

Suffolk Housing and Health Needs Assessment

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Key findings



As many as 1,230 excess winter deaths in Suffolk may have been due to cold homes in the last 10 years.

A median of 110 deaths per year

Fuel poverty in Suffolk has dropped from 11.4% to 9.1% in the last five years.

BUT There are still nearly 30,000 households in fuel poverty.

10,687 Properties in Suffolk which do not meet the Decent Home Standard under the Housing, Health and Safety rating because they are excessively cold

50% Nearly 50% of the housing stock in Suffolk is over 50 years old, with 15% built in the last 20 years.

£88m Half the annual cost of heating Suffolk homes (£88 million out of £170 million) could be saved by implementing standard energy efficiency improvements.

£ House prices in Suffolk have increased by 25.7% on average over the last 5 years.

Prices for the lowest-priced quartile increasing by 30.9% on average.

There has been a decline in numbers of affordable houses built over the last eight years, with only 320 completed across the county in 2015/16.

Nearly 11,000 households are on the housing register in Suffolk.

Person icon Suffolk's population is forecast to increase by 10% by 2037 (compared to 2015).
This increase is driven by older age groups.

Three person icons In twenty years' time...
1 in 3 people in Suffolk are forecast to be 65+.

The declining market share of social renting and rising barriers to affordability of home-ownership mean it is estimated that 60,000 (70%) of 25-34 yearolds in Suffolk will be living in privately rented accommodation by 2037.

Up arrow icon The number of people with a learning disability is forecast to increase by 9% by 2035.
9% Demand for housing which meets specialist needs is likely to increase.

At the 2011 Census for usual Suffolk residents:

- 78.7% lived in under-occupied housing.
- 89.5% of those aged 65+ lived in under-occupied housing.
- 5.7% lived in overcrowded housing.

Up arrow icon In the last 4.5 years, the number of households being housed in temporary accommodation in both England and Suffolk has increased.

Person and child icon 188 children were in temporary accommodation at the end of 2016/17.
The number of children in temporary accommodation in Suffolk has risen by 27% over the past three years.

Introduction

This Housing and Health Needs Assessment (HHNA) marks new territory for Public Health Suffolk, and is our first Health Needs Assessment (HNA) to consider this topic. The Public Health team are very grateful to the many colleagues across the Suffolk system who contributed to this work and represented a diverse range of stakeholders. These colleagues helped significantly with the co-production of this work, including defining and setting the scope and structure for the Needs Assessment; contributing data for the report; and commenting on draft versions.

This HNA focuses particularly on the relationship between housing and health, and explores that relationship in the context of Suffolk's housing stock and housing costs. The HHNA considers the following dimensions of health and housing:

- Unhealthy housing
- Unsafe housing
- Unsuitable housing
- Insecure housing

The HHNA considers the possible future picture for housing in Suffolk, and highlights areas for focused partnership work to improve health and housing in Suffolk. While some of these areas are familiar to partners in the Suffolk system, including the challenges posed by cold homes, some have evolved significantly in recent months and years (housing cost and the impact of welfare reform), and some relate to the likely needs of the future population. The Suffolk Health and Wellbeing Board has identified housing as a key focus area for 2018/19.

Key findings

Housing stock in Suffolk

- There were an estimated 335,370 dwellings in Suffolk in 2015, 85% of which were privately owned, 9% were owned by housing associations and 6% by local authorities.
- The current housing stock in Suffolk is predominantly old and inefficient to heat. There are large savings to be gained from increasing energy efficiency, but these savings are over the longer term and there would need to be substantial initial outlay to achieve them.
- Nearly 50% of the housing stock in Suffolk is over 50 years old, with 15% built in the last 20 years.
- Half the annual cost of heating Suffolk homes (£88 million out of £170 million) could be saved by implementing standard energy efficiency improvements. However, the costs of these improvements are substantial, depending on the archetype of home.

Housing costs in Suffolk

- The cost and availability of suitable housing is a significant factor for residents in Suffolk; particularly for those who rent privately.
- House prices in Suffolk have increased by 25.7% on average over the last 5 years, with prices for the lowest-priced quartile increasing by 30.9% on average.
- 31% of respondents in the 2014 Suffolk Housing Needs Survey had difficulty meeting some form of housing costs, with high proportions in the private rented sector (52%) and social renting (60%) compared to owner-occupiers (19%).
- The proportion of income that people in Suffolk spend on housing varies starkly by type of tenure: in the Suffolk Housing Needs Survey 24% of private renters estimated they spend 45% or more on housing costs, compared to only 8% of owner-occupiers with a mortgage.
- The most common difficulty was meeting fuel bills (22% of respondents). This was highest for those in private rental (36%) and social rental (41%) compared to owner-occupiers (14%).

- Four of the five top reasons preventing people who wanted to move home in Suffolk from doing so, were related to the costs involved with the moving process.
- Forecasts of population growth and market trends show ever expanding gaps in terms of meeting housing needs and growing risks to health, particularly for those residents who may be vulnerable or who have specialist housing needs; these factors may push housing costs still higher in the future.

Unhealthy housing in Suffolk

- Cold homes are bad for health. As many as 1,230 excess winter deaths in Suffolk may have been due to cold homes in the 10-year period from 2005 to 2015, with a median of 110 deaths per year.
- In the past 10 years there has been a rising trend in numbers of excess winter deaths, with a particular rise to 740 in 2014/15.
- The level of fuel poverty in Suffolk has dropped from 11.4% to 9.1% in the last five years. However, there are still nearly 30,000 households in Suffolk who experience fuel poverty and therefore are at risk of the (potentially severe) health impacts of living in a cold home.
- A median of 37 excess winter deaths per year in Suffolk may have been due directly to fuel poverty.
- Strengthened action to reduce excess winter deaths and illness associated with cold homes in Suffolk is highlighted as a priority for further work. There is good evidence for effective actions to prevent excess winter deaths, and modelling suggests that the estimated costs would be paid back within seven years, in terms of savings to the system.
- Estimates suggest that nearly 5% of cases of asthma morbidity and mortality in Suffolk could be prevented if children were not exposed to damp homes, and nearly 3% of cases of morbidity or mortality could be prevented if they were not exposed to mould in their homes; this is equivalent 622 cases of asthma in children across Suffolk Clinical Commissioning Groups (CCGs).
- According to the 2014 Suffolk Housing Survey, 15% of households who wanted to move said their main reason for wanting to do so was that their property was affecting their health. This varied by tenure with 31% of those in socially rented housing, 15% of those in privately rented housing and 6% of owner-occupiers giving this reason.

Unsafe housing in Suffolk

- There are an estimated 10,687 properties in Suffolk which do not meet the Decent Home Standard under the Housing, Health and Safety rating because they are excessively cold.
- If the risk of excess cold was removed, cost modelling suggests a potential average yearly saving to the NHS in Suffolk (in first year treatment costs) of £6.84 million. The estimated cost to remove the risk of excess cold (£48.9 million) would be paid back by only seven years of NHS savings.
- For falls hazards, a potential average yearly saving to the NHS (in first year treatment costs) of £5.3 million was found. The estimated cost to remove these falls risks (£22.5 million) would be paid back by just over four years of NHS savings.
- Local Authorities are continuing to take action to reduce the number of non-decent homes in Suffolk, with only 0.8% (147) of local authorities' housing stock 'non-decent' in 2015/16 and 238 private sector dwellings made 'decent' as a result of action by local authorities in the same year.

