

# Ashford Health and Wellbeing Board



ASHFORD  
BOROUGH COUNCIL

Notice of a meeting, to be held in Committee Room No. 2 (Bad Münstereifel Room), Civic Centre, Tannery Lane, Ashford, Kent TN23 1PL on Wednesday, the 23<sup>rd</sup> April 2014 at 12.00 noon

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## Agenda

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b) Other Significant Interests (OSI)	
c) Voluntary Announcements of Other Interests	
<p>See Agenda Item 2 for further details – but please note this is an Ashford Borough Council document which members might nonetheless find helpful. It is understood that KCC will be issuing guidance to members on interests in the near future.</p>	
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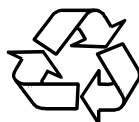
**Under the Council's Public Participation Scheme, members of the public can submit a petition, ask a question or speak concerning any item contained on this Agenda (Procedure Rule 9 Refers).**

KRF/VS  
11<sup>th</sup> April 2014

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**Declarations of Interest (see also “Advice to Members” below)**

- (a) **Disclosable Pecuniary Interests (DPI)** under the Localism Act 2011, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares a DPI in relation to any item will need to leave the meeting for that item (unless a relevant Dispensation has been granted).

- (b) **Other Significant Interests (OSI)** under the Kent Code of Conduct as adopted by the Council on 19 July 2012, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares an OSI in relation to any item will need to leave the meeting before the debate and vote on that item (unless a relevant Dispensation has been granted). However, prior to leaving, the Member may address the Committee in the same way that a member of the public may do so.

- (c) **Voluntary Announcements of Other Interests** not required to be disclosed under (a) and (b), i.e. announcements made for transparency reasons alone, such as:

- Membership of outside bodies that have made representations on agenda items, or
- Where a Member knows a person involved, but does not have a close association with that person, or
- Where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position.

[Note: an effect on the financial position of a Member, relative, close associate, employer, etc; OR an application made by a Member, relative, close associate, employer, etc, would both probably constitute either an OSI or in some cases a DPI].

**Advice to Members on Declarations of Interest:**

- (a) Government Guidance on DPI is available in DCLG’s Guide for Councillors, at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/240134/Openness\\_and\\_transparency\\_on\\_personal\\_interests.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/240134/Openness_and_transparency_on_personal_interests.pdf) plus the link sent out to Members at part of the Weekly Update email on the 3<sup>rd</sup> May 2013.
- (b) The Kent Code of Conduct was adopted by the Full Council on 19 July 2012, with revisions adopted on 17.10.13, and a copy can be found in the Constitution at <http://www.ashford.gov.uk/part-5---codes-and-protocols>
- (c) If any Councillor has any doubt about the existence or nature of any DPI or OSI which he/she may have in any item on this agenda, he/she should seek advice from the Head of Legal and Democratic Services and Monitoring Officer or from other Solicitors in Legal and Democratic Services as early as possible, and in advance of the Meeting.

# Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **22<sup>nd</sup> January 2014**

## Present:

Councillor Michael Cloughton – Chairman, Cabinet Member ABC;  
Navin Kumta – Vice-Chairman, Clinical Lead, Ashford CCG

John Bunnett – Chief Executive ABC  
Paula Parker – Families and Social Services Representative, KCC  
Andrew Scott-Clark – Public Health Representative, KCC  
Sheila Davison – Public Health Representative, ABC  
Neil Fisher – Head of Strategy and Planning, Ashford CCG  
Susan Scamell – Mental Health Commissioner, KCC  
Martin Harvey – Patient Participation Representative, Lay Member CCG  
Dr Anne Imkampe – Public Health Registrar, KCC  
Stephen Bell – Local Children’s Trust  
Mark Lemon – Policy and Strategic Relationships, KCC  
Simon Cole – Planning Policy Manager, ABC  
James Renwick – Policy Planner, Community Infrastructure and Levy  
Tracy Dighton-Brown – Voluntary Sector Representative  
Rory Franklin – Ashford Community Mental Health Team  
Keith Fearon – Member Services and Scrutiny Manager, ABC  
Belinda King – Management Assistant, ABC

## Apologies:

Cllr. Jenny Whittle, KCC  
Penny Southern, Social Services Lead, KCC  
Marion Gibbon, Public Health, KCC  
Simon Perks, Accountable Officer, CCG

## **1 Introduction**

1.1 The Chairman welcomed all those present to the meeting.

## **2 Notes of the Meeting of the Board on the 23<sup>rd</sup> October 2013**

2.1 It was agreed that the Minutes were a correct record of the meeting.

## **3 Mental Health Provision – Progress towards Kent Joint Health & Wellbeing Strategy – Outcome 4 Ashford**

- 3.1 The report provided a joint update on progress on the “Kent Joint Health & Wellbeing Strategy – Outcome 4 – Mental Health, people with mental health issues are supported to live well”.
- 3.2 The Chairman referred to a recent Government announcement by the Deputy Prime Minister, Nick Clegg, who had indicated that in terms of mental health appropriate resources would be allocated to it. Furthermore the Deputy Prime Minister had indicated that neither stigma nor inequalities should exist. Sue Scamell advised that in the region of £4.9m support was provided by the voluntary sector which could be seen as an additional investment above the current amount of funding allocated towards the service.
- 3.3 Navin Kumta explained that there were different levels of depression and it was important for GPs to ensure that people suffering from depression did not fall through any gaps in the system and that a seamless care service was provided. Neil Fisher explained that in terms of some illnesses there were clear waiting times/measures for which treatment should be made available. However these did not apply to the same degree to mental health issues and indeed some waiting times for assistance were excessive. Neil Fisher further explained that waiting times had reduced and that in terms of Ashford there was a reducing suicide rate, whereas in Canterbury this was increasing.
- 3.4 Tracy Dighton-Brown asked how the Ashford CCG Working Group integrated with the various organisations and Navin Kumta said it would be appropriate for an update from the CCG to be brought back to this Board.
- 3.5 Stephen Bell explained that his organisation was responsible for the “Young Healthy Mind” service which provided early intervention services and he said that in Ashford that was provided as a Tier 2 service and that there were no waiting lists for assistance with issues such as self-harming. There was, however a need for common assessment frameworks to be undertaken as there was a slow-down in referrals for onward support beyond his service.
- 3.6 In terms of the Community Safety Partnership, Sue Scamell advised that there were strategic meetings between the police and the CCG in West Kent which looked at the inter-relationship between the police and the ambulance services. There was also the development of a police triage service and a dedicated telephone number for police officers to use in terms of obtaining crisis support.
- 3.7 The Chairman referred to the recommendations in the report which asked that an East Kent summit be held for mental health to bring together key leaders and decision makers and he sought the views of the Board as to whether they supported this recommendation. Following discussion the Board agreed that this meeting should have an Ashford focus and be held late March, April period.
- 3.8 In accordance with Procedure Rule 9, Annie Jeffrey, a member of the public attended and asked a question relating to mental health provision in Ashford and Kent.

- 3.9 Navin Kumta reiterated the answer he had given to a similar question asked at the previous meeting of the Board on 23 October 2013 but said that work was continuing in GP practices to try and enhance the community services for people suffering with mental health issues.
- 3.10 Annie Jeffrey explained that she had raised this issue with Damian Green MP and others and the Chairman suggested that in view of comments made by the Deputy Prime Minister she should perhaps write to Nick Clegg MP.

**The Board:**

**Agreed to hold an Ashford based summit for mental health to bring together the key leaders and decision makers from the partner organisations represented on the AHWB Board to:-**

- a) **Consider and understand the Joint Strategic Needs Assessment and Assets (JSNA) for Ashford, including those most at risk of developing mental health problems.**
- b) **Set the strategic direction for mental health and wellbeing in Ashford and open up new ways for a mental health and wellbeing focus across all services and departments.**
- c) **Agree target groups and the actions required so frontline staff can make every contact count.**

## **4 Better Care Fund:- Update**

- 4.1 Included with the Agenda Papers was a draft planning guidance from NHS England which provided a significant amount of detail about the Better Care Fund (BCF).
- 4.2 Mark Lemon explained that the BCF related to the re-allocation of existing money from different pots and that the Kent Health and Wellbeing Board had to agree the BCF Plan for submission before the 14<sup>th</sup> February 2014 for initial assurance with final plans being submitted on or before the 4<sup>th</sup> April deadline to the Department of Health. He explained that the Kent Health and Wellbeing Board meeting date had been moved to the 12<sup>th</sup> February to allow them to consider the document. In financial terms, for Kent as a whole, £101m of funding already in the system had been earmarked for the fund, with the Ashford CCG proportion being approximately £7.3m. Disabled Facilities Grants were included within this overall sum for the Ashford CCG and there was a need to ensure it was properly transferred to districts in a timely manner. The BCF Plan was a minimum requirement that National Health England required in terms of what expenditure plans were in place. However, Mark Lemon explained that as Kent was in the Pioneer Programme, the DCLG expected the Pioneer Scheme to go much further.
- 4.3 Paula Parker said that it was expected that Disabled Facilities Grants would be handed straight to the District Councils without issue or delay. However, in

future she indicated that it might be appropriate to examine whether the services provided with the grant could be undertaken differently. Furthermore she indicated that each CCG had within its remit to protect adult social care. Overall the Better Care Fund was a push to ensure that all partner organisations worked together.

- 4.4 Given the tight timescales Sheila Davison enquired as to how the Ashford HWBB would feed into the final plan and in response Neil Fisher indicated that this would have to be undertaken electronically due to the tight timescale. He explained that the process was extremely complicated and furthermore the CCG had to submit a five year plan by June 2014.
- 4.5 John Bunnett commented that it appeared that there was limited scope to incorporate Ashford related initiatives within the Plan but stressed that it was important that these initiatives were picked up following the submission of the BCF.
- 4.6 Tracy Dighton-Brown explained that there were over 300 voluntary groups in Ashford and that in terms of acute primary care, small areas of consultation had been undertaken. However she hoped that the next year's consultation process would look rather different.

**The Board noted the progress on the Better Care Fund submission.**

## **5 Strategic Commissioning Plan – April 2014 - March 2019**

- 5.1 The Strategic Commissioning Plan April 2014 – March 2019 produced by the Ashford Clinical Commissioning Group was included within the Agenda Papers for the meeting.
- 5.2 Neil Fisher explained that the CCG was required to produce a two year operational plan with a five year plan to follow later. There was also a need to contribute to a plan referred to as “Unit of Planning” which was a whole plan covering the East Kent area with major providers. He drew attention to the following three key measures:-
- Improve health generally;
  - Reduce inequalities;
  - Ensure a parity of esteem (from a mental health point of view).
- 5.3 He also explained that there was a focus on the 75+ age group with more input from General Practice and to reflect a variety of several other plans. He explained that this draft plan would be brought back to each meeting of the Board and he stressed that it was vital that he had feedback from partners on the various components included within it.

- 5.4 John Bunnett expressed the hope that there would be a plan solely for Ashford as at the present time the plan did not contain any specific initiatives relating to the Ashford Borough area. Neil Fisher commented that if issues were picked up by the Integrated Commissioning Group they could be incorporated within the plan.
- 5.5 The Chairman considered that there was a need for guidance to be given to the Borough Council in terms of what the CCG required in terms of the plan to ensure it reflected its wishes. Sheila Davison suggested that it appeared that a number of different themes were not coming together and therefore it would be appropriate for a piece of work to be undertaken to agree how all organisations could work to achieve the desired result.

