By: Richard Robinson

To: Ashford Health and Wellbeing Board

Date: 23rd April 2014

Subject: **Think Housing First**

Classification: Unrestricted

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 heath 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 of 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 homeloss 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=docm93jijm4n3211.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 therefor 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

Objective 1: Reduce the negative impact of homelessness on health					
No.	**Action**	**Outcomes**	**Lead**	**Timescales**	**Progress**
1.1	**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**	• Porchlight to present referrals to GP link workers to KHOG in Jun 13. • KHOG to discuss referrals to GPs with KAASH service.
1.2	**Signpost households placed in temporary accommodation to GPs**	Increase no. of homeless households accessing primary health care services	LHAs	**Jun 2014**	• Work in progress to develop a template for local information sheets as part of homeless interview.
1.3	**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**	• Ask LHAs and RPs to put links on their websites? • Include reference to these resources in the 'Move on Toolkit'? • Ask LHAs & RPs to publicise in residents' newsletters. To provide a short article for this. • To consider requesting a campaign on the Kent Homechoice website. • Health and Wellbeing booklet drafted covering accessing health care services, healthy eating, exercise and mental wellbeing.
1.4	**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**	
1.5	**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**	
1.6	**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**	
1.7	**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**	• Contact made with Jacqui West KCC to liaise with Acute Care Coordinators (Feb 2014). • Attending Urgent Care Board in Dover 3 Apr 13. • Attending Navigation Pathway meeting 10 Apr 13.

Objective 2: Encourage people to live in homes with good air quality					
No.	**Action**	**Outcomes**	**Lead**	**Timescales**	**Progress**
2.1	**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	• KFRS contacted for stats to show concentration of accidental fires to encourage relevant LHAs to refer more vulnerable clients – awaiting info. • Include in housing action plan for Dementia Action Alliance –JPPB Apr 14.
2.2	**Investigate the feasibility of housing providers introducing no smoking clauses in tenancy agreements**	Increase no. of smoke free homes	LHAs Registered Providers	Dec 2014	• Have discussion with RPs about the possibility of providing ashtrays outside properties. HSE group to take forward for future developments.
2.3	**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	• Meeting with Malti Varshney 9 Apr 14 to take forward.
Objective 3: Ensure homes are warm, dry and free from hazards					
No.	**Action**	**Outcomes**	**Lead**	**Timescales**	**Progress**
3.1	**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	• YHYH now has an item re falls included. PSHG to look at feasibility of rolling out across Kent.
3.2	**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	• Awaiting meeting with Karen Shaw (Feb 2013) booking phone conversation March.
3.3	**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	• Awaiting feedback from Karen Shaw (Feb 2014) booking phone conversation March.
3.4	**Develop a falls hospital to home referral protocol for those requiring a return home to a safe**	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	• See 5.1

	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**	• See 5.1
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**	• SW attended KEG meeting in Oct 13 to request this is put on future programme of training. • KCC Health Trainers contacted to arrange one event each in West and East Kent. • Health and Wellbeing booklet drafted covering accessing health care services, healthy eating, exercise and mental wellbeing..
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**	• Take this action to KPOG. • SW to pull out the overlap with Think Housing First and the 'Planning Healthier Places' report. • Name of lead from Debbie Smith to progress.
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**	• As above
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**	• Task PSHG – requested to be on May 2014 agenda – relevant to 3.4 & 3.5.
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**	• 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.
5.3	**Provide training to housing partners**	The housing sector actively considers the impact of their policies and	Public Health LHAs	**Dec 2014**	

	on the Health Inequalities and Wellbeing Impact Assessment (HIWA)	services on health inequalities	Registered Providers		
5.4	**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**	• In progress – Swale BC (Amber Christou) working with Abraham George from PH on this.

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

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

John Littlemore

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

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

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

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

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

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

1. Introduction

About Think Housing First

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

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

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

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

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

Why housing is important

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

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

Vision

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

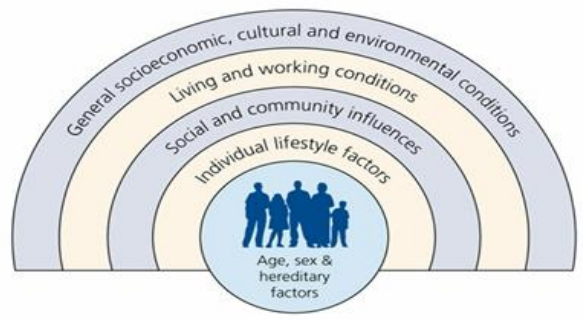
- To take advantage of the new opportunities, driven by the recent health reforms, for housing to strengthen collaboration and engagement with health
- To maximise the contribution of housing in improving people's health and wellbeing
- To raise awareness to health colleagues of the role of the housing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

2. Background

What are health inequalities?