Unsuitable housing

- An estimated 6,000 over 75's who need specialist housing (defined as sheltered, extra care, residential care, or nursing care), already have difficulties accessing that housing provision in Suffolk currently. As Suffolk's population ages, these needs are likely to increase.
- In addition to older people, other vulnerable people may also have specialist housing needs. Suffolk is currently significantly worse than the England average at meeting the need of our residents with learning disabilities for secure and appropriate accommodation.

- There are an estimated 1,750 residents with disabilities in need of significant care and support in Suffolk, of which a high proportion will have specialist housing needs, but only approximately 1,000 specialist housing places for disabled adults are currently available.
- The population with a learning disability is forecast to increase by 9% by 2035, which is likely to put further pressure on the requirements for suitable accommodation still further.
- Further populations in Suffolk who may have specialist housing needs include (but are not limited to): family carers, those affected by domestic abuse, transient populations (for example Gypsy, Roma and Traveller populations), those with substance misuse problems (drug, alcohol or both) and mental ill health (referred to 'dual diagnosis'), care leavers, people that have served a custodial sentence, and veterans.
- Usual residence is defined in the Census as the place where a person lives and sleeps most of the time. At the time of the 2011 Census:
 - 78.7% of usual residents in Suffolk (562,000 people) lived in under-occupied housing. This compared with 74.5% in the East of England and 69.7% in England. In the over 65 age group, this rose to 89.5%, compared with 87.4% in East of England and 85.3% in England living in under-occupied housing.
 - 5.7% of usual residents in Suffolk (40,704 people) lived in overcrowded housing. This compared with 7.9% in East of England and 11.1% in England.

Insecure housing

- A total of 4% (19/441) of small areas (Lower Super Output Areas- LSOAs) in Suffolk were in the most deprived 20% nationally in relation to 'wider barriers to housing' (defined as overcrowding, homelessness and difficulty of access to owner-occupied accommodation within the Indices of Deprivation 2015). These were concentrated in the most densely populated areas.
- The 2016 house price to income ratio for Suffolk shows that the average house price is just over 7.5 times the average gross annual earnings. In contrast to the national picture, in Suffolk the house price to income ratio is higher (less affordable) for those people in the lowest income bracket.
- There has been a decline in numbers of affordable houses built over the last eight years, with only 320 completed across the county in 2015/16. Nearly 11,000 households are on the housing register in Suffolk.
- In the last 4.5 years, the number of households being housed in temporary accommodation in both England and Suffolk has increased.
- The number of children in temporary accommodation in Suffolk has risen by 40 children over the past three years, with 188 children in temporary accommodation at the end of 2016/17.

Future picture

- Suffolk's population is forecast to increase by 10% by 2037 (compared to 2015). This increase is driven by older age groups, with a 54% increase in over 65s.
- The age, energy efficiency and rurality of Suffolk's housing stock, in combination with larger cohorts of older people (including more with long-term conditions), will influence the numbers of vulnerable older people at risk of the severe health impacts of cold and hazardous homes.
- Without substantial investment, predominantly at the level of individual owner-occupiers or private landlords, the burden of fuel costs, carbon emissions, poor health outcomes and the associated costs to the NHS and society associated with inadequate housing will continue to increase.
- Rents are forecast to rise by around 90% in real terms between 2008 and 2040 – more than twice as fast as incomes.
- With the declining market share of social renting and the rising barriers to affordability of home-ownership, it is estimated that 60,000 (70%) of 25-34 year olds in Suffolk will be living in privately rented accommodation by 2037.

A future focus

Through completion of this housing and health needs assessment (HHNA) a list of the areas for focused partnership work has been produced. It is only by working with a broad range of partners across Suffolk that the changes needed to strengthen health through housing can be achieved. The section in this HHNA giving further information about each focus area is included in brackets.

1. System wide commitment and strategy

- Renew political commitment to recognise housing as a major determinant of both the health and wellbeing of the local population, and the productivity and growth of the local economy (Literature review).
- Use the HHNA to help produce a Suffolk system wide strategy that prioritises the main health related issues and populations to be addressed and includes:
 - building upon the commitments made in the Suffolk Housing and Health Charter
 - improving the energy efficiency of the existing housing stock (Current picture in Suffolk)
 - working towards meeting the National Institute for Health and Care Excellence (NICE) quality statements to prevent excess winter deaths and illness associated with cold homes (Current picture in Suffolk, Literature review best practice)

2. Planning

- Formalise links between Strategic Housing Market Assessments, local housing strategies and the Suffolk HHNA to help ensure a focus on the relationship between housing and health, and that strategic housing work is informed by the latest evidence of current and future population need (Future picture in Suffolk).
- Support work that recognises the value to local communities of ensuring a mix of accommodation that enables people and families to maintain their connection to a community throughout the life course should they wish, and the value this can add to local communities by maintaining social networks (Literature review).
- Use this HHNA as evidence to enhance quality standards in new builds and renovations that go beyond nationally mandated minimum standards (e.g. in terms of space, energy efficiency, Life homes design criteria) by making the objectives of protecting and promoting health explicit in the planning process (Energy efficiency).
- Continue promoting healthy behaviours in housing development design e.g. active travel, access to green space, social interaction, and access to services (Literature review).
- Ensure there are clear links and systems that maximise the use of local expertise on housing and health (e.g. district and borough housing teams, Environmental Health teams, housing associations, Public Health) in the strategic planning process (Literature review).
- Consider updating the Suffolk Design Guide to take account of recent evidence for example on design features that encourage active travel (Literature review).

3. Housing improvements

- Work on ensuring that local housing strategies and their resourcing recognise the requirement both for additional new housing and for maintaining/upgrading the existing housing stock, their potential contribution to improving population health, reducing demand and cost to the health and care system, and improving productivity and growth (Energy efficiency, Unhealthy housing).
- Explore avenues for enhanced regulatory approaches to address the quality of housing and security of tenancy in the private rented sector (National Policy, Insecure Housing), e.g.:

- registration/licensing of landlordsⁱ
- surveys of housing conditions
- star rating of PRS properties
- incentives to make energy efficiency improvements
- incentives to offer longer-term tenancies
- targets for minimum EPC ratings over time
- ensure landlords are aware of their duties and responsibilities

4. Vulnerable groups

- Review the sustainability of funding arrangements for non-statutory services that feature housing support/interventions as a key component in addressing health needs of vulnerable people (e.g. Warm Homes Healthy People (WHHP), STARS, Alcohol Recovery Project for Street Drinkers) (Current service provision).
- Ensure the WHHP service is included in system wide Health and Social Care winter planning, and explore novel ways to promote awareness both to vulnerable households and to health and social care workers who engage with them, particularly where home visits occur. Public Health/NHS campaigns to promote “Stay Well This Winter” and flu vaccination for eligible groups could incorporate messaging about the WHHP service (Literature review best practice).
- Raise awareness among frontline health and social care staff of the benefits of housing adaptations for older people and the risks of cold homes (and other hazards); empower them with the knowledge and skills to discuss patients’ home environment and how it may impact their health, and how to address issues (including referral to WHHP or other services) (Literature review best practice).
- Ensure information on housing improvement grants and initiatives are shared widely with community support groups such as Citizens Advice, Age Concern etc.so they can promote the links with the vulnerable groups they work with (Current service provision).
- Consider health coaching training for non-health staff who engage with people about their housing and health needs e.g. Housing Officers (Literature review best practice).
- Explore the feasibility and cost effectiveness in the Suffolk context of housing interventions, such as Housing First, that are aimed at people with complex and multiple needs whose contact with services has been unsuccessful in breaking the cycle of housing instability (Literature review best practice).
- In response to the recently published House of Commons Committee of Public Accounts report on homeless households, Suffolk County Council as well as District and Borough councils, have an opportunity to lobby for change to work together, and also work to provide wrap-around support for those who are most vulnerable.
- The needs of specialist population groups in Suffolk need to be considered in more detail in relation to current and future housing need.