**The Board received and noted the report.**

## **6 Health and Wellbeing in Planning – Ashford Emerging Local Plan**

- 6.1 Simon Cole explained that his team was currently working on reviewing the Local Plan which had to look to the year 2030. He said that there were several areas related to the Health Agenda which included spatial planning, i.e. where development went, cycling initiatives; infrastructure for health services, and he explained that the National Planning Policy Framework gave guidance on how a plan should be formed. Therefore the Borough Council had to work with a range of organisations to decide where mutual benefits lay in terms of planning to ensure each plans were complementary. He said that another key change was that the funding from Section 106 Agreements would change following the introduction of the Community Infrastructure Levy (CIL) from April 2015 and the Council's ability to ensure strategic infrastructure was provided was likely to be more difficult to achieve.
- 6.2 Simon Cole then emphasised that the Borough Council needs to know what it considered should be provided could actually be delivered. He then ran through the principal key thoughts set out within his report and said that he was more than happy to talk off line with representatives of the various organisations on those key thoughts.
- 6.3 Navin Kumta questioned whether the Integrated Commissioning Group needed to have a representative from the Planning Unit at future meetings.
- 6.4 Tracy Dighton-Brown explained that MIND had produced an excellent booklet showing ways in which Planning Departments could work with local communities in terms of mental health provision.
- 6.5 Andrew Scott-Clark gave examples of the initiatives the Public Health Service Team at KCC was involved with which included in some areas trying to restrict the number of fast food outlets in the vicinity of schools, reducing traffic speed and providing health impact assessments. Simon Cole emphasised that it was important to justify any policies included within the



Local Plan and to provide a justifiable evidence base which could be tested on enquiry.

6.6 The contact details for Simon Cole and James Renwick are shown below:-

simon.cole@ashford.gov.uk,  
james.renwick@ashford.gov.uk

**The Board noted the report.**

## **7 Local Children's Trust**

- 7.1 Stephen Bell explained that the Local Children's Trust was a multi-agency service and had been in place for a number of years. He considered it extremely important to support the prevention agenda and he believed that the Trust Board had a valuable contribution to make to the work of the Ashford Health and Wellbeing Board and the priorities for Ashford as a whole. Tabled at the meeting was a diagram which set out the priorities for Ashford Children and Young People covering Early Years (foetal to 5 years); Middle Childhood (6-11 years); Early Adolescence (12-18 years) and Late Adolescence (18-21 years).
- 7.2 The Chairman explained that the Local Children's Trust Board was a Sub-Committee of the Ashford Health and Wellbeing Board.
- 7.3 Stephen Bell referred to various initiatives the Trust had been involved in and in particular he drew attention to the work in Ashford to assist parents in terms of how to play with their children. He said that if initiatives were put in place in the early years of the child's development, it helped in later years.
- 7.4 In terms of the future the Chairman commented that Stephen Bell was welcome to be a member of the Ashford Health and Wellbeing Board and Navin Kumta said he would like to see a report on the work of the Trust Board to be considered at a future meeting.

**The Board noted the report.**

## **8 Report from the Voluntary Sector Representative**

- 8.1 Tracy Dighton-Brown of the Ashford Counselling Service was the representative on the Ashford Health and Wellbeing Board and she explained that CASEKent and the Ashford Volunteer Centre had created a Steering Group to take forward engagement with the Statutory Sector. The aim was for the Voluntary Sector to be able to speak to the Ashford Health and Wellbeing Board with one voice, even though they represented over 300 voluntary groups in Ashford.
- 8.2 The Local Voluntary Sector intended to highlight 3-4 case studies of organisations working with people in some of these groups and provide

examples to illustrate good relationships between the two sectors. It would also outline cases where commissioning had worked well, including bringing in ideas from elsewhere in the county and the rest of the UK. The report was hoped to be available by mid-March. Martin Harvey explained that there had been a successful event held the previous week which had shown the willingness of the voluntary sector to work with the CCG.

**The Board received and noted the report.**

## **9 Integrated Commissioning Group**

- 9.1 Paula Parker explained that the ICG had last met before Christmas and it had become apparent that work on preparing and submitting the BCF would take urgent precedence over other issues. She considered there was a need to refocus what the ICG was doing and commissioning for Ashford and to work with the Local Children's Trust to provide input into this process. She indicated that she would like to be in a position to report back to the main Board on progress by its next meeting in April.
- 9.2 In response to a question about what Ashford Borough Council could be doing in terms of moving forward initiatives, Paula Parker said that there were several initiatives discussed at the ICG which included an Obesity Plan for Ashford; a Fall Strategy for Ashford; and work on Dementia Services. However, the final work on these projects had yet to be signed off bearing in mind that they needed to relate to the Better Care Fund.
- 9.3 John Bunnnett expressed concern over the lack of progress jointly commissioning any new projects within Ashford. He highlighted several areas of work undertaken by the Borough Council that had a direct impact on health and wellbeing but he was unable to find them reflected within KCC or CCG commissioning plans. Reference was made to the JSNA and the need to develop specific projects aimed at the health issues outlined within this document.
- 9.4 Neil Fisher commented that via the ICG the Borough Council's representatives could have input into the Borough Council's budget plans if the Borough Council wished to take forward any specific initiatives. John Bunnnett considered that it was apparent to him that there was a need for there to be a plan for Ashford sitting within the various overarching plans discussed at the meeting.
- 9.5 The Chairman suggested that the representatives on the Board meet separately to clarify the way forward.

**The Board received and noted the report.**

## **10 Ashford Health Profile**

- 10.1 Dr Anne Imkampe, Registrar in Public Health gave a presentation on the Ashford Health Profile. The slides covered the following issues:-
- Overview
  - Life Expectancy
  - Adult Obesity
  - Smoking
  - Smoking in Pregnancy
  - Breast feeding
  - Homelessness
  - Cancer
  - New Developments
- 10.2 Andrew Scott-Clark referred to the issue of smoking and explained that initiatives were moving to the development of a harm reduction strategy by the use of long-term nicotine therapy. This would lead to a change in policy of NICE. In terms of obesity there would be a report to the KCC's Cabinet in May, in terms of breast feeding he explained that KCC offered a breast feeding support service, and on the issue of smoking in pregnancy work was being undertaken at midwives' level.
- 10.3 John Bunnett said that the presentation was very informative and in particular it highlighted that the Borough Council needed to do more in terms of looking at the issue of homelessness.
- 10.4 The Chairman thanked Dr Imkampe for her presentation.

**The Board received and noted the report.**

## **11 Items for the Forward Plan**

- 11.1 The following items were suggested for forthcoming agendas of the Board:-
- Forward planning to enable more timely discussion of commission plans
  - Inequalities
  - Jasmin Vardimon Dance Academy (perhaps July meeting)

## **12 Next Meeting**

- 12.1 The next meeting would be held on Wednesday, 23<sup>rd</sup> April 2014.

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## **Ashford Health & Wellbeing Board (AHWB)**

### **AGENDA ITEM 4 – Lead Officer Group Quarterly Report April to June 2014**

(Christina Fuller, Chair)

#### **What have we been up to since the last update?**

1. Since the last AHWB meeting a Lead Officer Group (LOG) has been established. The group involves senior managers from each of the following organisations/service areas:
  - CCG
  - KCC
  - Public Health
  - ABC
  - Local Children's Trust
2. The purpose of the group is to provide support to the AHWB. In particular it will:
  - Oversee performance against Ashford's health & wellbeing priorities
  - Advise on the progress of key projects and task and finish groups
  - Coordinate requests from third parties to make presentations to Board
  - Coordinate and review the submission of partners strategies to the Board
  - Review local health data and information and report as necessary
  - Maintain a forward plan for meetings of the Board which supports dialogue on priority areas.
3. The LOG proposes to pull together a report for each AHWB meeting. The LOG report will append a single page update from each partner to inform Board members of what is going on in their world, tell others about key achievements, indicate what they are focusing on over the next quarter and identify any challenges and risk.
4. The first set of Partner Updates are provided at Agenda Item 5. Each partner will provided an overview of its content and answer any specific questions at that point in the meeting.
5. Future LOG reports will draw on the information provided by the partners and provide a summary for the Board on common themes and risks.
6. It is requested that the Chair of the LOG becomes a member of the AHWB.

#### **What are our local priorities?**

7. The Ashford Health Profile 2013 presented to the last AHWB highlighted many health & wellbeing concerns that need to be tackled. A summary is provided at Appendix A.
8. The LOG have informally consider this information and believe that the following should become the agreed priority areas for the AHWB:
  - Independent living & self management for those with long-term conditions

- Dementia
  - Homelessness
  - Obesity
  - Falls prevention
  - Sustainable development for health & wellbeing
9. It should be noted that domestic abuse and road traffic accidents are also areas of considerable concern for Ashford. They have not been suggested as priority areas for the AHWB primarily because they already have a focus within the Community Safety Partnership.

### **Why are these areas a priority?**

10. **Independent living & self management for those with long-term conditions** is highlighted as a priority for several reasons. Our population is ageing and therefore there is an increasing need for health and social care for the elderly. While emergency admissions are lower than the rest of Kent, more can be done to avoid admissions. Encouraging self-management of those with long-term conditions and ensuring good access to primary care including out-of-hours is vital. Our aim needs to be the development of projects where health and social care services work together to support people.
11. **Dementia** is increasing as our population ages. There is a need to improve rates of recognition and diagnosis and getting people into the right services when they need them. Improved access to community support including housing, supported housing options and dementia friendly communities is crucial in enabling patients to stay within their own communities for longer.
12. **Homelessness** is high within Ashford compared to the England average and getting worse. Those who are homeless have disproportionately more health problems compared to the general population. Hospital services are used more frequently and the health needs of homeless people are currently not met and access to primary care and prevention programmes need to improve.
13. **Obesity** is a significant problem for Ashford which starts when people are young. In Year 6 (i.e. the last year of primary school) almost 1/5<sup>th</sup> of Ashford's children are classified as obese. Ashford also performs particularly badly in terms of adult inactivity which is clearly contributing to a picture of Ashford adult obesity that is worse than the England average. Obesity prevalence in Ashford is higher in high deprivation areas, with 25-30% of the population being classified as obese. Obesity, however, is not confined to areas of high deprivation. In most wards the percentage of people being obese is also high, with 20-25%.
14. **Falls prevention** - rates of hip fractures are high in some Ashford wards. Access to falls prevention services needs to focus on worst wards.
15. **Sustainable development for health & wellbeing** has to be a priority for an area such as Ashford which is growing rapidly and will continue to do so for many years. There is a need to not only ensure access to primary care for new communities but as a need to ensure that new residents are able to access preventative health programme. We need to encourage a physical environment that encourages physical activity and design new built areas with community space, safe roads and cycle lanes. We need to design making healthy choices

into our communities, encourage social cohesion and create environments that have a positive influence on our mental health. There is a strong and growing body of evidence that community-based approaches to improving health and providing care and support can be cost effective, deliver better outcomes and help to prevent health and social care needs arising. This is where we get ahead of the game.

### **What do we need to focus on specifically?**

16. In order to make any progress against these priorities it is necessary to focus together on those projects/initiatives that have the greatest chance of improving the health & wellbeing of our community.
17. AHWB members are of course working on numerous projects that contribute to these priorities. It is suggested, however, that the Board can through focusing on specific projects ensure not only that they are delivered but that all partners support how they can contribute to their design and delivery.
18. For the next AHWB it is suggested that the LOG presents what it jointly believes are the 'must do projects'. Partners will need to consider what are the most crucial initiatives that will impact the priorities. These projects will then be given a focus at future AHWB meeting and monitored accordingly.
19. In identifying the 'must do projects' it is suggested that the following criteria be employed:
  - High level of contribution to our Area's priorities;
  - The outcome of this project brings significant long term value to our customers;
  - The requirement to meet legal, compliance, or regulatory mandates (i.e. would the partner or customer be exposed to a significant risk or impact if the project is not offered?);
  - Provides for multi-partner involvement and other services/products can depend on it to deliver their outcomes (i.e. adds significant value and leverage for other partners) and
  - Supports the principles of integrated commissioning.
20. Future LOG reports will highlight key risks for our AGREED 'must do projects', report on any success stories particularly relevant to our priorities plus future planning and horizon scanning.
21. The LOG also recommends that each AHWB meeting focuses on a specific priority area with a view to identifying progress and gaps in service provision. Over time the presentations will help influence future projects and inform commissioning decisions.

