, the level of excess winter deaths in 2013 is slightly higher than the England average. Districts that have significantly higher levels of excess winter deaths above the England average are Tunbridge Wells, Swale and Shepway.

Falls

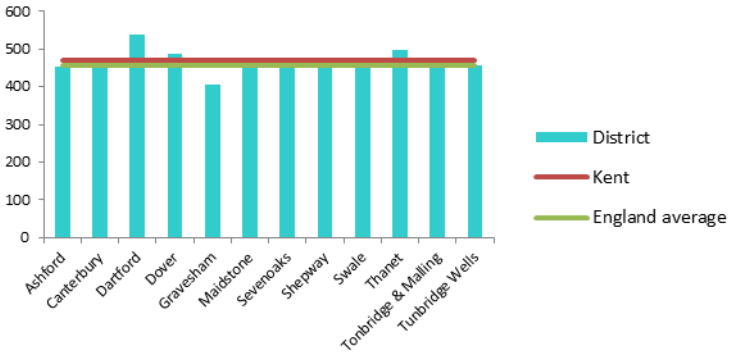
Falls lead to fractures and broken bones, particularly hip fractures in older people. There is a high mortality rate after a hip fracture which is around 30% after one year of having the fracture. Health related causes of falls include the use of certain medications, having a chronic condition such as heart disease, dementia, and low blood pressure which can cause dizziness and a brief loss of consciousness. It can also be caused by conditions that affect balance such as labyrinthitis, poor eyesight, loss of muscle strength and osteoarthritis.

There is a high prevalence of falls in the older population over the age of 65 years. It can have an adverse psychological impact on a person as after having a fall. Some people can lose confidence, become withdrawn and may feel as if they have lost their independence.

Most falls occur within the home environment. In 2009 to 2011, 55% of falls in Kent took place in the home while 15% of falls were in a residential care setting[xviii]. The housing conditions that contribute to falls include poor maintenance, slippery floors, bad lighting, loose carpets, difficulty getting in and out of the bath and using stairs, reaching for storage areas such as cupboards, clutter and excessive cold.

Older people who fall are likely to suffer a repeat fall and in most cases this will require the recurrent use of health and social care services. Falling is estimated to cost the NHS over £2.3billion per year[xix]. Therefore, preventing falls through addressing home adaptations and trip hazards will enable older people to stay living independently in their homes for longer, increasing their quality of life, preventing hospital admissions and residential care, as well as providing substantial cost savings to health and social care budgets.

The Kent picture – Hip fracture in 65s and over[xx]



In Kent in 2013, the level of hip fractures in the over 65s is not significantly different to the England average. Yet there has been an increase seen in falls related hospital admissions with the West of Kent experiencing the highest increase

Recommendations

3a Improve identification of people at risk of excess winter deaths and falls
3b Improve the coordination between housing, health and social care in falls programmes
3c Improve housing conditions so people can return home from hospital sooner after a fall
3d Increase the activity by housing on falls prevention
3e Increase the activity by housing on preventing a second fall

Objective 4: Develop our neighbourhoods to be healthy places

Obesity

Eating healthily and taking part in regular physical activity helps to control weight and prevent obesity which is a predisposing factor for developing diabetes, coronary heart disease, stroke, and certain forms of cancer. According to Public Health England, life expectancy from obesity is reduced by an average of three years, and in severely obese cases, by eight to ten years. It is estimated to cost the NHS over £5billion per year[xxi].

There is a strong correlation between deprivation and obesity. For adults, this correlation is found to be strongest in women where obesity prevalence rises from 21.5% in the least deprived quintile to 31.5% in the most deprived quintile[xxii]. For children, the prevalence of obesity in the least deprived quintile rises from 12.8% in 10 to 12 year olds to 24.2% in the most deprived quintile[xxiii].