5. Information and intelligence

- Capitalise on the innovative work done in constructing the Suffolk Housing Stock database: consider options for how it can be updated periodically from routine and local data sources, and explore opportunities via data-sharing agreements for how it could be linked to health, social care and housing data to create a housing risk register (both in terms of quality of housing and vulnerable households) to identify needs and target campaigns and interventions (Housing stock).

ⁱ It should be noted that security of tenancy is different from poor practices of landlords, and there are already powers of licencing of HMOs. It may be prudent for system partners to explore whether there is scope for a common approach to additional HMO and/or selective licencing.

- Consider establishing metrics at smaller area levels to enable more granular monitoring and assessment of the patterns and trends in housing and health needs in each district and borough (Unhealthy housing).

6. Individual advice

- Promote partnership working to raise public awareness about the relationship between housing and health, and actions that people can take according to their tenure and circumstance (Literature review), e.g.:
 - behaviour advice such as ventilation/heating to prevent condensation/damp/mould, monitoring room temperatures and using heating to ensure thermal comfort
 - energy efficiency upgrades to improve thermal efficiency, reduce fuel costs, and reduce associated carbon emissions
 - how to access advice and support
 - links to reputable providers, services, products and designers that may help older people and their families adapt their homes to their needs as they age
 - rights of tenants and how to report poor housing conditions - under the Housing Health and Safety Rating System



Main Report

1. Introduction

The relationship between poor housing and poor health has long been recognised. It is tied in to the history of public health itself, and to early victories against infectious diseases associated with poor sanitation and overcrowding. Good housing is essential to our health and wellbeing. Not only directly, where poor housing conditions can cause or exacerbate ill health, but also indirectly, through supporting other wider determinants of health such as education, employment and social interaction.

The UK has one of the oldest housing stocks in the world which presents particular challenges for the health of our population, especially as that population ages. Low building rates, fewer affordable options, rising prices and high living costs mean that more people are finding themselves without ready access to good quality homes of a tenure of choice, in precarious housing situations, or even homeless, with profound impacts on health and wellbeing.

This is the first time that the Suffolk Public Health team have gathered and analysed a health and housing evidence base in a Suffolk context. This topic is a fluid and developing area in relation to public policy, so for the purposes of this needs assessment the focus had been on:

- Unhealthy housing
- Unsafe housing
- Unsuitable housing
- Insecure housing

Housing and health was the topic for consideration of the Health and Wellbeing Board in January 2018, and it is a key topic area for 2018/19. The main findings from this Housing and Health Needs Assessment were presented to the board and there was a particular focus on housing and insecurity.

1.1 Aims and objectives

The aim of this housing and health needs assessment (HHNA) is to examine the evidence and relevant policy contexts, so that those working within the Suffolk System have a shared understanding and can co-produce a workable strategy to ensure more and improved homes, which reduce health inequalities, and support people to live independent lives.

Specifically, the objectives are:

- to review the evidence for the relationship between housing and health
- to review key national and local policy relevant to housing and health
- to identify current and future need in Suffolk relating to housing and health
- to review evidence and policy regarding how to improve health through a focus on housing

2. Policy context

This section outlines the key national and local policies in relation to housing and health.

2.1 National context

'A Memorandum of Understanding (MoU) to support joint action on improving health through the home'

In 2014 a "Memorandum of Understanding (MoU) to support joint action on improving health through the home" was agreed between government departments, agencies such as Public Health England, NHS England, the Association of Directors of Adult Social Services, the Association of Directors of Public Health (ADPH), and other housing and health sector organisations¹. It set out a shared commitment to joint action and a framework for cross-sector partnerships to deliver healthy homes, better health and wellbeing outcomes, more integrated services, and to reduce health inequalities. Its stated aims were to:

- establish and support national and local dialogue, information and decision-making across government, health, social care and housing sectors
- co-ordinate health, social care, and housing policy
- enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services
- promote the housing sector contribution to: addressing the wider determinants of health, health equity, improvements to patient experience
- develop the workforce across sectors so that they are confident and skilled in understanding the relationship between where people live and their health and wellbeing, and are able to identify suitable solutions to improve outcomes

As well as highlighting the negative health impacts of poor housing, the MoU states that the key features of the right home environment are:

- it is warm and affordable to heat
- it is free from hazards, safe from harm and promotes a sense of security
- it enables movement around the home and is accessible, including to visitors
- there is support from others if needed

The right home environment can:

- protect and improve health and wellbeing and prevent physical and mental ill-health
- enable people to manage their health and care needs, including long-term conditions, and ensure positive care experiences by integrating services in the home
- allow people to remain in their own home for as long as they choose

In doing so it can:

- delay and reduce the requirement for primary care and social care interventions, including admission to long-term care settings
- prevent hospital admissions
- enable timely discharge from hospital and prevent re-admissions to hospital
- enable rapid recovery from periods of ill-health or planned admissions

The MoU identifies the key local stakeholders who are in a position to enable the right home environment for the local population, and highlights how local authority and voluntary and community services have knowledge and insight that can enable health partners to target services to those most in need.

Care Act 2014

Under the Care Act 2014, there is a requirement for closer cooperation between services that support the health and wellbeing of those who require care and support, in order to deliver more person-centred outcomes². This legislation specifically calls for:

- a shared vision and culture of cooperation and coordination across health, public health, social care and local authority roles, e.g. as housing commissioners, working closely with public, voluntary and private sector providers to improve services
- services that will address the wider determinants of health, e.g. housing, employment

Housing White Paper 2017: “Fixing our broken housing market”

In 2017 the UK Government released a housing white paper setting out its plans to reform the housing market and boost the supply of new homes in England³. It acknowledges that years of under-supply of housing has led to the doubling of the affordability ratio (the ratio of average house prices to average income) in the past 20 years, and to a failure to keep up with population growth³. It recognises: the growing challenge for young people to get on the property ladder without assistance from their parents; the rising cost of private renting; the increasing difficulty of renting a safe, secure property. The paper highlights that the loss of a private sector tenancy is now the most common cause of homelessness in the country³. The white paper makes no explicit mention of the relationship with health, something which was highlighted as a missed opportunity in the Association of Directors of Public Health (ADPH) consultation response, given that housing is a key determinant of health. It also missed the opportunity to look more broadly at healthy neighbourhoods⁴.