### **The AHWB is asked to:**

- a) **Approve the Membership, purpose and reporting arrangement of the Lead Officer Group;**
- b) **Consider the quarterly update templates provided by partners;**
- c) **Agree the Chair of the LOG becomes a non voting member of the AHWB**
- d) **Agree the six local priorities for 2014/15;**
- e) **Agree that LOG identify the 'must do projects' linked to the AHWB priorities and present these for approval at the next meeting;**

- f) Agree to focus future meetings on each priority area to enable debate and further joined up working.**



### Ashford Health Profile Summary

#### Demographics

- Population is ageing therefore increasing need for health and social care for elderly people at home or in care homes
- Large difference in life expectancy between wards and this is a strong indicator of health inequalities. Need to ensure that access to care is equitable across different groups

#### Community

- Level of GCSE attainment is lower compared to the England average
- Homelessness is high and homeless people have disproportionately more health problems than the general population. Hospital services are used more frequently. Health needs of homeless people are currently not met and access to primary care and prevention programmes need to improve.

#### Lifestyle

- People living in deprived areas consume less fruit and vegetables. Need to ensure public health healthy eating programmes continue to be delivered
- Adult obesity is a particular problem. Need a combined group approach addressing diet and exercise. Provision mainly consists of 1:1 appointments and commissioners may wish to consider installing group level interventions in addition.
- Smoking prevalence is highest in those from routine and manual occupations. Need an approach based on harm-reduction for those who are not able to stop. Suggested we encourage use of licensed nicotine-containing products and support programme expected to roll out in Kent in 2014.

#### Inequalities by group

##### *Young people*

- Obesity is a significant problem. There are many programmes running but are they reaching the correct target groups.
- Teenage pregnancy rates are falling but still high in areas of deprivation. Need to continue supporting services including school-based SRE provided within Health Schools Programme. Also involvement of HOUSE.

##### *Maternity*

- Smoking during pregnancy is a problem with rates significantly higher than England average. NICE guidance indicates a number of interventions. Are they available within Ashford?
- Breast feeding initiations rates are low in Ashford.

##### *Older people*

- Rates of hip fractures are high in some wards. Access to falls prevention services needs to focus on worst wards

#### Use of health service

- Emergency admissions lower than in rest of Kent. But can more be avoided?  
Encouraging self-management of those with long-term conditions and good access to primary care including out-of-hours are important.
- National screening uptake targets not met for all practices. This is an issue for those serving more deprived wards.

### **Long term conditions**

- Likely to increase as the population ages. Large variations in prevalence by practice suggesting a risk of under diagnosis in some population groups.
- Focus should be on self-care but with appropriate services and equipment to support patients and carers.

### **Population expansion**

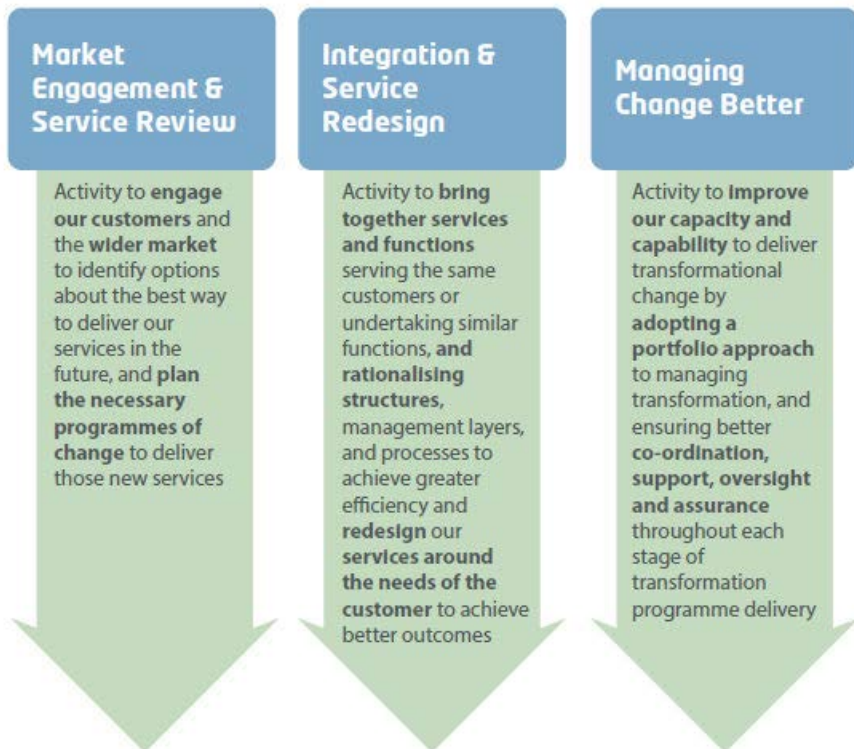
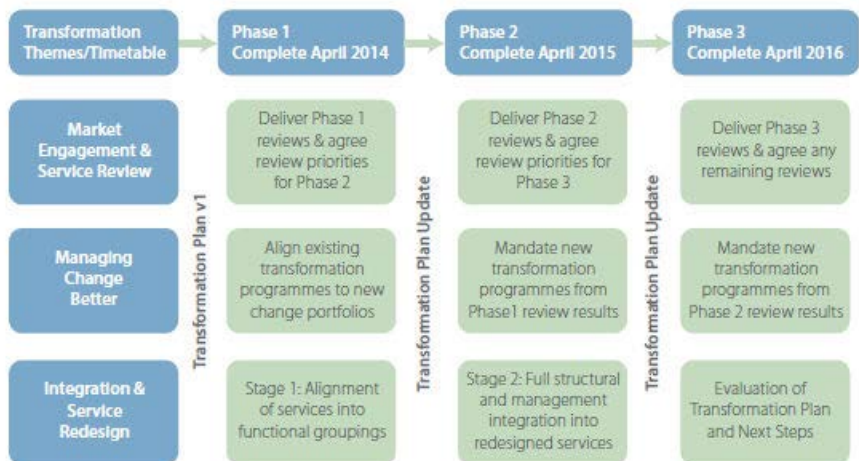
- Ashford is going to grow rapidly over the next few years. Need to:
  - Ensure access to primary care with capacity to include new residents in preventative health programmes
  - Encourage physical activity and design new built areas with community space, safe roads and cycle lanes
  - Promote health eating by making fresh food available locally and give space for own/community gardens.
  - Design that encourages social cohesion and have positive influences on people with mental health problems.

## Ashford Health & Wellbeing Board (AHWB) – CCG Partner Quarterly Update

Update from	CCG
Quarter concerned (delete as applicable)?	April to June 2014
What's going on in our world	<p>Continue to work with partners to develop the integrated teams which include the LRU provision.</p> <p>Care home project continues with plan to deliver some aspects within Farrow Court</p> <p>Developing concept of community hubs with members and partners.</p> <p>Westview project continues</p> <p>Introduction of Share my Care on plan</p> <p>Dementia working group identified key service gaps</p>
Success stories since last AHWB	Ivy Court 7 day pilot which included support from ICT/SS due to report outcome – this has proved to be successful in admission avoidance
What we are focusing on for the next quarter	<p>Implementation of town and rural teams to develop community hubs</p> <p>Development of mental health and CYP strategies across KCC/CCG</p> <p>Over 75 pathway to include primary care</p>
Strategic challenges & risks including horizon scanning?	
Anything specific to the AHWB priorities NOT mentioned above	
Any thing else the Board needs to know	
Signed & dated	<p>Sue Luff</p> <p>11 April 2014</p>

# Ashford Health & Wellbeing Board (AHWB)

## Partner Quarterly Update Template

Update from	KCC
Quarter concerned	April to June 2014
What's going on in our world	<p>KCC are undergoing a transformation programme, 'Facing the Challenge: Whole-Council Transformation' which set out KCC response to the increasing financial pressure local government faces as public sector austerity continues beyond 2015. The three themes which set out KCC transformation are:</p>  <p><b>Market Engagement &amp; Service Review</b> Activity to <b>engage our customers</b> and the <b>wider market</b> to identify options about the best way to deliver our services in the future, and <b>plan the necessary programmes of change</b> to deliver those new services</p> <p><b>Integration &amp; Service Redesign</b> Activity to <b>bring together services and functions</b> serving the same customers or undertaking similar functions, <b>and rationalising structures</b>, management layers, and processes to achieve greater efficiency and <b>redesign our services around the needs of the customer</b> to achieve better outcomes</p> <p><b>Managing Change Better</b> Activity to <b>improve our capacity and capability</b> to deliver transformational change by <b>adopting a portfolio approach</b> to managing transformation, and ensuring better <b>co-ordination, support, oversight and assurance</b> throughout each stage of transformation programme delivery</p> <p>Below is the KCC roadmap</p>  <p><b>Transformation Themes/Timetable</b></p> <ul style="list-style-type: none"> <li>Phase 1 Complete April 2014</li> <li>Phase 2 Complete April 2015</li> <li>Phase 3 Complete April 2016</li> </ul> <p><b>Market Engagement &amp; Service Review</b></p> <ul style="list-style-type: none"> <li>Deliver Phase 1 reviews &amp; agree review priorities for Phase 2</li> <li>Deliver Phase 2 reviews &amp; agree review priorities for Phase 3</li> <li>Deliver Phase 3 reviews &amp; agree any remaining reviews</li> </ul> <p><b>Managing Change Better</b></p> <ul style="list-style-type: none"> <li>Align existing transformation programmes to new change portfolios</li> <li>Mandate new transformation programmes from Phase 1 review results</li> <li>Mandate new transformation programmes from Phase 2 review results</li> </ul> <p><b>Integration &amp; Service Redesign</b></p> <ul style="list-style-type: none"> <li>Stage 1: Alignment of services into functional groupings</li> <li>Stage 2: Full structural and management integration into redesigned services</li> <li>Evaluation of Transformation Plan and Next Steps</li> </ul>

### REMINDER AHWB priorities are:

- Independent living & self management for those with long-term conditions
- Dementia
- Homelessness
- Obesity
- Falls prevention
- Sustainable development for health & wellbeing

	Facing the Challenge is an extensive transformation programme that seeks to radically reshape the authority in response to the future financial and service pressures it faces. Phase one is due to be completed end April 2014.
Success stories since last update	<ul style="list-style-type: none"> <li>• Successfully implemented new ways of working for Case Management teams in South Kent Coast and Thanet, due to be rolled out across Kent.</li> <li>• Successfully held project workshops in each district to gather feedback on KCC Accommodation strategy</li> <li>• Home Care tender</li> <li>• Telecare tender</li> <li>• Kent has been made an agreed pilot site (one in three nationally) to tackle malnutrition in older people supported by the Malnutrition Task Force and Department of Kent County Council</li> <li>• Dementia Friendly Alliance</li> <li>• Better Care Fund agreed in principle at Kent Health and Wellbeing board</li> </ul>
What we are focusing on for the next quarter	<ul style="list-style-type: none"> <li>• Launch event to raise awareness on Malnutrition</li> <li>• Better Care fund schemes continue to be developed</li> <li>• Continue work on Falls</li> <li>• Residential Relet</li> <li>• Community equipment review</li> </ul>
Strategic challenges & risks including horizon scanning	Developing Core Offer- what services KCC need to ensure are available in the community to support people to remain independent
Anything specific to the AHWB priorities NOT mentioned above	
Signed & dated	Paula Parker 31/013/14