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

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



Dahlgren and Whitehead (1991)

The Marmot Review

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

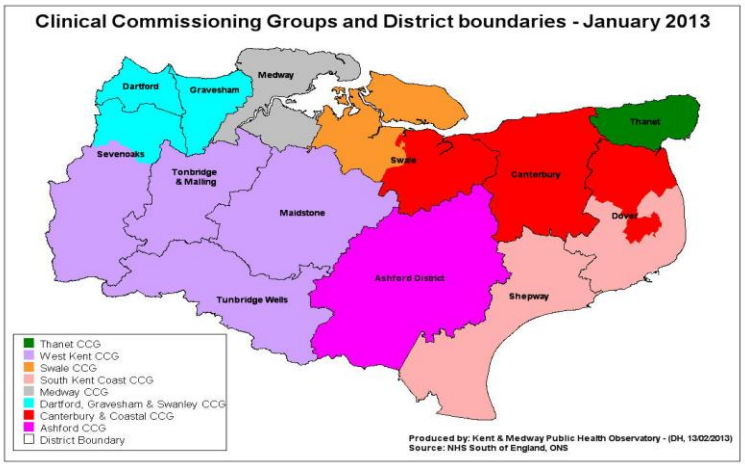
1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places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

Health inequalities in Kent

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

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

Public health in Kent



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

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

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

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

3. The role of the housing sector

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

Homelessness

Homelessness advice and assistance

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

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

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

Joint homeless protocols

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

Housing related support

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

Affordable housing provision

Supply of housing

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

Housing allocation schemes

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

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

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

Private Sector Housing

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

Housing, Health and Safety Rating System (HHSRS)

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

Green Deal

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

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

Accreditation schemes

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

Licensing

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

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

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

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

Safe and accessible housing

Disabled Facilities Grants (DFG)

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

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

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

Housing Assistance

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

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

Home Improvement Agencies (HIA)

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

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

Referral schemes

Your Home Your Health

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

HELP

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

4. How housing impacts on health inequalities

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

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

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

Mental health and wellbeing

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

Objective 1: Reduce the negative impact of homelessness on health

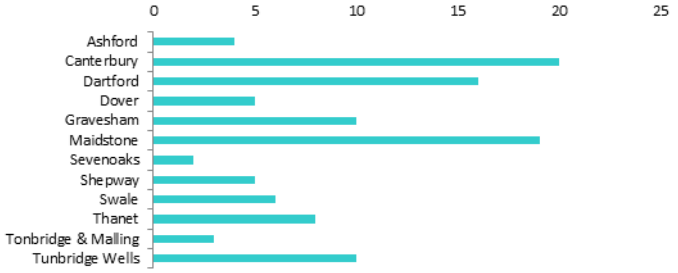
Rough sleeping

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

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

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

The Kent picture – rough sleeping[vii]



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

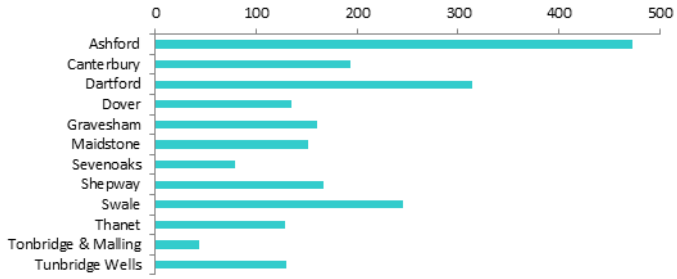
Homeless households in temporary accommodation

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

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

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

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



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

Recommendations

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

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

Smoking

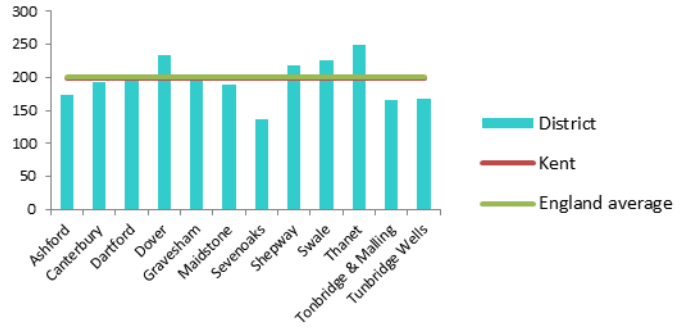
Smoking contributes to three main health problems; lung cancer, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Smoking during pregnancy increases the risk of low birth weights, miscarriage and perinatal death. Smoking after pregnancy increases the risk of sudden infant death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