All Party Parliamentary Group (APPG) for Healthy Homes and Buildings Green paper 2017

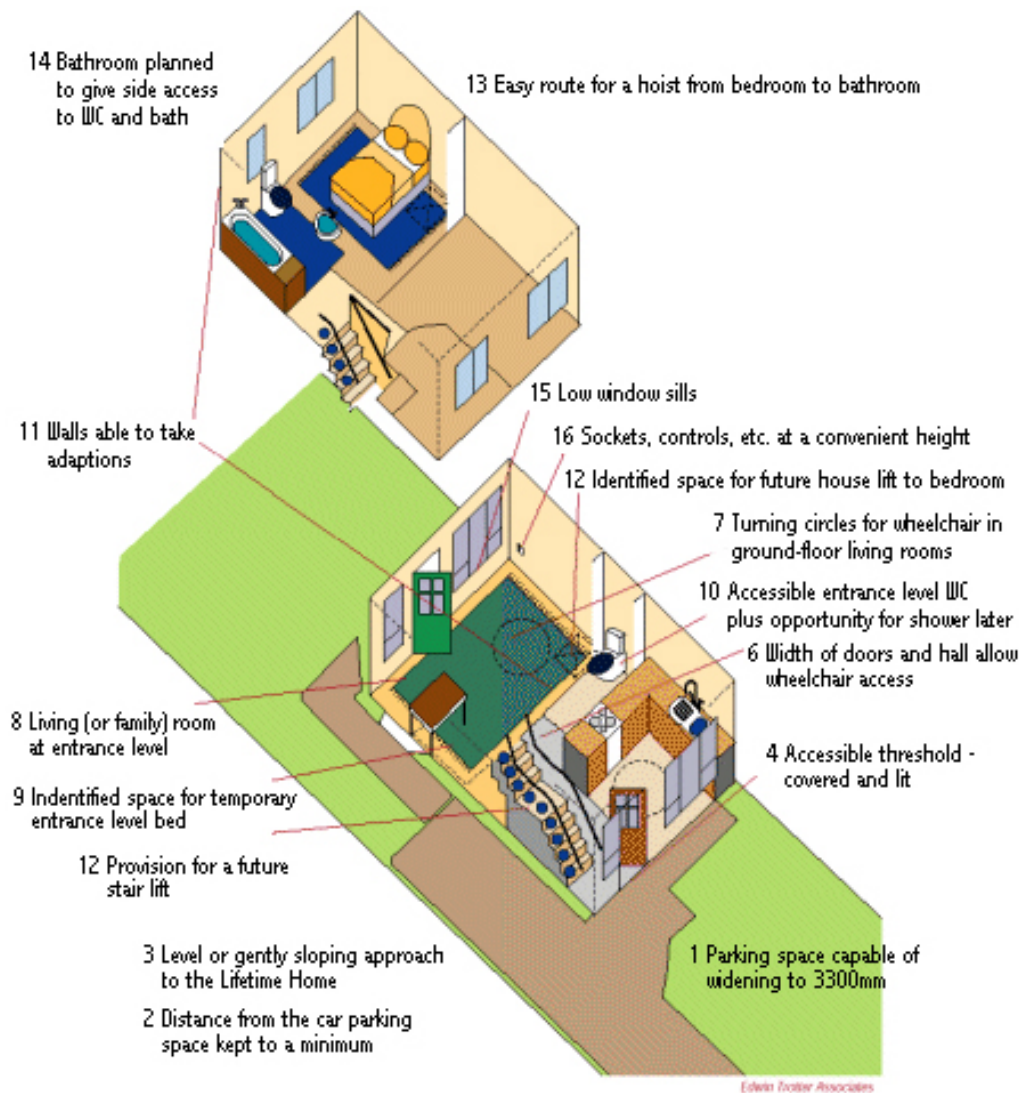
The APPG for Healthy Homes and Buildings recently launched a consultation on their draft green paper. The APPG seeks to influence legislators to recognise the significant health impacts of unhealthy buildings, to raise standards, and to improve building regulations to ensure that every home and building is fit for purpose and does not create or exacerbate health problems⁵. It sets out the political, economic and business case for healthy homes and buildings, arguing that both existing stock and new housing should be seen as part of the infrastructure crucial to strengthening economic development, and improving productivity through its influence on health, education and employment⁵. It highlights the benefits of healthy homes and buildings as leading to:

- lower costs to the health service and a healthier population
- better educational attainment and higher productivity
- reduced emissions, lower energy bills and a lower carbon footprint
- improved wellbeing and comfort
- greater life chances, independent living and care

Accessible and Adaptable Dwellings (Lifetime Homes)

The concept of Lifetime Homes originates from the Joseph Rowntree Foundation and Habinteg Housing Association⁶. A lifetime home is any home that has incorporated 16 design criteria to provide a flexible and adaptable home based on an individual’s differing needs. The figure below shows these 16 heading level criteria, each contains further sub levels:

Figure 1: Design criteria for a lifetime home



In 2008, the Department of Health's national strategy *Housing in an Ageing Society* cited a vision to see all new homes built to Lifetime Homes standard by 2013⁷. A report by the Lords Committee on Public Service and Demographic Change⁸ in 2012 made two recommendations regarding Lifetime Homes:

- the government should support research and initiatives such as lifelong homes and the use of technology in the home to support older residents
- there should be investment in services that help older people adapt their own homes to allow them to live there for longer

The Government reviewed housing standards, including the potential to introduce the Lifetime Homes Standard in 2013. A new section of the building regulations was introduced in 2015 - Part M4(2) – with the aim to make dwellings usable by a wide range of householders; from families with young children, to older less agile people, and anyone living with a mobility impairment, whether temporarily or on a longer-term basis. Whilst 18 sublevels of the Lifetime Homes Standard had been disapplied or downgraded, 16 sublevels had been improved or added⁹. Through Local Plans, local authorities can require a proportion of new homes to be built to the new Part 4(M2) standard (but not the Lifetime Homes Standard) if they address a clearly evidenced need, and where their impact on viability has been considered.

2.2 Local context

The importance of the role housing has to play in health and wellbeing has been recognised by the Health and Wellbeing Board in Suffolk by adopting “A Housing and Health Charter for Suffolk”. This was Suffolk’s response to the national MoU. It sets out the vision “for Suffolk people to live in a suitable affordable home that is in good condition where they feel safe and supported by the local community”¹⁰. It recognises the potential for investment in housing to have a significant impact on the prevention of ill health and admission to hospital or care settings. It also recognises that there should be closer working between health, social care and housing partners to deliver better outcomes for the system, and describes how partners from diverse sectors will work together via the Health and Wellbeing Board¹⁰.

The key health benefits identified by the Charter to be delivered by greater integration of services are:

- reducing hospital admissions
- speeding up and improving hospital discharge arrangements
- supporting care at home and in the community to prevent people needing to enter institutional care too early
- decreasing health inequalities

The focus areas for action are identified as:

- specialist housing for older people
- meeting the housing needs of vulnerable young people
- tackling homelessness
- increasing the supply of and access to suitable affordable housing
- reducing overcrowding
- increased access to decent homes including improving the supply of affordable housing for all
- raise awareness of housing’s role in tackling mental health and isolation issues including loneliness

Housing and health was the topic for consideration of the Health and Wellbeing Board in January 2018. Key findings from the Housing and Health Needs Assessment were presented to the board and there was a particular focus on housing and insecurity. It was acknowledged by the Health and Wellbeing Board that it had been difficult to work towards implementation of the vision from the Housing and Health Charter for Suffolk because the subject was so wide and needed coordinated actions across the county. The Board noted the need for the following work:

- i) In relation to **warm homes**, to explore how the Suffolk system could capitalise further on the existing programme to make greater impact on the issue of colder homes and associated health problems.
- ii) To explore how Board partners could work as a system to engage more effectively with **private landlords**.
- iii) To consider how as a system Board partners could improve **support** to individuals beyond bricks and mortar, recognising that the voluntary, community and social enterprise sector had an important role which could be enhanced through greater collaboration.
- iv) That work should take place to understand what existed in housing authority plans/stocks for **small sites** that could be used for specialist housing and improved support to vulnerable people.
- v) In relation to **impact on cohorts** that detailed work should be undertaken with a small number of individuals, with possible areas of focus being care leavers and warm homes.
- vi) To support **additional research into 16 year-olds with a housing need** (not necessarily those in care).

The Health and Wellbeing board agreed to return to the subject of housing and health at the Board meeting in September 2018 and to further consider the impact of the Board’s recommendations at that point.