**REMINDER AHWB priorities are:**

- Independent living & self management for those with long-term conditions
- Dementia
- Homelessness
- Obesity
- Falls prevention
- Sustainable development for health & wellbeing

# Ashford Health & Wellbeing Board (AHWB)

## Partner Quarterly Update Template

Update from	CCG / KCC / Public Health / Children's Operational Group / ABC
Quarter concerned (delete as applicable)?	April to June 2014 July to September 2014 October to December 2014 January to March 2015
What's going on in our world	Healthy weight review underway Smoking and tobacco control review about to start Harm reduction pilot started Smoking in pregnancy work taking place Procurement of breastfeeding support
Success stories since last update	Healthy Living Pharmacy action plan developed New plans for the Healthy Club to morph into a more innovative way of working that supports people in Kent to be more active Health check invitation target met
What we are focusing on for the next quarter	Engagement in planning for new strategy for stop smoking and tobacco control Research with Jasmin Vardimon dance company (Ashford)
Strategic challenges & risks including horizon scanning	Capacity within the Health Improvement Team Need to re-commission Healthy weight, stop smoking services
Anything specific to the AHWB priorities NOT mentioned above	Mental well-being implementation plan being developed
Signed & dated	M Gibbon 20/3/14

### REMINDER AHWB priorities are:

- Independent living & self management for those with long-term conditions
- Dementia
- Homelessness
- Obesity
- Falls prevention
- Sustainable development for health & wellbeing

# Ashford Health & Wellbeing Board (AHWB)

## Partner Quarterly Update Template

Update from	<b>The Local Children's Trust</b>
Quarter concerned (delete as applicable)?	Jan to April 2014
What's going on in our world	<ul style="list-style-type: none"> <li>- Formal notification of KCC's decision to disband the local children's trusts across Kent has been received.</li> <li>- There have been significant structural changes in personnel for the delivery of Children's Centres and KIAS (Kent Integrated Adolescent Service).</li> <li>- A new initiative, HeadStart Kent, is bidding for £10m to support resilience amongst vulnerable young people.</li> </ul>
Success stories since last AHWB	<p>The H&amp;WBoard received a priorities report collated from the LCT partner organisations and work continues in:</p> <ul style="list-style-type: none"> <li>- DV (refer ABC update), this is very much supported in Children's Centres,</li> <li>- Ashford Supporting Families is achieving well (63% of families identified in Year 1 have a worker assigned to them). Brief note on gaps and needs are attached.</li> </ul>
What we are focusing on for the next quarter	<p>Work to set up the COG will be crucial to ensure a continued joined up approach for future commissioning to benefit local children and young people.</p> <p>Other areas include:</p> <ul style="list-style-type: none"> <li>- Monitoring the roll out of the new commissioned ASF projects</li> <li>- Work on obesity in schools and ensuring approach is joined up with community initiatives and referral programmes</li> <li>- Access accurate data on issues e.g. self harm and pathways to CAMHs</li> <li>- Working on Stanhope needs for young people and children with the John Wallis Academy and other local partners.</li> </ul>
Strategic challenges & risks including horizon scanning?	Increasingly poverty is a concern for children and young people with the changes to the welfare system.
Anything specific to the AHWB priorities NOT mentioned above	
Any thing else the Board needs to know	
Signed & dated	Stephen Bell

## **Ashford Supporting Families (ASF) – March 2014 Briefing on identified gaps and needs in services**

Over the past 18 months the Ashford Supporting Families (ASF) programme has been engaging and supporting families, who need extra support and help to improve their situation. The focus of the work has been to reduce crime and anti-social behaviour (ASB), increase school attendance and progression after school, and to improve access to work and training for adults.

Through the process of engaging with families, a number of needs and gaps in services have been identified by the commissioned ASF Workers, partners and the families themselves. Bids for projects have then been submitted to meet these needs including:

### **Family Support:**

- Domestic Abuse support – local partners and workers value existing IDVA provision. Intel from ASF workers reflects the need - 90% of FIP cases and 50% of FIP Light cases have experienced DA.;
- Low-level mental health issues resulting in and from: isolation, lack of confidence, low self-esteem, conflict and relationship difficulties – need for support and tools – Identified by FIP Light and CAF screening;

### **Employment/Training:**

- Mentoring support to help individuals post 16 into the workplace or further training through up-skilling and coaching – need identified by the workers and evidence of NEETs and unemployment figures.

### **Support for under 16s**

- 1-1 mentoring for under 16s has been identified as a significant gap, particularly for young people who are not engaging well within other settings such as group activities or specialised programmes. ASF workers, Youth Offending workers, Police, Schools and other partners have identified this is the case. A substantial group of young people being worked with by ASF Workers (and others) are not responding to other services and more intensive 1-1 mentoring work is recommended.

### **Attendance/Education**

- Reducing the impact and frequency of fixed-term exclusions in Schools – via restorative approach training to teachers. Mediation between the school and family during and after exclusions was a need raised at the Ashford multi-agency LOG meeting after seeing recent exclusion statistics.

Other gaps/needs which have been raised include: Budgeting/finance training for families; Scooter Academy (for under 16s); Support for young people on the Autism Disorder Spectrum; Elective Home Education awareness; Healthy Eating Programme, Walking club.

Discussions are ongoing around these needs and potential bids being developed for a second round of funding applications to ASF if money is still available after the first round.



Abbreviations:

ASB- Anti-Social Behaviour

ASF- Ashford Supporting Families

CAF - Common Assessment Framework

DA - Domestic Abuse

FIP - Family Intervention Project Worker

IDVA- Independent Domestic Violence Advocacy

LOG - Local Operational Group

NEETs - Not in Education Employment or Training

RBLI - Royal British Legion Industries

RJ- Restorative Justice

Chris Beale

Ashford Supporting Families Project Coordinator

**For more details the following people can be contacted for more information:**

James Hann - Assistant Health, Parking and Community Safety Manager

- E-mail: [James.Hann@Ashford.gov.uk](mailto:James.Hann@Ashford.gov.uk)
- Phone: 07931359656

Chris Beale - Ashford Supporting Families, Project Coordinator

- E-mail: [Christopher.Beale@kent.gov.uk](mailto:Christopher.Beale@kent.gov.uk)
- Phone: 07545104886

## Ashford Health & Wellbeing Board (AHWB) - Ashford Borough Council Quarterly Update

Update from	Ashford Borough Council (ABC)
Quarter concerned	April to June 2014
What's going on in our world	<ul style="list-style-type: none"> <li>• Green travel champions launched 18<sup>th</sup> March. All target schools have agreed to participate in active travel to school. Selected on the basis of obesity data. Commence participation between Easter and Summer term, continuing in new academic year. Next Green travel champions event 20th October.</li> <li>• Community Safety Partnership has agreed its priorities for 2014/15; anti-social behaviour, domestic abuse, acquisitive crime, substance misuse, violent crime, road safety and rural crime. Workshops held to develop the action plans for partners.</li> <li>• The latest position on major planning applications and developments is provided at <a href="http://www.ashford.gov.uk/development-update">http://www.ashford.gov.uk/development-update</a>.</li> <li>• Ashford Strategic Delivery Board established. Key strategic projects; Ashford Commercial Quarter, Elwick Place, Designer Outlet Expansion, International College Campus, M20 junction 10A, Jasmin Vardimon International Dance Academy, Chilmington Green &amp; Ashford International Station Spur.</li> <li>• <b>Housing (given in some detail as this quarters focus for the Ashford HWB):</b> <ul style="list-style-type: none"> <li>○ Progress on Farrow Court; assessing plans for redevelopment of subsequent scheme.</li> <li>○ Plans to develop own homeless hostel in Ashford</li> <li>○ Planning approval for move-on facility for 16 -25 year olds in the Limes (8 units)</li> <li>○ Hopefully handing over land for PFI extra care scheme in St. Michael's in May (scheme due for completion early 2016).</li> <li>○ Extra care scheme progressing at the Warren in Ashford: due to complete March 2015.</li> <li>○ Slower progress on extra care scheme in Aldington</li> <li>○ Working on securing maximum amount of affordable housing on major sites e.g. Chessman's / Chilmington.</li> <li>○ Assessing planned maintenance programme for 15/16. Additional focus on energy efficiency and hard to heat (bigger impact in rural areas). Link to fuel poverty.</li> <li>○ Sheltered scheme managers given specific health related target for 2014 to promote events in scheme with health theme e.g. exercise, healthy eating, falls prevention work.</li> <li>○ Progress on delivering further 39 new build dwellings by March 2015. Will ensure some are tailored around families with complex needs i.e. adapted properties</li> </ul> </li> </ul>
Success stories since last AHWB	<ul style="list-style-type: none"> <li>• Rural crime, community engagement day in Victoria Park on 10th April due to increased levels of Anti-Social Behaviour &amp; substance misuse.</li> <li>• Domestic abuse awareness day on 2nd April.</li> </ul>

	<ul style="list-style-type: none"> <li>• ABC became a member of the Dementia Action Alliance</li> <li>• Housing success stories: <ul style="list-style-type: none"> <li>○ Much of the above but specifically</li> <li>○ Continued progress on Farrow Court</li> <li>○ Approval of Limes move-on facility and homeless hostel</li> <li>○ Affordable homes grant bid to deliver more council new build</li> </ul> </li> </ul>
<p>What we are focusing on for the next quarter</p>	<ul style="list-style-type: none"> <li>• Safety in Action fortnight in June (safety messages to all primary school pupils about to enter secondary school).</li> <li>• Repton Community Facility and potential links to KCC/CCG community hub</li> <li>• Improving Mental Well-Being Project for Young People in Ashford. This project has been well received and is progressing as planned. First front line youth professional training session took place in late March (adolescent brain development), which was well attended (20+). The remaining sessions will take place over the coming few months.</li> <li>• A project brief has been agreed with Sk8side for the Saturday night opening at HOUSE, with a funding agreement to follow. It is hoped that the sessions will start up over the summer with a range of educational and diversionary activities which support young people in improving and managing their mental well-being.</li> <li>• <b>Housing focus:</b> <ul style="list-style-type: none"> <li>○ Further progress on Farrow Court especially around service models and joint working with social care and voluntary sector. Will have key focus on independent living and supporting clients with dementia.</li> <li>○ Successful bid to HCA for more grant to do more new build</li> <li>○ Use of council resources to acquire more street properties and 'buy-backs' (of former council owned home lost under Right To Buy) to increase stock numbers. Will impact on helping homeless families.</li> </ul> </li> </ul>
<p>Strategic challenges &amp; risks including horizon scanning?</p>	<ul style="list-style-type: none"> <li>• Organisational change amongst partners</li> <li>• Lack of clarity or disagreement over what are the key health &amp; wellbeing priorities/projects</li> <li>• <b>Housing Focus:</b> <ul style="list-style-type: none"> <li>○ Ensuring BCF supports work of making better use of funding to commission works such as Disabled Facilities Grants.</li> <li>○ Ensuring all partners genuinely commit to joint delivery e.g. Farrow Court (schemes not fulfilling potential if we don't 'join up')</li> <li>○ More discussion on need for better use of budgets to support work such as falls prevention with (pooled budgets?) to enable providers to do more in terms of avoiding emergency interventions.</li> </ul> </li> </ul>
<p>Anything specific to the AHWB priorities NOT mentioned above</p>	

Any thing else the Board needs to know	<ul style="list-style-type: none"><li>• Preparing an Ashford Mind the Gap Plan. Aim being to draw together the various health &amp; wellbeing projects linked to reducing inequalities in health.</li><li>• Establishment of the Local Officer Group to support the Ashford HWB</li></ul>
Signed & dated	Sheila Davison 11 April 2014

## **Focus on Homelessness**

### **Introduction** (Sheila Davison)

1. The priority theme for today's meeting is Homelessness. Three presentations are being given. In order to help members to prepare for the meeting, a brief summary of each presentation is provided below along with specific recommendations for the Ashford Health & Wellbeing (HWB).
2. The link between poor health outcomes and the type of housing (or lack of housing) is well acknowledged. Housing factors that can influence health inequalities include being homeless, living in poor quality or stressful housing conditions; living in communities that make health lifestyle choices difficult or living in relative poverty with expensive housing and high living costs
3. While homelessness is a specific priority for the Ashford HWB, taking action to deal with poor housing will have a positive outcome for other Ashford health and wellbeing priorities. It is suggested that the Board examines the recommendations in this light.
4. The purpose of the presentations is to help the Ashford HWB identify progress and gaps in service provision and to question how the information provided can be used to influence future projects and inform commissioning decisions.
5. Members are also asked, in advance of the meeting, to consider how the subject of homelessness links to their sphere of influence, to ask what more they believe could or should be done and to think about how the Lead Officer Group might assist the Board in terms of this priority.