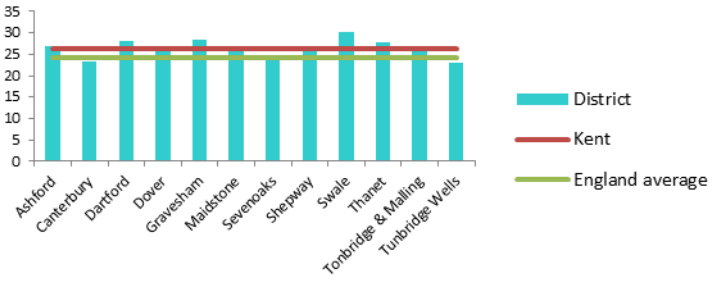
Where people live affects their chances of having an active life. The built environment helps to shape the communities in which people live and their access to amenities. Public spaces and transport networks can facilitate healthy lifestyles by providing opportunities for physical activity, social interaction and access to social goods.

Disadvantaged people are more likely to live in poor quality built environments. If you live in a deprived inner-city area, you have access to five times fewer public parks and good quality general green space than people in more affluent areas[xxiv]. If public space is available, a lack of use can be due to concerns about it being of poor quality and unsafe.

Housing is closely linked to the provision of accessible, safe, green space and play areas, and 'walkable' neighbourhoods. Housing providers and local housing authorities are often responsible for the areas of existing green spaces that incorporate their housing developments. They are also responsible for the design of well laid out new affordable housing development.

There are also clear links between poverty and poor diet. Low income households with high housing and living costs, and the impact of a reduction in benefits under the welfare reforms, can lead to unhealthy diet choices. This will make healthier and more expensive foods, such as fresh fruit and vegetables, a less likely option over cheaper and less nutritious food. There is also an issue with the lack of proper kitchen facilities for people living in temporary accommodation, including bed & breakfast, which can affect the ability to prepare healthy food.

The Kent picture – Obese adults[xxv]



The level of obese adults in Kent in 2013 is significantly worse than the England average. All districts apart from Canterbury, Sevenoaks, Shepway, Tonbridge & Malling and Tunbridge Wells have significantly worse levels of obese adults than the England average

Recommendations

4a Ensure well designed and well laid out housing with access to open and green spaces
4b Encourage residents to make use of existing open spaces
4c Play a role on getting across the messages on healthy eating

Objective 5: Strengthen the role housing plays in ill health prevention

Preventing ill health by recognising the early warning signs and understanding the way people live their lives on a strategic level helps to inform future plans for reducing health inequalities.

Various tools are used for assessing the health impacts and needs of a population from Joint Strategic Needs Assessments (JSNA), risk stratification and predicting risk to impact assessments and screening. These are all tools that the housing sector has the potential to embrace.

It is also important to understand the resources that will be required for the housing sector, health and its partners to make the recommendations happen, and the likely savings that could be made to health budgets as a result of preventing ill health through the action plan.

For housing and health to come together to work collaboratively on ill health prevention will require the careful sharing of information, which will be an area needing attention and improvement to achieve the best possible outcomes when working together.

Recommendations

5a Understand the costs for delivering the recommendations and the savings made to health
5b Include housing in future Joint Strategic Needs Assessments (JSNA)
5c Involve housing in risk stratification to predict those most at risk of poorer health in the future
5d Measure the impact of housing services on health inequalities