Suffolk County Council Priorities 2017-2021

Housing, and its links to health, wellbeing, care and support, is reflected in two of Suffolk County Council's priorities for the next four years: Inclusive Growth, and Health, Care and Wellbeing¹¹. The priority for inclusive growth explicitly acknowledges the requirement to build more homes, as well as improving economic productivity and educational attainment, both of which are supported by healthy, secure housing¹¹. For growth to be inclusive, the Council recognises that those who are vulnerable and disadvantaged must also benefit, and that housing has a role to play in reducing health and social inequalities.

Reducing health inequalities is a key aim, along with reducing mental and physical ill health and improving everyone's ability to live longer, healthier lives¹¹. Along with the commitment to support and care for the most vulnerable residents, there is the aim to support people who wish to remain in their homes and live independently, an aim which suitably designed or adapted housing can support.

In this HHNA, vulnerable groups are defined as those that are at particular increased risk of poor physical, psychological, and/or social health. This is taken to be a larger group than the groups at risk of disadvantage (GAROD) identified for particular attention in Suffolk¹². For example, having poor physical health (such as a debilitating chronic illness which is more prevalent in elderly people) may also make one at risk of poor mental health or social health (few supportive social contacts). The risk of harm or neglect would be multiplied for those who are in poor health and have few economic and nonmaterial (psychological or social) resources to assist in coping with illness¹³.



Literature Review

3. Literature review: relationship between housing and health

The literature review below is organised according to the framework adapted from Public Health England's National Homes and Health programme of:

- **Unhealthy housing** – Cold; damp; indoor air quality; noise
- **Unsafe housing** – Hazards associated with falls and injuries
- **Unsuitable housing** – Overcrowding; meeting needs of older and disabled people
- **Insecure housing** – Insecurity and stress; homelessness; affordability
- **External home environment** – Gardens and green space; accessibility; active travel; safety

For each of the sections the key literature is discussed and summarised in terms of the effect of identified issues on the health of the population. The final section in the literature review covers the evidence for housing interventions that have been shown to have a positive impact on health.

3.1 Unhealthy housing

Cold

Cold homes are linked to a wide range of poor health outcomes, including mortality. Cold homes can increase the risk of lung conditions including asthma and bronchitis, cardiovascular disease and stroke. Cold homes exacerbate long-term conditions such as diabetes and asthma, and impair recovery after discharge from hospital¹⁴.

Being cold at home impacts on mental health for all age groups, increasing the risk of depression and anxiety¹⁴, and has been associated with increasing the risk of multiple mental health problems in teenagers¹⁵. More than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems, compared to 1 in 20 adolescents in warm housing¹⁶.

Vulnerable groups, such as young children, older people, and those with long-term conditions, are particularly susceptible to the impact of cold. Cold homes and poor housing conditions have been linked to a range of health issues in children and young people. These issues include respiratory health (children living in cold versus warm homes are more than twice as likely to suffer from respiratory conditions¹⁶), emotional wellbeing and resilience, mental health, growth, long-term health, and wider determinants of health such as educational performance¹⁴.

Older people may also be particularly vulnerable: cold temperatures increase the risk of strokes and circulatory problems, lung problems, and hospital admissions. Cold temperatures lower strength and stability leading to an increase in the likelihood of falls and accidental injuries¹⁴.

Damp

Damp in homes is directly linked to ill health: living in damp or mouldy properties can lead to an increased risk of respiratory symptoms and infections, and the onset and exacerbation of asthma¹⁷. The World Health Organisation (WHO) has proposed a methodology to calculate the proportion of asthma onset among children attributable to low, medium and high population estimates exposure to mould. Exposure to mould may differ due to differences in climate, housing stock and other factors. These calculations are applied to Suffolk to calculate the numbers of children whose asthma onset is due to mould or damp later in the HHNA¹⁸. Damp and mould also increase the risk of allergic symptoms such as coughing, sneezing, red eyes, skin rash, rhinitis and eczema¹⁹.

Indoor air quality

Poor indoor air quality has been linked to allergies and asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease²⁰ and, more recently, potentially linked to dementia²¹. Indoor air pollutants come from building materials, furnishing and cleaning products, and activities such as cooking and smoking. They also come from biological sources, for example, mould, house dust mites,

bacteria, pests or pet dander²². Outdoor air pollutants can enter through windows or gaps and significantly contribute to indoor air quality, particularly in deprived areas.

Children and older people are particularly vulnerable to health problems due to poor indoor air quality²³. In particular, second-hand smoke is a class A carcinogen and there are no safe levels of second-hand smoke exposure²⁴. In 2010 the Royal College of Physicians estimated that passive smoking in the UK caused 22,600 new cases of wheeze and asthma, 121,400 cases of middle ear infection and 40 sudden infant deaths²⁵. Applying the relative risks to the Suffolk population, this would translate into 440 new cases of wheeze and asthma and 1416 cases of middle ear infection.

The prevalence of smoking varies significantly by socio-economic group, with lowest levels in managerial and professional roles rising to highest levels in routine and manual workers²⁶. A systematic review looking at predictors of children's second-hand smoke exposure at home found that parental smoking, low socio-economic status and lower levels of educational attainment were all frequently, and consistently, found to be independently associated with children's exposure to second-hand smoke. Associations were strongest for parental cigarette smoking status; compared to children of non-smokers, those whose other or both parent smoked were between two and 13 times more likely to be exposed to second-hand smoke²⁷.

Noise

Environmental noise is associated with a range of adverse health outcomes, such as impaired cognitive function in children, sleep disturbance, and cardiovascular diseases²⁸. The long-term presence of noise disturbance can cause stress and anxiety²⁹. A review of systematic reviews found very low quality evidence of associations between aircraft noise and preterm birth, low birth weight and congenital anomalies, and low quality evidence for an association between road traffic noise and low birth weight, preterm birth and small for gestational age births³⁰.

3.2 Unsafe housing

Hazards

Inadequate housing is a potential source of a wide range of hazards, from burns, scalds and fire, to cuts and falls¹⁸. Research suggests that the burden of such injuries, both personal and national, is significant. Injuries in the home can affect people of any age, though it is often the case that certain hazards present more of a problem for specific age groups, such as falls in the elderly³¹. An estimated one third of elderly people (over 65s) fall each year and are at high risk of injury and death as well as rapid decline with loss of independence³¹. Children represent another vulnerable group who are particularly prone to injury from scalds and burns as well as falls and physical injury. This is particularly true for children under five years of age, for whom the leading cause of death is injury in the home³².

Much of the risk related to these injuries can be associated with inappropriate housing and affected by the presence/absence of certain adaptations or safety features. These can include devices such as window guards to prevent falls, or smoke detectors (which approximately 15.8% of English homes lack) as well as adaptations such as pre-set limits on the temperature of tap water^{18,33}. Following the tragic loss of life in the Grenfell fire of 2017, there is a clear national call for an assessment of building materials, over and above promoting adaptations to detect fires. The Government has announced an independent review into building regulations and fire safety that will be released in Spring 2018.

Hoarding disorder may cause an unsafe living environment for an individual or family. A hoarding disorder is defined as: "where someone acquires an excessive number of items and stores them in a chaotic manner. The items can be of little or no monetary value and usually result in unmanageable amounts of clutter"³⁴. The clutter can result in health risks such as: cleaning difficulties leading to unhygienic conditions (encouraging rodent or insect infestations), fire risk and blocked exits, and trips and falls³⁴.

3.3 Unsuitable housing

Overcrowding

Overcrowded homes are associated with lower educational attainment, child developmental issues, respiratory infections, and stress, anxiety and depression¹⁶. The effects of overcrowding in childhood are long-lasting and can go on to affect health in adulthood as well. There are links with heart disease, strokes and lasting lung problems, as well as chronic infections such as *Helicobacter pylori* which are further associated with cancer³⁵.