### **Mind the Gap** (Richard Robinson, Housing Improvement Manager, Ashford Borough Council)

6. This report presents 'Think Housing First', a strategy to reduce health inequalities in Kent through access to good quality and affordable housing.
7. The report requests that partners of the Ashford HWB support implementation and delivery of the 'Think Housing First' and associated action plans. The action plans have a countywide focus and it is acknowledged that some parts of the plan will have greater relevance within Ashford than others.
8. Focusing more locally the report makes additional recommendations for Ashford as follows:
  - Making available additional funding (s.106 and BCF) to help deliver remodelling of sheltered accommodation
  - Making available additional funding to delivery more disabled adaptations
  - Expanding the handyman service within sheltered schemes
  - Exploring how better support can be provided for young homeless people in order to reduce the negative impacts on their health
  - Exploring how better joint working would help to improve standards in private sector accommodation

**KCC Accommodation Strategy** (Christy Holden, Head of Strategic Commissioning Accommodation Solutions, Social Care)

9. This presentation is an information item that provides an overview on the Accommodation Strategy that is being developed by KCC. It will look at the future accommodation based services required for all adult client groups reviewing key considerations from the evidence base.

**Ashford's Homelessness Strategy** (Sharon Williams, Housing Operations Manager, Ashford Borough Council & Sylvia Roberts, Senior Housing Options Officer, Ashford Borough Council)

10. This report and presentation concerns Ashford's Homelessness Strategy. The key elements to the strategy are as follows:
  - Giving commitment to preventing homelessness wherever possible. This involves having a clear understanding of the homelessness situation in Ashford, having a commitment from all agencies to recognise homelessness triggers and supporting referral to services and providing housing advice aimed at preventing homelessness.
  - Ensuring quality housing services and suitable accommodation is provided for people for whom homelessness cannot be prevented. This involves providing quality homeless services and provision of suitable temporary accommodation.
  - Securing settled and sustainable homes, with access to housing support if needed.
11. Much of the emphasis within the strategy is on preventing homelessness, early intervention and developing housing pathways.
12. The importance of partners working together on homelessness is considered vital and having the support of the Ashford HWB is an important part of this.
13. The report raises particular issues for discussion including the following:
  - How to encourage partners to refer those under potential threat of homelessness to the Housing Options Team as soon as possible
  - Whether partners could work together in terms of securing local private rented accommodation
  - What mechanism can be employed to open and then maintain dialogue between partners over the re-fresh and subsequent updating of the Homelessness Strategy
  - How to jointly identify clear housing pathways for vulnerable people
  - Can we develop a rapid response service for young people early intervention or adolescent teams to make the maximum joint effort to keep a young person at home, with support to sustain them at home
  - How does the Council further develop links with the health & social care in relation to preventing people from becoming homeless and what are the communication networks to achieve this.

## **Recommendations to the Board (Christina Fuller)**

### **14. The AHWB is asked to:**

- a) Support the implementation and delivery of the 'Think Housing First' and agree a further report is presented to the Ashford HWB where detailed costs and benefits of delivering the action plans are presented together with recommendations as to how Ashford intends to take the actions forward.
- b) Note the information provided within the KCC Accommodation Strategy and provide feedback as appropriate.
- c) Support the implementation and delivery of the Homelessness Strategy and to address as part of that process up the issues highlighted within the report. Progress to be reported to a future Ashford HWB.

By: Richard Robinson

To: Ashford Health and Wellbeing Board

Date: 23<sup>rd</sup> April 2014

Subject: **Think Housing First**

Classification: Unrestricted

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### **Summary**

This report presents Think Housing First, a strategy to reduce health inequalities in Kent through access to good quality and affordable housing.

### **Recommendation**

The Ashford Health and Wellbeing Board is asked to support the implementation and delivery of Think Housing First, as set out in sections 4, 5 and 6.

## **1. Background**

- 1.1 There is a strong link between poor health outcomes and the type of housing (or lack of housing) and communities in which people live. Housing factors that can influence health inequalities include being homeless; living in poor quality or stressful housing conditions; living in neighbourhoods that discourage a healthy lifestyle; or living in relative poverty with expensive housing and high living costs. Such factors influence people's health behaviours, the risk of developing illnesses and having accidents in the home, and the actions taken to deal with health problems when they arise.
- 1.2 The Kent Joint Policy and Planning Board (Housing) (JPPB) is a joint strategic partnership between health, local housing authorities, social care and other statutory agencies in Kent. It provides a forum where issues requiring joint working can be raised and measures put in place to address those issues. The JPPB was invited by its health partners to lead on the development of a housing 'Mind The Gap' to address the housing factors that contribute to health inequalities in Kent.
- 1.3 Think Housing First (attached at Appendix A) is a result of the work that has taken place over the last year and is the first housing 'Mind the Gap' in England. It is an action plan with a life span to 2015 that is intended to complement the county health inequalities action plan Mind the Gap. The principle aim of the strategy is to reduce health inequalities through access to good quality and affordable housing



## **2. How the Think Housing First was developed**

- 2.1 In developing Think Housing First, a 'Housing Mind the Gap' event was facilitated by Public Health in March 2013, where invited partner organisations from a range of sectors came together to explore the key issues surrounding poorer health outcomes related to housing, and the additional interventions that should be introduced to inform the strategy.
- 2.2 Once drafted, the strategy was then open to wider partner consultation and then launched on the 6 December 2013 with the endorsement of Roger Gough, Chair of the Kent Health and Wellbeing Board, and with the support of the Kent Housing Group.

## **3. Objectives of Think Housing First**

- 3.1 Think Housing First contains the following five objectives:
  1. Reduce the negative impact of homelessness on health
  2. Encourage people to live in homes with good air quality
  3. Ensure homes are warm, dry and free from hazards
  4. Develop our neighbourhoods to be healthy places
  5. Strengthen the role housing plays in ill health prevention
- 3.2 It also aims to raise awareness of the role of the housing sector and demonstrate that, by spending relatively modest sums through various housing interventions, we can achieve real cost benefits to health budgets and contribute towards the effort to reduce the disparities in health and morbidity levels in the county.

## **4. Implementation and monitoring success**

- 4.1 The implementation of Think Housing First relies on close collaboration and partnership working between housing, health and other partner stakeholder organisations. The recent health reforms have provided an excellent opportunity to make this a reality through the establishment of Health and Wellbeing Boards and Clinical Commissioning Groups (CCGs).
- 4.2 Given the role that district local authorities now have 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 they will implement the strategy locally, integrating it as appropriate into their individual health inequality plans.
- 4.3 For this reason, the success of Think Housing First in Ashford is dependent on full endorsement, support and involvement of the borough council and our partners on the Ashford Health and Wellbeing Board.
- 4.4 In terms of tracking success, the JPPB will co-ordinate the monitoring of the strategy in relation to the progress made in its implementation and the outcomes achieved, providing support in delivery where required.
- 4.5 The Kent Health and Wellbeing Board will be kept informed of progress through an annual report produced by the JPPB at the end of the year.

## 5. Housing and Health in Ashford

- 5.1 Although the least densely populated borough in Kent, Ashford's population grew by 13% between 2001 and 2011. Estimated growth is around 5% each five years to 2033 taking the population to c.148, 000 by that time. Of this increase, there is a disproportionate increase in the number of older people (65 years+)
- 5.2 There is a general trend towards fewer married couple households and an increase in single person households, which will have some bearing on housing market provision in the future, although there are a range of other factors that influence people's housing choices.
- 5.3 Income is obviously a key feature in relation to people's housing choices, but in 2014 we have an assessed need for 368 new affordable homes per year in the borough. With delivery below this figure, and demand still rising, the pressure on use of existing social/affordable housing continues to grow.
- 5.4 Private housing, both owned and rented represents over 80% of the tenure types in the borough, but it does not follow that private equates to good quality well maintained homes. A number of people, often older private renters or owner occupiers can live in poor quality housing leading to health issues. There are significant numbers of householders who are equity rich but cash poor, and who are unwilling to release that equity.
- 5.5 Homelessness remains a key issue for the borough both in terms of provision of temporary and permanent accommodation, and the links homelessness has to someone's health. Traditionally Ashford has had a higher rate of applications and acceptances of homelessness than the county average and the on-going economic situation means this area of work remains hugely important.
- 5.6 Data from the Joint Strategic Needs Assessment of 2010 confirms what many of us experience professionally which is the longest life spans and best health is enjoyed by the higher socio-economic groups, whilst correspondingly the poorest health and shortest lives are in the poorest groups. In Ashford this equates to Stanhope, Norman, Bybrook, Victoria, Downs West, Bockhanger and Aylesford Green wards
- 5.7 Key health issues for the borough are:
  - Obesity and eating disorders – affects all socio-economic groups but prevalence is greater in poorer households
  - Older people – greater longevity places huge pressure on all agencies dealing with services for older people, with domestic or independent living seen as one of the biggest ways of delivering better value to the public purse
  - Dementia – huge increases in the numbers living with dementia are expected in the next 30 years. With the borough's disproportionate increase in older people this will be a huge challenge to all agencies supporting older people

- Mental Health – there are strong links between mental health and homelessness (or the threat of) and support services need to be in the right place at the right time to help prevent homelessness wherever possible
- Learning Disability – greater provision of suitable accommodation to help people with a learning disability live independently is needed. In doing so the health benefits and cost to the public purse can be greatly improved.
- Physical / Sensory Disability – there have been significant increases in numbers of people living for longer with a range of disabilities. It is now the normal expectation that people with all but the most severe disabilities can and should live in their home with the right adaptations.
- In addition there are a range of housing-related factors affecting young people, former services personnel, ex-offenders, those with substance misuse problems, and people suffering from domestic violence. In many cases, the right housing with, if necessary the right support, can transform lives.
- More detail around all of these groups can be found in Ashford's Housing Framework 2013-2018

<http://www.ashford.gov.uk/download.cfm?doc=docm93jjm4n3211.pdf&ver=5196>

## 5.8 What are we doing?

- We like to think we have a good record of delivering and enabling good quality appropriate housing in the borough.
- Our record on affordable rural housing delivery is amongst the best in the *country*; we were the first borough in Kent to achieve the decent homes status for maintenance of our own stock, jointly with KCC we created one of the first recuperative care facilities linked to a sheltered scheme, we have delivered more council new builds since 2012 (with more to come) than the rest of the county combined, and we were amongst the trailblazers pilot schemes providing joined up work around homelessness and employment/training opportunities to help break the cycle.
- Currently:-
  - We are remodelling the first of our sheltered schemes (Farrow Court) to deliver 104 care-ready dwellings along with a new day centre and restaurant, adapted bathing facility, shop, hairdressers, and communal lounge. The scheme will include 12 flats designed specifically for clients with learning disabilities
  - After Farrow Court we will continue with a programme of remodelling work on 7 other sheltered schemes
  - We are working jointly with developers to deliver more extra care sheltered housing in Ashford (Chamberlain Manor), Aldington (Ragstone Meadows) and Little Hill in St. Michaels (PFI project with KCC)

- We are continuing our work to provide more affordable accommodation through our own property company which will both develop property and acquire suitable existing dwellings.
- We work with planners and developers in seeking to maximise delivery of affordable housing on all developments, but with particular reference to larger schemes such as Cheesemans Green and Chilmington Green. These larger developments often create opportunities to deliver both specialist and general needs housing.
- We are doing a lot of joint working to help prevent and reduce homelessness; we will also shortly be providing our own short-term accommodation as an alternative to B & B for some clients
- We are working to deliver two move-on facilities providing short term (up to two years) accommodation, support and training for 16-24 year olds helping them acquire the skills to live independently in due course
- We spend over £400k per annum on disabled facilities grants for adaptation work to private sector accommodation, and over £300k per annum on adapting council properties
- Our planned maintenance programme will see a key focus in 2015 of improving energy efficiency in some of our hard to heat homes, especially in rural areas which have no gas. This will help significantly in terms of fuel poverty for those people.
- We are about to commence work on building another 39 new homes; and will shortly bid for further funds from the Homes & Community Agency to build 106 more. Such new build would also involve over £15m of the borough's HRA resources and we have in the past used this opportunity to create some bespoke housing for families with very particular needs e.g. severe disability.
- We have signed up to the Dementia Action Alliance which will see us training our staff to improve the way we deal with tenants with dementia. The plan is to make Farrow Court a dementia centre of excellence with appropriate design features and services for residents and the broader community.