5. Action plan

Objective 1: Reduce the negative impact of homelessness on health					
Recommendation		**Action**	**Outcomes**	**Lead**	**Timescales**
1a	**Improve access and registration with GPs for rough sleepers**	**Explore the feasibility of introducing joint GP and housing appointment systems for rough sleepers in GP surgeries**	Increase no. of rough sleepers accessing primary health care and housing services	GPs LHAs Support Providers	Jun 2015
1b	**Take primary health care services to where rough sleepers are**	**Explore the feasibility of introducing a mobile GP outreach service in areas with a high concentration of rough sleeping**	Increase no. of rough sleepers accessing primary health care services	GPs LHAs	Jun 2015
1c	**Make plans for accommodation for rough sleepers upon hospital admission**	**Introduce homeless hospital discharge protocols in every district**	Homeless people have accommodation upon discharge so increasing opportunities for continuation of care and reduction of readmission	Hospitals LHAs	Jun 2015
1d	**Raise awareness of health, housing and support services available to rough sleepers**	**Develop a publicity campaign on housing and health services available to rough sleepers**	Rough sleepers are signposted and connected to housing, primary health care, mental health and substance misuse services	JPPB LHAs Support Providers	Jun 2014
1e	**Link homeless households in temporary accommodation to GPs**	**Signpost households placed in temporary accommodation to GPs**	Increase no. of homeless households accessing primary health care services	LHAs	Jun 2014
1f	**Improve identification of people in housing need who have mental health problems**	**Set up a Task & Finish Group to explore how to identify people in housing need who have mental health problems and ensure they are appropriately assessed**	Increase no. of households receiving help from mental health services	JPPB	Dec 2014
1g	**Raise awareness of resources for promoting healthy mental wellbeing**	**Publicise the 5 ways to mental wellbeing, Live It Well website and Mental Health Matters helpline**	Increased awareness of the resources available to promote mental wellbeing	LHAs Registered Providers	Jun 2014
Objective 2: Encourage people to live in homes with good air quality					
Recommendation		**Action**	**Outcomes**	**Lead**	**Timescales**
2a	**Promote smoke free homes**	**Investigate the feasibility of housing providers introducing no smoking clauses in tenancy agreements**	Increase no. of smoke free homes	LHAs Registered Providers	Dec 2014
2b	**Prevent accidental deaths due to fire caused by careless disposal of cigarettes**	**Target referrals to the Kent Fire & Rescue Service home safety visits scheme**	Decrease in no. of accidental fires caused by careless disposal of cigarettes	LHAs Registered Providers	Jun 2014
2c	**Provide information to at risk households on recognising the signs of tuberculosis**	**Housing to take part in public health publicity campaigns on tuberculosis targeting those who are in temporary accommodation, living in poor housing, overcrowded housing and HMOs**	Increased awareness of recognising the signs of tuberculosis to encourage earlier diagnosis and treatment	LHAs Registered Providers Public Health	Dec 2014
Objective 3: Ensure homes are warm, dry and free from hazards					
Recommendation		**Action**	**Outcomes**	**Lead**	**Timescales**
3a	**Improve identification of people at risk of excess winter deaths and falls**	**Explore funding opportunities with health to roll out Your Home Your Health in areas of Kent with high prevalence of excess winter deaths and falls**	Improved housing conditions Reduction of nos. in fuel poverty Reduction of no. excess winter deaths and falls	LHAs HIAs H&WBs	Dec 2014