Disabled people

Disabled people, particularly those with mobility issues, are at increased risk of accidents in the home³⁶. This can be exacerbated by inadequate space, both indoors and in the surrounding neighbourhood. Furthermore, these can then have indirect impacts on health through reduced activity, increased isolation, mental health problems and poor access to services³⁶.

Disabled people, along with the elderly, are the most likely groups to occupy poor housing requiring repair. This in turn makes them more susceptible to issues including injury and hazards, cold and damp³⁷.

Older people

Increasing age is associated with an increased risk of health impacts from unsuitable housing, as well as increased severity of those impacts³⁸. Older people are vulnerable to the issues already mentioned as well as their associated health problems, such as cold, damp and housing-related hazards. These are further exacerbated by pre-existing health conditions along with associated disabilities and general increasing frailty experienced by the elderly. Health in this group changes much more rapidly than in younger people, with factors such as worsening eyesight, cognition/dementia and reducing mobility causing particular problems in ensuring homes remain 'age-friendly' over time³⁹.

These problems are exacerbated by the amount of time that the elderly spend within the home, which is estimated to be between 70-90%. This is more than any other age group³⁹. This in turn is linked to social isolation. Other housing factors such as the environment and neighbourhoods can further increase this³⁹. A cycle can be created such that isolation increases mental and physical health issues, in turn exacerbating the problem⁴⁰. The effects of isolation on the elderly are considered in more detail in the Suffolk Healthy Ageing Needs Assessment, due for publication in early 2018.

3.4 Insecure housing

Frequent house moves are associated with long-term mental health problems and substance abuse as well as teen pregnancy, behavioural problems and underachievement at school in young people⁴¹. Frequent moves are associated with financial issues and a lack of security for families, which in turn can impact on health and have lasting effects into adulthood³².

Insecure housing is associated with cycles of poverty and debt, and is a cause of psychological stress for people who often have complex and challenging lives. Stress impacts negatively on mental and physical health, with the cumulative effects of stress over time associated with high blood pressure, cardiovascular disease and diabetes⁴². Anxiety and stress can lead to decision-making behaviours that reinforce poverty, tending towards short-term gratification over long-term gains⁴³. 'Scarcity' (e.g. of money) can have a negative impact on decision-making and healthy behaviours by forcing attention onto short-term coping rather than long-term planning⁴⁴.

The quality and quantity of our social relationships affect our mental and physical health and even mortality risk; being part of social networks is associated with better mental health outcomes and more healthy behaviours, and social support can protect against stress⁴². Insecure housing can render it difficult to establish networks, or can force people to move away from established networks. This can in turn lead to social isolation and loneliness, which are associated with an increased risk of heart disease similar in

size to that caused by work-related stress⁴⁵. The concept of social capital has been subject to debate in the literature⁴⁶, but there is general agreement that it covers positive social networks of different types and can be defined as an asset which has the potential to influence health and wellbeing. Systematic reviews of the research on associations between social capital and health have been hampered by unclear definitions of the concept, even so they have indicated favourable impacts of social capital on overall mental and physical health and use of health-related resources in older people in particular⁴⁷. Insecure housing would act to reduce the effect of this asset on people's health and wellbeing.

Rough sleeping is the extreme (and most visible) outcome of insecure housing. All forms of homelessness are associated with very poor physical and mental health outcomes, along with substantially reduced access to primary care and other services³⁶. Homeless men and women die young, with men living on average to the age of 47, and women living to the age of 43. This compares to 79.5 for males and 83.1 for females in the general population⁴⁸. Additionally, an estimated 41% of people classified as 'rough sleepers' have long-term physical health problems such as heart disease, diabetes and addiction problems, compared to 28% of the general population.

People experiencing mental ill health or substance misuse problems are at a higher risk of homelessness³⁶. Not all homelessness is as visible as rough sleeping, and many people who are homeless do not show up in official figures (hidden homelessness)⁴⁹. For example, some people may find a temporary solution by staying with friends or relatives – 'sofa surfing', or in squats or other insecure accommodation⁴⁹.

A recent Institute for Public Policy Research (IPPR) report highlighted the added complexities associated with homelessness in rural areas (such as Suffolk). The report asserts that many cases of rural homelessness go undetected. Individuals may be more likely to bed down in alternative countryside locations, such as outhouses, barns, tents and parked cars. Additionally, the stigma of being visibly homeless in rural areas can be much stronger than in urban areas and difficulties accessing local authority services can mean households remain uncounted in official records⁵⁰.

Causes of rural homelessness are often similar to urban areas such as the ending of an assured shorthold tenancy or family breakdown. However, rural areas can experience extra challenges in their housing markets which exacerbate these struggles. These include: lower levels of housing affordability; shortages in affordable homes and appropriate tenure options; high prevalence of second and holiday homes; and decline in local authority-owned housing stock⁵⁰.

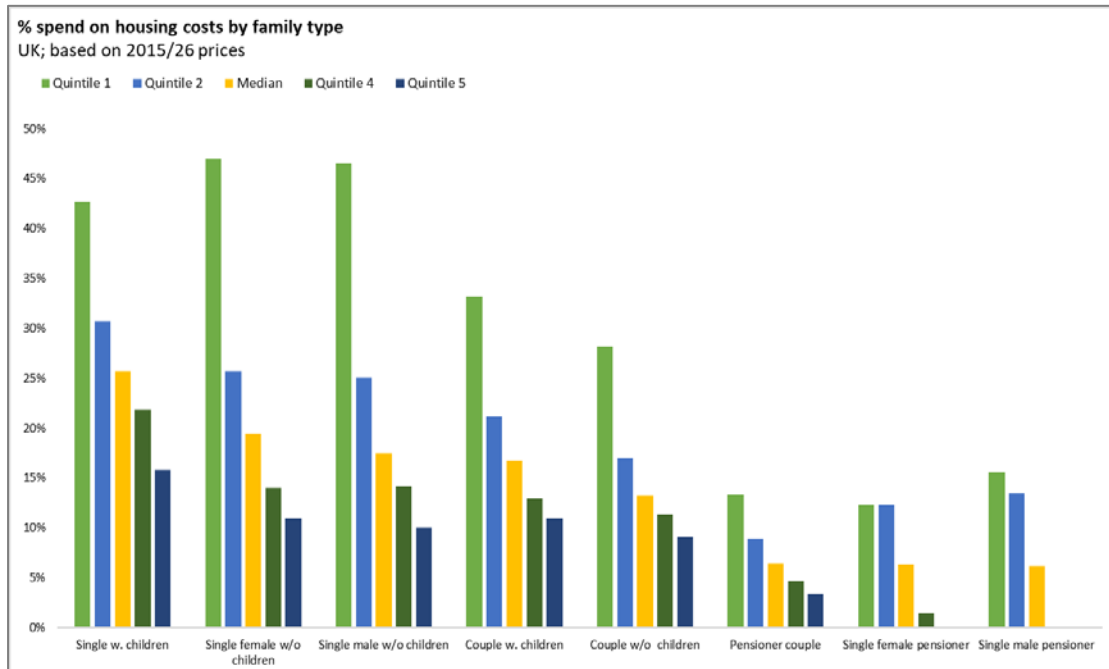
From a service perspective, the IPPR report notes that individualities of rural areas can make delivering services to prevent and relieve homelessness particularly difficult⁵⁰. They cite some of the difficulties as relating to: balancing economies of scale; providing specialist services; overcoming travel distances and accessing public transport; reaching isolated groups; commissioning in two-tier structures; ensuring accurate monitoring and reporting; finding alternative accommodation; and managing falling local authority budgets⁵⁰.