5.9 We would expect all these projects or pieces of work to have an impact, directly or indirectly on the health of a significant number of people in the borough. The borough council is not just about the bricks and mortar though and we have an excellent record of delivery good quality housing support services that complement the management of the stock that we do. This could be the work of scheme managers in sheltered schemes promoting healthy living and offering training in falls prevention and sustaining independence, to community engagement work where we can encourage a range of initiatives in neighbourhoods such as greater physical activity.

## 6. What Can Health and Social Care Do For Us?

6.1 Are we doing the right things in terms of supporting the health and social care agenda? We believe we are and hopefully the 'Think Housing First' report identifies what impact housing providers can have in this regard.

6.2 We take the initiative in a number of areas such as ensuring the remodelling work in our sheltered schemes meets standards that will provide care-ready accommodation and related services that will greatly help sustain independence and reduce costs associated with nursing or care homes.

6.3 Where we build new homes and bid for various grants from different government departments, we ensure we do so in a joined up way that reflects the aims and ambitions of other agencies involved too.

6.4 However, it is always a case of we could do more and with more resources we feel we could achieve more still. The 'Think Housing First' action plan (attached) summarises the range of initiatives that impact on health and wellbeing which districts and boroughs have signed up to deliver. It has been suggested a full update report is provided later in the year to show progress against these actions locally and this Board would seem the appropriate place to provide that update. In addition though, we would also ask specifically for Ashford :

- More funding from KCC (s.106 monies; social care budgets) to help deliver on some of the remodelled work we are doing in sheltered housing. There are huge benefits from remodelled schemes that provide arguably better facilities than many care homes whilst helping sustain independence in a far more cost effective setting
- More funding from CCG or KCC could help us deliver more disabled adaptations. Some small expenditure items e.g. grab rails at c. £50 can help prevent costly emergency hospital admissions.
- As disabled facilities grants (DFGs) become absorbed into the Better Care Fund we should take the opportunities this creates to achieve better value from our procurement across the county
- We employ a handyman to work in our sheltered schemes. More funding could help employ more staff and therefore extend the number of properties and tenants who could benefit from such services. Equally this could be achieved through home improvement agencies given more support, and provision could be extended to include private tenants too.
- Better support arrangements for younger homeless people could be achieved with better joint working between KCC and ABC, thereby helping to avoid a possible cycle of housing and health related problems. A key focus to achieving this would be better communication networks and creating a whole needs assessment taking an holistic view of all a persons needs i.e. housing, health and social care.

- Looking at how we could work jointly to respond proactively to young people under threat of homelessness with a joint focus on putting the support into households at the first signs of difficulty to help parents and their children continue to remain living together and avoid homelessness.
- Where homelessness cannot be avoided looking at a joint response to procuring suitable accommodation for young people regardless of whether they are housing or social services responsibility.
- More joint working to better help improve standards in private sector accommodation, leading to better action on fuel poverty and falls prevention

6.5 As part of the implementation process, it is intended that a further report will be presented to the Ashford Health & Wellbeing Board in mid 2014 which will ask members to consider:

- the cost/benefit implications of delivering the key actions within the strategy
- how each district envisages to take the actions forward
- any support and assistance requested from the Ashford Health and Wellbeing Board

## **7. Supporting Documents**

- Think Housing First
- Think Housing First Action Plan

## Appendix 1

# THINK HOUSING FIRST – ACTION PLAN

V1 – 27/03/14

<b>Objective 1: Reduce the negative impact of homelessness on health</b>					
No.	Action	Outcomes	Lead	Timescales	Progress
1.1	<b>Develop a publicity campaign on housing and health services available to rough sleepers</b>	Rough sleepers are signposted and connected to housing, primary health care, mental health and substance misuse services	JPPB LHAs Support Providers	Jun 2014	<ul style="list-style-type: none"> <li>• Porchlight to present referrals to GP link workers to KHOG in Jun 13.</li> <li>• KHOG to discuss referrals to GPs with KAASH service.</li> </ul>
1.2	<b>Signpost households placed in temporary accommodation to GPs</b>	Increase no. of homeless households accessing primary health care services	LHAs	Jun 2014	<ul style="list-style-type: none"> <li>• Work in progress to develop a template for local information sheets as part of homeless interview.</li> </ul>
1.3	<b>Publicise the 6 ways to wellbeing, Live It Well website and Mental Health Matters helpline</b>	Increased awareness of the resources available to promote mental wellbeing	LHAs Registered Providers	Jun 2014	<ul style="list-style-type: none"> <li>• Ask LHAs and RPs to put links on their websites?</li> <li>• Include reference to these resources in the 'Move on Toolkit'?</li> <li>• Ask LHAs &amp; RPs to publicise in residents' newsletters. To provide a short article for this.</li> <li>• To consider requesting a campaign on the Kent Homechoice website.</li> <li>• Health and Wellbeing booklet drafted covering accessing health care services, healthy eating, exercise and mental wellbeing.</li> </ul>
1.4	<b>Set up a Task &amp; Finish Group to explore how to identify people in housing need who have mental health problems and ensure they are appropriately assessed</b>	Increase no. of households receiving help from mental health services	JPPB	Dec 2014	
1.5	<b>Explore the feasibility of introducing joint GP and housing appointment systems for rough sleepers in GP surgeries</b>	Increase no. of rough sleepers accessing primary health care and housing services	GPs LHAs Support Providers	Jun 2015	
1.6	<b>Explore the feasibility of introducing a mobile GP outreach service in areas with a high concentration of rough sleeping</b>	Increase no. of rough sleepers accessing primary health care services	GPs LHAs	Jun 2015	
1.7	<b>Introduce homeless hospital discharge protocols in every district</b>	Homeless people have accommodation upon discharge so increasing opportunities for continuation of care and reduction of readmission	Hospitals LHAs	Jun 2015	<ul style="list-style-type: none"> <li>• Contact made with Jacqui West KCC to liaise with Acute Care Coordinators (Feb 2014).</li> <li>• Attending Urgent Care Board in Dover 3 Apr 13.</li> <li>• Attending Navigation Pathway meeting 10 Apr 13.</li> </ul>



<b>Objective 2: Encourage people to live in homes with good air quality</b>					
No.	Action	Outcomes	Lead	Timescales	Progress
2.1	<b>Target referrals to the Kent Fire &amp; Rescue Service home safety visits scheme</b>	Decrease in no. of accidental fires caused by careless disposal of cigarettes	LHAs Registered Providers	Jun 2014	<ul style="list-style-type: none"> <li>• KFRS contacted for stats to show concentration of accidental fires to encourage relevant LHAs to refer more vulnerable clients – awaiting info.</li> <li>• Include in housing action plan for Dementia Action Alliance –JPPB Apr 14.</li> </ul>
2.2	<b>Investigate the feasibility of housing providers introducing no smoking clauses in tenancy agreements</b>	Increase no. of smoke free homes	LHAs Registered Providers	Dec 2014	<ul style="list-style-type: none"> <li>• Have discussion with RPs about the possibility of providing ashtrays outside properties. HSE group to take forward for future developments.</li> </ul>
2.3	<b>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</b>	Increased awareness of recognising the signs of tuberculosis to encourage earlier diagnosis and treatment	LHAs Registered Providers Public Health	Dec 2014	<ul style="list-style-type: none"> <li>• Meeting with Malti Varshney 9 Apr 14 to take forward.</li> </ul>
<b>Objective 3: Ensure homes are warm, dry and free from hazards</b>					
No.	Action	Outcomes	Lead	Timescales	Progress
3.1	<b>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</b>	Improved housing conditions Reduction of nos. in fuel poverty Reduction of no. excess winter deaths and falls	LHAs HIAs H&WBs	Dec 2014	<ul style="list-style-type: none"> <li>• YHYH now has an item re falls included. PSHG to look at feasibility of rolling out across Kent.</li> </ul>
3.2	<b>Expand postural stability exercise classes in sheltered accommodation schemes and include access to the wider community</b>	Improves muscle strength and balance and reduces the risk of a fall	Registered Providers LHAs Public Health H&WBs	Dec 2014	<ul style="list-style-type: none"> <li>• Awaiting meeting with Karen Shaw (Feb 2013) booking phone conversation March.</li> </ul>
3.3	<b>Include private sector teams and HIAs in the falls prevention pathway and home care reablement service</b>	Increased number of homes made safe from the risk factors of falling	LHAs Public Health Social Care H&WBs	Jun 2015	<ul style="list-style-type: none"> <li>• Awaiting feedback from Karen Shaw (Feb 2014) booking phone conversation March.</li> </ul>
3.4	<b>Develop a falls hospital to home referral protocol for those requiring a return home to a safe</b>	People who have had a fall can return home sooner from hospital as their home will be adapted and	Hospitals LHAs RPs Social Care	Jun 2015	<ul style="list-style-type: none"> <li>• See 5.1</li> </ul>

	environment (i.e. a 'safe room') using minor adaptations	made safe preventing a second fall	H&WBs		
3.5	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	<ul style="list-style-type: none"> <li>• See 5.1</li> </ul>

#### Objective 4: Develop our neighbourhoods to be healthy places

No.	Action	Outcomes	Lead	Timescales	Progress
4.1	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	<ul style="list-style-type: none"> <li>• SW attended KEG meeting in Oct 13 to request this is put on future programme of training.</li> <li>• KCC Health Trainers contacted to arrange one event each in West and East Kent.</li> <li>• Health and Wellbeing booklet drafted covering accessing health care services, healthy eating, exercise and mental wellbeing..</li> </ul>
4.2	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	<ul style="list-style-type: none"> <li>• Take this action to KPOG.</li> <li>• SW to pull out the overlap with Think Housing First and the 'Planning Healthier Places' report.</li> <li>• Name of lead from Debbie Smith to progress.</li> </ul>
4.3	Housing providers to encourage community engagement in using open spaces	Increased participation in the use of open spaces	Registered Providers LHAs KCC	Dec 2014	<ul style="list-style-type: none"> <li>• As above</li> </ul>

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

No.	Action	Outcomes	Lead	Timescales	Progress
5.1	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	<ul style="list-style-type: none"> <li>• Task PSHG – requested to be on May 2014 agenda – relevant to 3.4 &amp; 3.5.</li> </ul>
5.2	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	<ul style="list-style-type: none"> <li>• Completed – statistics to be included in next version. Further stats re homelessness etc to be obtained via Kent Homechoice homeless module and Dashboard of Indicators.</li> </ul>
5.3	Provide training to housing partners	The housing sector actively considers the impact of their policies and	Public Health LHAs	Dec 2014	

	<b>on the Health Inequalities and Wellbeing Impact Assessment (HIWA)</b>	services on health inequalities	Registered Providers		
5.4	<b>Pilot risk stratification involving housing data in one district and roll out if successful</b>	The most appropriate people for whom interventions in health are identified for actions to be taken to prevent future ill health	LHAs Public Health	<b>Jun 2015</b>	<ul style="list-style-type: none"> <li>• In progress – Swale BC (Amber Christou) working with Abraham George from PH on this.</li> </ul>

# 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*

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## Foreword

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### 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.