3b	Improve the coordination between housing, health and social care in falls programmes	Include private sector teams and HIAs in the falls prevention pathway and home care reablement service	Increased number of homes made safe from the risk factors of falling	LHAs Public Health Social Care H&WBs	Jun 2015
3c	Improve housing conditions so people can return from hospital sooner after a fall	Develop a falls hospital to home referral protocol for those requiring a return home to a safe environment (i.e. a 'safe room') using minor adaptations	People who have had a fall can return home sooner from hospital as their home will be adapted and made safe preventing a second fall	Hospitals LHAs RPs Social Care H&WBs	Jun 2015
3d	Increase the activity by housing on falls prevention	Expand postural stability exercise classes in sheltered accommodation schemes and include access to the wider community	Improves muscle strength and balance and reduces the risk of a fall	Registered Providers LHAs Public Health H&WBs	Dec 2014
3e	Increase the activity by housing on preventing a second fall	Pilot a rapid response team for those who have had a fall to make their home safe	Prevents a second fall	Ambulance Service Nurses LHAs HIAs H&WBs	Jun 2015
Objective 4: Develop our neighbourhoods to be healthy places					
Recommendation		**Action**	**Outcomes**	**Lead**	**Timescales**
4a	Ensure well designed and well laid out housing with access to open and green spaces	Develop a housing and health design guide incorporating the Health Inequalities and Wellbeing Impact Assessment (HIWA) and Screening Toolkit	New affordable housing developments and the re-design of existing schemes are well designed, inclusive and encourage participation in open spaces and local services	LHAs Registered Providers Planning Officers	Dec 2014
4b	Encourage residents to make use of existing open spaces	Housing providers to encourage community engagement in using open spaces	Increased participation in the use of open spaces	Registered Providers LHAs KCC	Dec 2014
4c	Play a role in getting across messages on healthy eating	Add a 'healthy eating on a budget' course to the future programme of tenancy training events delivered by the Kent Engagement Group	Increased awareness of making healthy and cost effective choices over diet	KEG LHAs RPs	Jun 2014
Objective 5: Strengthen the role housing plays in ill health prevention					
Recommendation		**Action**	**Outcomes**	**Lead**	**Timescales**
5a	Understand the costs for delivering the recommendations and the savings made to health	Undertake a cost-benefit analysis of the savings to health under the above actions	Enables a case to be presented to local Health and Wellbeing Boards and CCGs for additional funding	LHAs Public Health H&WBs	Jun 2014
5b	Include housing in future Joint Strategic Needs Assessments (JSNA)	Ensure housing is included in future Joint Strategic Needs Assessments (JSNA)	Housing informs and guides county health inequality plans and the commissioning of health, wellbeing and social care services	JPPB	Jun 2014
5c	Involve housing in risk stratification to predict those most at risk of poor health in the future	Pilot risk stratification involving housing data in one district and roll out if successful	The most appropriate people for whom interventions in health are identified for actions to be taken to prevent future ill health	LHAs Public Health	Jun 2015
5d	Measure the impact of housing services on health inequalities	Provide training to housing partners on the Health Inequalities and Wellbeing Impact Assessment (HIWA)	The housing sector actively considers the impact of their policies and services on health inequalities	Public Health LHAs Registered Providers	Dec 2014

6. Implementation and monitoring success

Given the role of districts to work with their local Health and Wellbeing Boards and CCGs to plan and develop services based on local needs and issues, the ambition is that districts will implement this action plan locally, integrating it as appropriate into their individual health inequality plans.

The success of the action plan will be monitored by the JPPB and Kent Housing Group. Progress will be reported to Kent Health and Wellbeing Board on an annual basis.

The following monitoring data will be collected on a bi-annual basis by the JPPB to inform of the progress of the implementation of the action plan. This will be collected in conjunction with key health data to measure the impact of the interventions on health inequalities:

Objective 1: Reduce the negative impact of homelessness on health

- Number of rough sleepers accessing GP surgeries and outreach clinics
- Number of homeless households signposted to local GPs
- Number of referrals made under homeless hospital discharge protocols and outcomes
- Number of homeless households placed in temporary accommodation
- Number of housing referrals to mental health services

Objective 2: Encourage people to live in homes with good indoor air quality

- Number of housing providers with no smoking clauses in tenancy agreements
- Number of referrals by housing providers to the Kent Fire & Rescue home safety visit scheme
- Number of households reached in tuberculosis publicity campaigns

Objective 3: Ensure homes are warm, dry and free from hazards

- Number of referrals made after risk assessments carried out and outcomes
- Number of interventions for excess winter death and falls prevention
- Number of homes made free from category 1 hazards

Objective 4: Develop our neighbourhoods to be healthy places

- Number of housing schemes designed and existing schemes re-designed using the housing and health design guide
- Number of community engagement projects to encourage use of open spaces
- Number of participants who attended 'healthy eating on a budget' training courses

Objective 5: Strengthen the role housing plays in ill health prevention

- Number of housing organisations that have received Health Inequalities and Wellbeing Impact Assessment (HIWA) and Screening Toolkit training

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