The Homelessness Reduction Act 2017 will also come into force during 2018, placing a statutory duty on local authorities to prevent homelessness and support all those requesting help who may be at risk of homelessness, irrespective of whether or not they are in the groups which previously allowed them to prioritise⁴⁸ - For example, irrespective of whether or not an applicant has 'priority need' or may be 'intentionally homeless'. These are difficult challenges for district and borough councils both in Suffolk and nationally, especially when factoring in the lack of available and affordable housing; changes to the benefits system; the financial pressures which councils are under and other risk factors⁴⁸.

Affordability is a crucial limiting factor in people's choice of where they can live, impacting on the proportion of their income spent on housing costs. The impact of the housing market on affordability has

been identified as one of four key barriers to social mobility⁵¹. The proportion of income spent on housing varies across the income groups, the figure below shows that in the lowest income group (quartile 1), housing costs may take up as much as 45% of income. In the highest income group (quintile 5) housing takes up to 15% of income⁵².

Figure 2: The percentage of income spent on housing costs, by family type in the UK



Source: DWP, *Households Below Average Income, 2015/16*

3.5 External home environment

Green space in general, including gardens, promotes physical activity and better self-rated mental health, and is linked to reductions in a range of poor health outcomes⁵³. Gardening has been found to reduce depression and anxiety and improve social functioning⁵³. As people age, gardens may provide a greater source of physical activity, which can contribute to falls prevention. One of the few studies to look at gardening and its relationships with falls amongst older people found that gardeners were significantly more likely to have better balance and gait, and 30% less likely to report falls than non-gardeners when controlling for other factors such as age, gender, education and functional limitations⁵⁴.

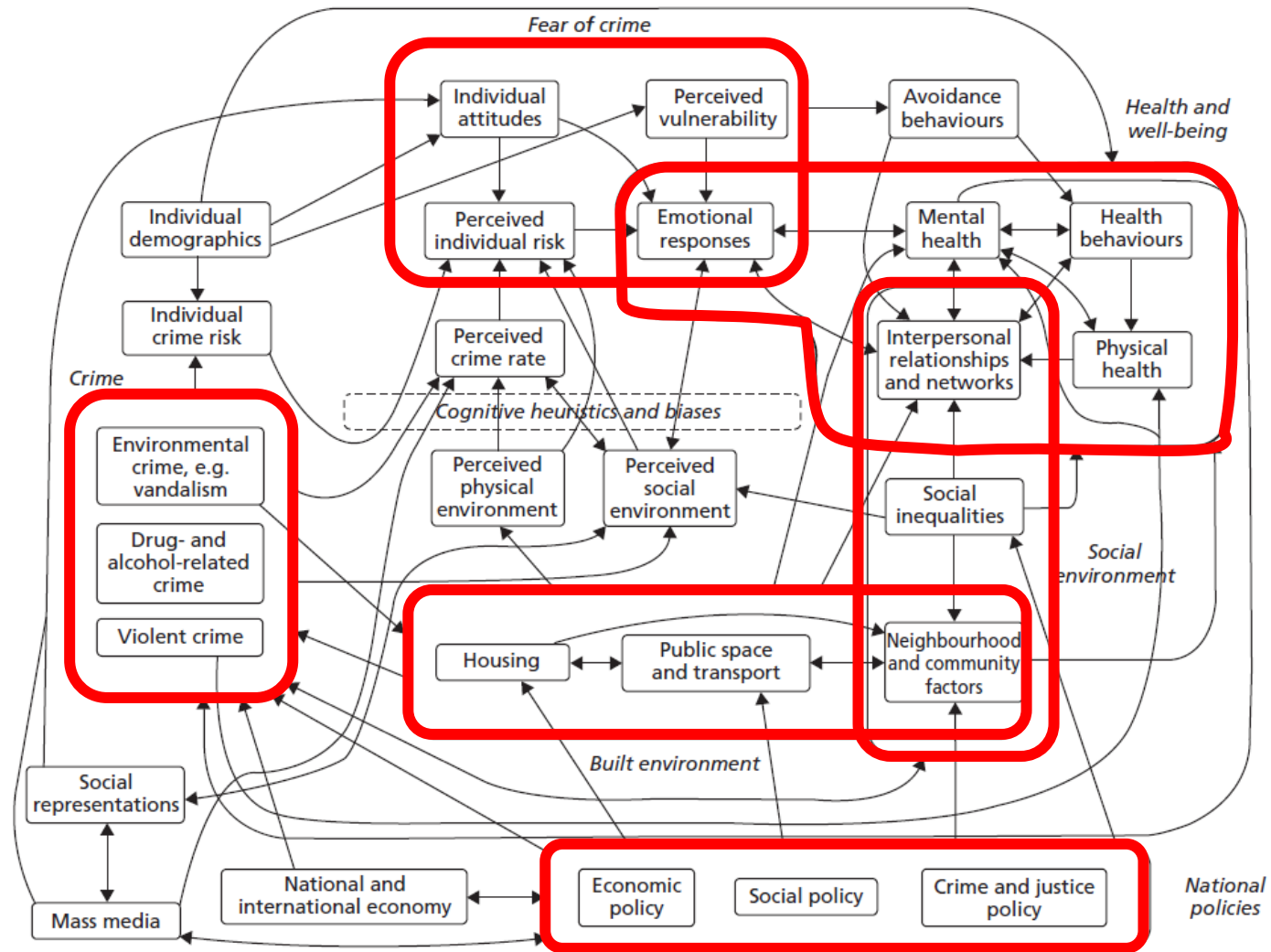
Gardens may also reduce loneliness and protect against cognitive decline and dementia⁵³. A systematic review looked at how outdoor space and gardens worked to alleviate symptoms of dementia in care home residents, the studies were of low quality, but they did consistently show a reduction in agitation and a trend towards reduction in aggression as well as other symptoms such as pacing and exit-seeking behaviour⁵⁵.

The design of the external home environment can ensure accessible routes to and from people’s homes, as well as promoting physical activity by making active travel (walking or cycling) an easy and appealing natural option. Improving neighbourhood walkability, and access to recreational areas and amenities, can increase levels of physical activity in all ages, and increase social interaction in older people⁵⁶. Environmental improvement (e.g. street lighting) can reduce fears regarding crime and safety⁵⁶, although recent studies have indicated that street lighting may potentially be reduced without any negative impact on either crime or road traffic accidents⁵⁷. The research did not however take avoidance behaviour into account e.g. that people might have avoided dimly lit streets at night out of fear.

Crime, and the fear of crime, may affect a range of physical and mental health status outcomes, health behaviour outcomes (e.g. physical activity), and social wellbeing outcomes (e.g. social cohesion). Both crime and the fear of crime may be influenced by factors in the built environment. Fear of crime has been associated with environmental factors such as litter, graffiti and patterns of land use (for example residential versus non-residential)⁵⁸.

A National Institute for Health Research study reviewed theories and data about the links between crime, fear of crime, the environment, and health and wellbeing, to develop a conceptual map shown on the next page. The map shows six key concepts (large bold boxes): crime, fear of crime, health and well-being, national policies, built environment and cognitive biases that people have for perceiving their environment. It also shows the large number of sub-concepts together with the hypothesized relations between them. It highlights there is a complex relationship between the components and that whilst crime and fear of crime have impacts on health, they operate through largely distinct pathways. Both crime and fear of crime are affected by the built environment, through direct and indirect means.