## Foreword

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### 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

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## 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<sup>1</sup>, 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



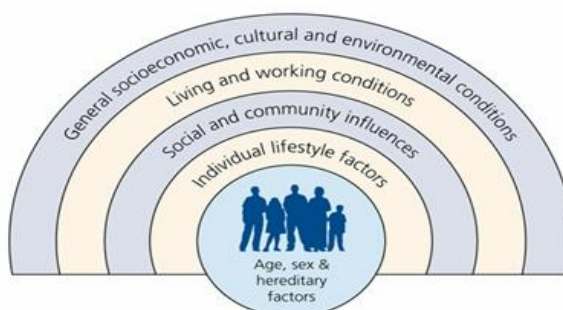
## 2. Background

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### 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:

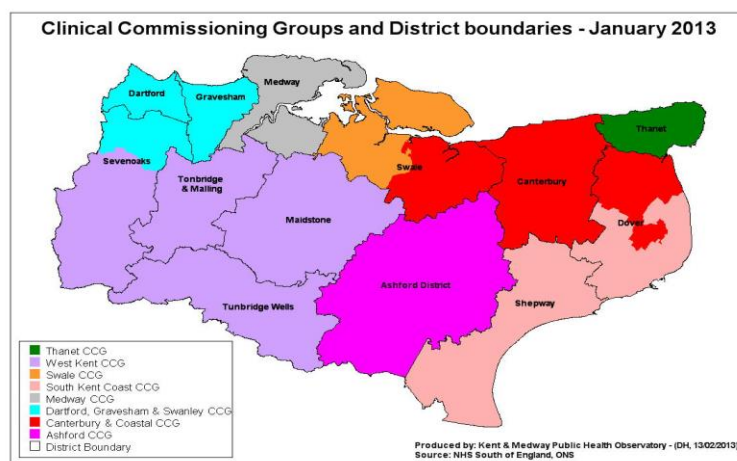
1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places 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.<sup>ii</sup>

## 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

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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 handyman 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 through 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

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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'<sup>iii</sup>, 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

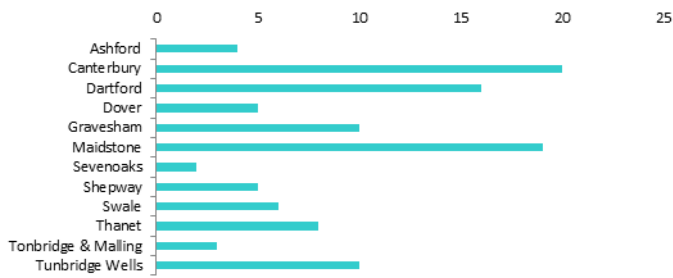
#### Rough sleeping

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<sup>iv</sup>.

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<sup>v</sup>.

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<sup>vi</sup>.

### The Kent picture – rough sleeping<sup>vii</sup>



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

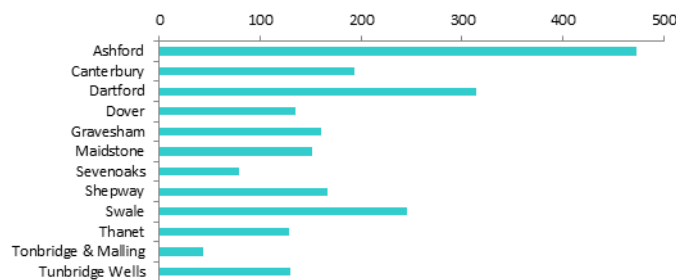
### Homeless households in temporary accommodation

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<sup>viii</sup>.

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<sup>ix</sup>.

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<sup>x</sup>



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

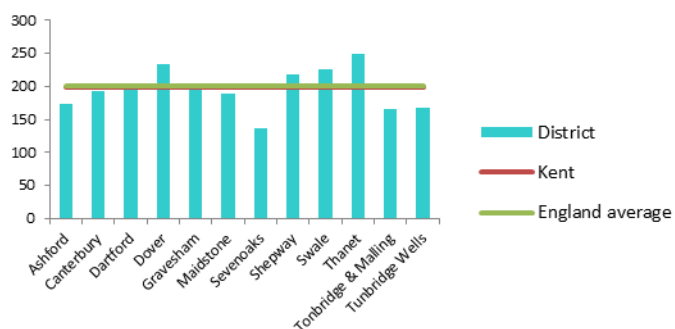
Smoking contributes to three main health problems; lung cancer, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Smoking during pregnancy increases the risk of low birth weights, miscarriage and perinatal death. Smoking after pregnancy increases the risk of sudden infant death 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<sup>xi</sup>. 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<sup>xii</sup>.

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<sup>xiii</sup>



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.

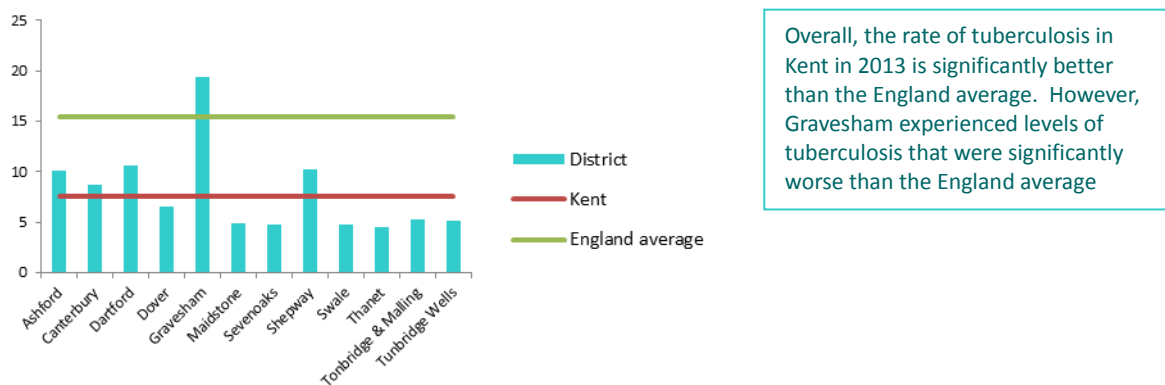
People who have tuberculosis are more likely to be homeless people and those living in poor housing, overcrowded housing and houses in multiple occupation (HMOs), where the infection can be spread more easily. Areas with higher rates of migration or established communities originating from countries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

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<sup>xv</sup>**



- 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.

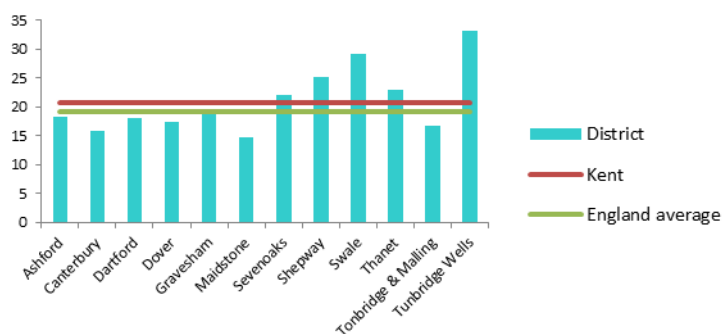
Damp housing can be caused by poor maintenance such as a leaky roof or from water from the ground getting into floors and walls. Condensation can also cause dampness and lead to black mould forming. This increases the risk of causing or exacerbating asthma and other respiratory illnesses due to the inhalation 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<sup>xvi</sup>. 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<sup>xvii</sup>



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

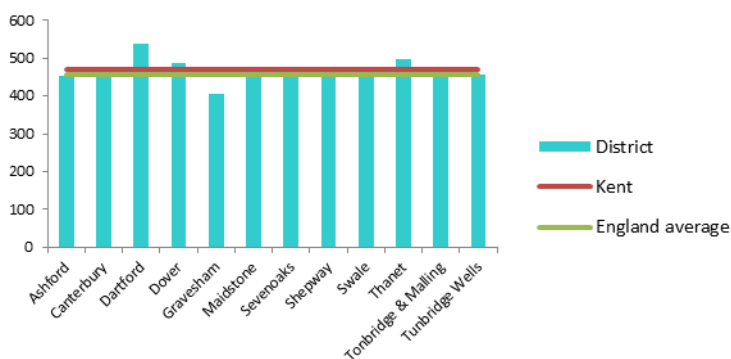
Falls are a significant health issue that can lead to fractures and broken bones, particularly hip fractures in older people. There is a high mortality rate after a hip fracture which is around 30% after one year of having the fracture. Health related causes of falls include the use of certain medications, 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, and loss of muscle strength.

There is a high prevalence of falls in the older population over the age of 65 years. Kent has an aging population and the number of people aged 65 and over is expected to rise by 21% over the next ten years<sup>xviii</sup>. For older people who have had a fall, this can have an adverse psychological impact as 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<sup>xix</sup>. 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. Falls related to hip fracture is estimated to cost the NHS over £2.3billion per year<sup>xx</sup>. 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 fractures in the over 65s<sup>xxi</sup>



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 £5 billion per year<sup>xxii</sup>.

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<sup>xxiii</sup>. 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<sup>xxiv</sup>.