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

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

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

The Kent picture – Smoking related deaths[xiii]



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

Tuberculosis

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

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

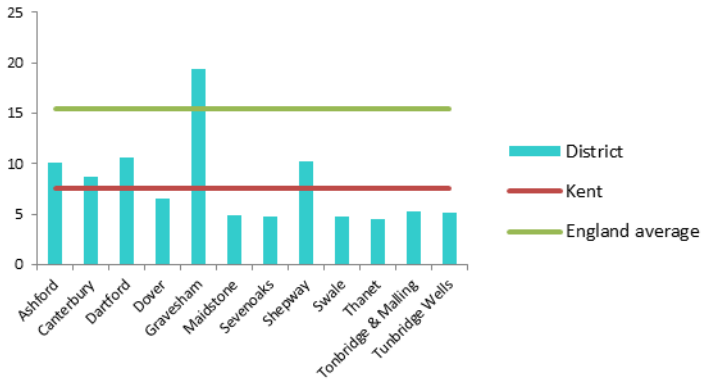
People who have tuberculosis are more likely to be homeless people and those living in poor housing, overcrowded housing and houses in multiple occupation (HMOs), where the infection can be spread more easily. Areas with higher rates of migration or established communities originating from countries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

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

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

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

The Kent picture – New cases of tuberculosis[xv]



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

Recommendations

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

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

Excess winter deaths

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

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

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

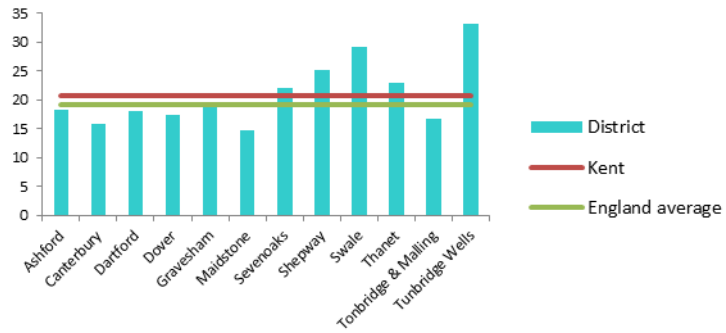
Damp housing can be caused by poor maintenance such as a leaky roof or from water from the ground getting into floors and walls. Condensation can also cause dampness and lead to black mould forming. This increases the risk of causing or exacerbating asthma and other respiratory illnesses due to the inhalation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

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

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

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

The Kent picture – Excess winter deaths[xvii]



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

Falls

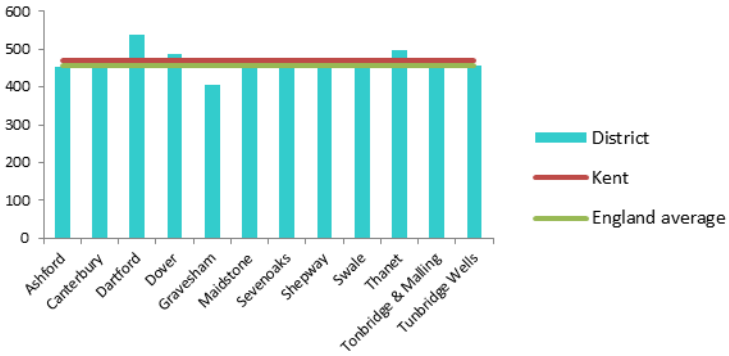
Falls are a significant health issue that can lead to fractures and broken bones, particularly hip fractures in older people. There is a high mortality rate after a hip fracture which is around 30% after one year of having the fracture. Health related causes of falls include the use of certain medications,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



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

Recommendations

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

Objective 4: Develop our neighbourhoods to be healthy places

Obesity

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

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[xxiii]. 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[xxiv].

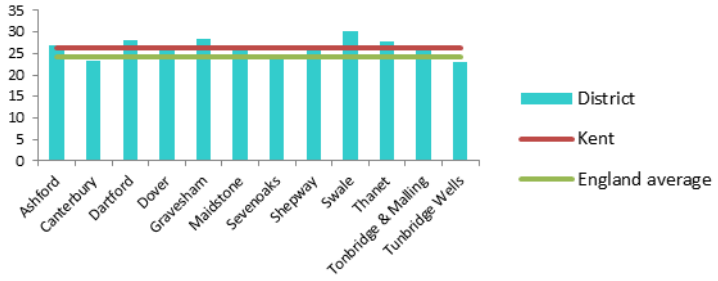
Where people live affects their chances of having an active life. The built environment helps to shape the communities in which people live and their access to amenities. Public spaces and transport networks can facilitate healthy lifestyles by providing opportunities for physical activity, social interaction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



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

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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