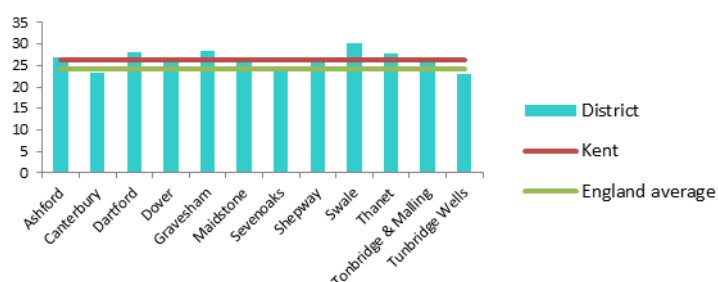
Where people live affects their chances of having an active life. The built environment helps to shape the communities in which people live and their access to amenities. Public spaces and transport networks can facilitate healthy lifestyles by providing opportunities for physical activity, social interaction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



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 6 ways to 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

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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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# Accommodation Strategy

Christy Holden  
Head of Strategic Commissioning – Accommodation  
Ashford Health and Wellbeing Board - 23 April 2014

# Why?

- Adult Social Care ~£180m per annum on residential care across all client groups
- Growing care market - ? Location ? Type
- Growing population and demand
- Quality and safeguarding
- Better outcomes for individuals
- Transformation and prevention

# The Accommodation Strategy

- Developed in partnership – KCC, KHG, KPOG, JPPB, Health, KCHA, HCA
- Needs analysis commissioned on adult social care – placement patterns, forecasting tools, stock
- District boundaries – district profiles
- Transformational commissioning activity across health and social care
- Forecasting
- Approvals and Governance
- Prioritisation, sequencing, options appraisals, business cases

# Ashford

- Population set to increase by 26% from 2011 to 2021 and 44% from 2011 to 2031
- 17% of the population is aged 65+, 8% over 75 and 2% over 85. Compares to 18%, 9% and 3% for Kent
- Two out of the three highest areas of 85+ population are in the Tenterden rural area

# Ashford Provision

Service	LD	MH	PD	OP
Residential	22/141	1/5	1/45	16/590 res 4/220 nurs 5/300 dem
Supported	27			
Sheltered				1530
Extra Care				1/36 (4/215)
Intermediate				30
Community Hospitals				

# Future Developments






- Known developments in Ashford that attract Development Contributions
- Adult Social Care collect on prevalence of population likely to have a social care need
  - Building Community Capacity, accessible provision
  - Wheelchair Accessible Housing
  - Assistive Technology



# Funded Service Profile - Ashford

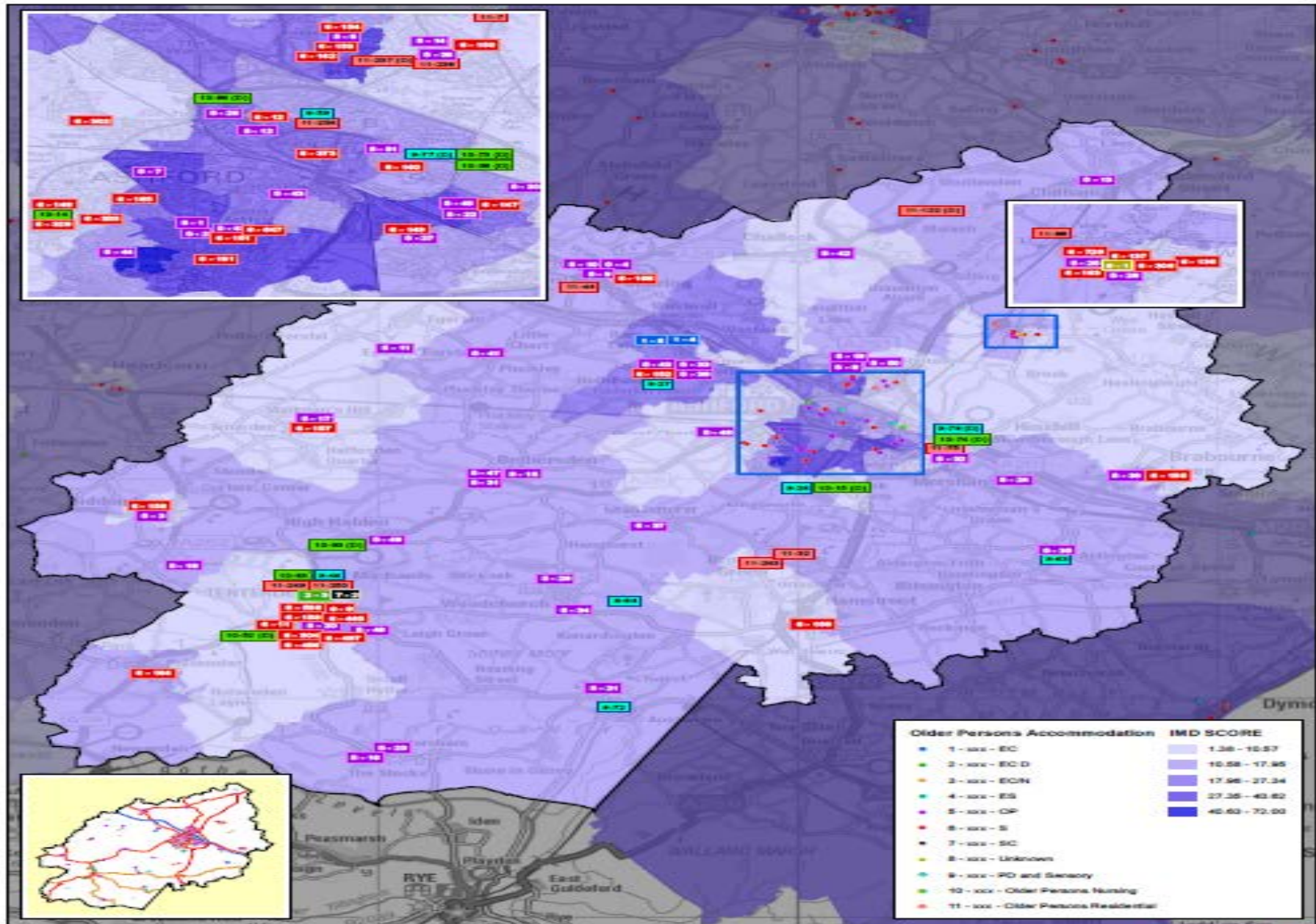
	LD	MH	PD	OP
Residential	55	2	9	134 res (23%) 166 nur (75%)
Supported Accommodation	70	20	20	30
Adult Placement	10			
Community Service	180	10	100	460
Direct Payment	80	10	100	40
DLA Claimants			3,380	

# Service Ratios

Service Type	National Ratio	Kent Ratio	Ashford Ratio	
Sheltered	<b>125</b> units per 1000 pop 75+	144	167	
Extra Care	<b>45</b> units per 1000 pop 75+	1.51	4.37	
Residential Care	<b>65</b> units per 1000 pop 75+	65.7	64.7	
Nursing Care	<b>45</b> units per 1000 pop 75+	30	24	
Intermediate Care	<b>26.3</b> units per 100,000 pop	29.7	41.6	

# Placement Profile

- 42% of residential placements made in Shepway
- 41% of residential placements made in Ashford
- 7% of nursing placements made in Maidstone
- 9% of nursing placements made in Shepway
- 76% of nursing placements made in Ashford



# Considerations

- Average size of care home in Ashford for older people = 35 beds
- Vacancy rate for older person's care homes = 3% across East Kent – national vacancy rate = 7%
- CCG investment into community services
- KCC focus on prevention
- Additional 215 extra care units in development
- KCC purchase 23% of the residential market in Ashford and 75% of the nursing market

# Ashford District Profile

<b>Older People:</b>	<b>EXISTING</b>	<b>2021</b>	<b>+/-</b>	<b>Known Activity</b>
Residential incl Dementia Care	590	496	-94	
Nursing incl Dementia Care	220	490	270	
Extra Care	36	452	416	262
Sheltered Housing	1530	1200	0	-36
Intermediate Care	30	tba		

# Some Conclusions

- More extra care housing – all tenure
- More supported accommodation
- A greater focus on prevention
- Flexible business models for short term enablement
- Innovative design and technology ready accommodation
- Reduce long term reliance on care homes

# Any Questions?

## Christy Holden

Head of Strategic Commissioning – Accommodation

Kent County Council

Social Care, Health and Wellbeing

[Christy.holden@kent.gov.uk](mailto:Christy.holden@kent.gov.uk)

07920 780623



By: Sharon Williams

To: Ashford Health and Wellbeing Board

Date: 23<sup>rd</sup> April 2014

Subject: **Homelessness Strategy**

Classification: Unrestricted

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### **Summary**

This report presents an outline of Ashford Borough Council's Homelessness Strategy and identifies current operational practices.

### **Recommendation**

The Ashford Health and Wellbeing Board is asked to support the implementation and delivery of the Homelessness Strategy. The Board is also asked to consider the issues raised at the conclusion of the report.

## **Homelessness Strategy Overview**

### **Vision**

The vision for the borough, described in the Ashford 2030 Framework is

#### ***Best Placed in Britain for Living and Opportunity***

The direction we provide to prevent homelessness in Ashford in the homelessness strategy will contribute to this ambition. We want to see a reduction in the number of households who become homeless and an end to rough sleeping. To do this there will be 3 main outcomes:

- 1. Ashford wide commitment to preventing homelessness wherever possible, beginning with access to information and advice for all.**
- 2. Quality housing services and suitable accommodation for people for whom homelessness cannot be prevented.**
- 3. Settled and sustainable homes, with access to housing support where needed.**

Our strategy describes how we will achieve these outcomes whilst contributing to the 2030 priorities.

<b>2030 priority</b>	<b>For people who are at risk of homelessness, or homeless, the council and partners, will:</b>
<b>Prosperity:</b>	<ul style="list-style-type: none"> <li>• Support people who have lost their job to keep their home until they find work, and prevent repossession</li> <li>• Enable access to education, training and employment, and support people to contribute to the local economy</li> <li>• Advise people about their housing and employment options, and other matters that will affect their prospects and prosperity</li> </ul>
<b>Community:</b>	<ul style="list-style-type: none"> <li>• Encourage and enable people to meet their own housing needs wherever possible</li> <li>• Provide timely information and advice so people can make informed choices and avoid crisis</li> <li>• Support voluntary and community groups who work with people who are at risk of homelessness, or homeless</li> <li>• Enable people to contribute to the local community and neighbourhood</li> <li>• Involve people in decisions about homes and housing services</li> </ul>
<b>Quality:</b>	<ul style="list-style-type: none"> <li>• Improve access to quality, affordable and suitable, housing</li> <li>• Enable people to access services that will improve their quality of life, for example health or leisure services</li> <li>• Support people to overcome crises and to move towards independent living</li> <li>• Ensure that homes and housing services that contribute to our outcomes are value for money</li> </ul>

## Summary of detailed outcomes

### Outcome 1

#### Ashford wide commitment to preventing homelessness wherever possible

There will be:

- An up-to-date understanding of homelessness in Ashford so that we are able to direct our resources appropriately.
- A commitment from all agencies in Ashford to recognise homelessness triggers and to refer those at risk to appropriate services.
- Readily available information and advice so that residents are able to meet their own housing needs as far as possible, and prevent homelessness.

## **Outcome 2**

### **Quality housing services and suitable accommodation for people for whom homelessness cannot be prevented**

There will be:

- Quality homelessness services and temporary accommodation suitable for people with different needs.
- Clear pathways to settled housing, a better quality of life, health and wellbeing.

## **Outcome 3**

### **Settled and sustainable homes, with access to housing support if needed**

There will be:

- Suitable accommodation and support for people with health, care or support needs who are at risk of homelessness, or homeless.
- More social and affordable housing, and effective housing management to ensure this resource meets housing needs and prevents homelessness.
- Improved access to suitable and good quality private rented homes, that are affordable and sustainable in the longer term.

## **Issues for discussion with the Board**

1. Demand for accommodation outstrips supply which often results in the use of costly and unsuitable bed and breakfast accommodation. It is therefore essential that all partners refer those under potential threat of homelessness to the Housing Options Team as soon as possible so that there is maximum opportunity to prevent homelessness.
2. The Housing Options Team is developing work with the private rented sector so that we can secure suitable alternative housing for those under threat of homelessness. We offer a range of options and also manage our own in house lettings agency to try to achieve this. However we are aware that partners may also be engaging with the private rented sector locally and it is important that we have a joint strategy for this.
3. We need to undertake a re-refresh of the homelessness strategy to ensure it is fit for purpose. To this end we need a mechanism to

open an ongoing dialogue with partners within the Board. The strategy is not just about housing but also the services and support networks that other partners provide such as health and social services.

4. We need to jointly identify clear housing pathways for vulnerable people. Especially those leaving prison, hospital or care who often have other vulnerabilities including drug and/ or alcohol addiction, anger management, learning disability, mental health issues, etc.
5. Young People are of particular interest and we are trying to look at how we can operate a rapid response service jointly with social services either early intervention team or adolescent team to make the maximum joint effort to keep a young person at home and put in the relevant support to sustain them at home.
6. We need to develop further our links with health and work more effectively both in relation to preventing clients from becoming homeless and also if they become homeless and we need clear communication networks to achieve this.

**Flowchart depicting the process of a homelessness application:**