Figure 3: Causal map of the relationships between crime, fear of crime, health wellbeing and the physical environment



4. Literature review: Interventions and best practice in housing and health

The full set of interventions considered in this summary is included in Appendix 2. There is an encouraging amount of evidence, guidance, policy and good practice examples available in the area of health and housing.

NICE have produced guidance (NG6) and a quality standard (QS117) which address the areas of cold homes and excess winter deaths. Both encourage a system wide, targeted approach to positively tackle poor health and housing associated with cold homes. The NICE quality statements are:

- Statement 1 - local populations who are vulnerable to the health problems associated with a cold home are identified through year-round planning by local health and social care commissioners and providers
- Statement 2 - local health and social care commissioners and providers share data to identify people who are vulnerable to the health problems associated with a cold home
- Statement 3 - people who are vulnerable to the health problems associated with a cold home receive tailored support with help from a local single point of contact health and housing referral service
- Statement 4 - people who are vulnerable to the health problems associated with a cold home are asked at least once a year whether they have difficulty keeping warm at home by their primary or community healthcare or home care practitioner
- Statement 5 - hospitals, mental health services and social care services identify people who are vulnerable to health problems associated with a cold home as part of the admission process
- Statement 6 - people who are vulnerable to the health problems associated with a cold home who will be discharged to their own home from hospital, or a mental health or social care setting have a discharge plan that includes ensuring that their home is warm enough

An analysis of the progress that Suffolk has made towards meeting these standards was recently carried out in 2016 and is shown in the appendix. Current gaps appear to be predominantly around identifying people vulnerable to health problems associated with a cold home.

In addition to this, NICE has recently published *Quality and productivity: Proven case study. Liverpool Healthy Homes: Delivering sustainable health and housing improvements (2017)*, as a good example for others to follow. The King's Fund also offers some insight to good practice on their blog about *Healthy New Towns*. This programme provides opportunities to embed healthy living into everyday lives. It includes some nationally estimated savings, such as investing £1.6 billion annually in housing-related support services could generate net savings of £3.41 billion, this includes £315.2 million in health service costs.

Both the literature and policy documents recognise that there is strong evidence for health gains in relation to interventions that address fuel poverty, including adequate and affordable heating, and energy efficiency. There is further, stronger evidence that these interventions are most effective when they are targeted at specific population groups and the vulnerable. For example, fuel poverty, adequate and affordable heating and energy efficiency interventions that target people with respiratory diseases (including asthma), were most effective.

More general evidence on other housing interventions included some links to better health outcomes where the quality of housing or housing in a specific geographical area is improved. This can include

initiatives such as refurbishment or the removal of hazards. This was further supported in the report by the Chartered Institute of Environmental Health (CIEH).

Importantly, partnership and effective joint working featured in many of the policy documents and good practice examples included in the review. This is hugely evident in the CIEH report, particularly the sections 'effective working for health improvement' and 'working more effectively together'. Together with the *Memorandum of Understanding (MoU); to support joint action on improving health through the home*, there is a willingness to improve health through housing related interventions.

A paper by the Department of Communities and Development in 2012, assessed the direct and indirect benefits of Lifetime Homes⁵⁹. The report suggested that the indirect health benefits of Lifetime Homes included improved mental health and wellbeing. For example, having neighbourhoods that are formed of Lifetime Homes may create closer communities, therefore tackling social isolation and promoting independent living. Potential direct health benefits of Lifetime Homes were calculated through a model based on the English House Condition Survey and the Housing Health and Safety Rating Scheme. It predicted that reductions in falls on level surfaces, falls on stairs and intruders in the home would be the top three benefits of residents in Lifetime Homes. The modelling predicted a 20% reduced risk of falling on levels surfaces and 10% reduced risk of falling on stairs with lifetime home adaptations.

The Centre for Ageing Better, the University of Bristol and the Building Research Establishment recently reviewed the evidence for how home adaptations can contribute to improving later life⁶⁰. They found good evidence, mostly from outside the UK, that both major and minor home adaptations can improve a range of outcomes for people in later life. This included improving the performance of everyday activities, mental health and preventing falls and injuries. They found that effectiveness was greatest when improvements were done to lighting and trip hazards, in combination with necessary repairs, in a timely manner, and in line with people's personal goals.

Another area where there is a growing literature is around home improvements that enable people with dementia to stay safely in their homes as long as possible. The *University of Stirling Dementia Services Development Centre* has identified four priority areas for dementia friendly homes:

1. Improve lighting
2. Ensure flooring/paving is consistent in tone
3. Ensure the toilet is easy to find
4. Ensure good contrast in the toilet/bathroom

They recommend that lighting levels for older people (regardless of whether they have dementia or not), should be twice those required for a younger person, with every effort made to let in as much natural light as possible. High levels of natural light can help people with dementia retain a usual sleep/wake cycle for longer⁶¹. They recommend that corridors and complex layouts are best avoided, doors should open fully so that the interior of the room is clearly visible and sliding doors should be avoided. The Kings Fund have developed a tool to allow housing authorities to assess whether their homes are dementia-friendly⁶². The evidence base for whether such improvements have the desired effect of enabling people to stay in their homes for longer is not fully developed. A systematic review of changes to the built environment to manage symptoms of dementia identified only five low quality studies and inconclusive evidence that any of the interventions had any impact⁶³. There is however a stronger literature base on the symptoms of dementia^{64,65} which has guided the adaptations. A stronger evidence base in support of the interventions may develop over time.

On the issue of complex needs, partnership working literature indicates that housing organisations can have an impact on health and health outcomes, including work on affordable housing. A

December 2017 briefing from the Mental Health Network notes that the housing sector has the potential to deliver both improved outcomes and financial savings through partnership working with providers of NHS services, clinical commissioning groups and local government⁶⁶.

There is evidence to suggest that affordable housing interventions with vulnerable groups, for example the homeless, can have positive health impacts, assisting with medical or substance abuse treatment and compliance. Since the Suffolk GAROD health needs assessment was written in 2015, there have been developments in the theory of what works in supporting people to access housing who have multiple complex support needs, may suffer from multiple disadvantage, and may be resistant to existing service interventions. Traditional models of housing for this group have been described as linear in that, whilst the exact form of the service varied, people would essentially progress through a series of separate residential services – typically emergency shelter programmes, transitional housing and supportive housing until they attained independent living when they reached a state of readiness. Progress along the continuum was usually conditional on compliance with treatment and support programmes⁶⁷. The evidence of the effectiveness of these programmes has been challenged in terms of their high attrition rate⁶⁸, and the fact that they were based on a linear model of progression when people with complex needs may be likely to relapse⁶⁹.

Housing First is an alternative model which is growing in international popularity⁷⁰. Although different variants exist, the model is based on the premise of separating treatment from housing. It seeks to move homeless people into permanent housing as quickly as possible; support is provided to those who need it, but is not attached to housing conditions. A failure to comply with support services does not lead to an eviction. There have been positive evaluations of Housing First in Europe and North America⁷¹, and recent pilots across the UK have indicated similar success, with the potential for the model to be a cost effective solution to long-term and recurrent homelessness^{68,70}. However, as the authors of the review of pilot studies in the UK emphasise, Housing First should be regarded as a supplement for particular clients with multiple and complex needs, rather than a whole scale replacement for existing homelessness services.

Housing problems can exacerbate mental ill health, and a healthy living environment can significantly improve outcomes⁶⁶. For those experiencing mental ill health the provision of appropriate supported housing plays an important role in both transitioning patients from clinical settings to community based care, as well as preventing unnecessary readmissions⁶⁶. The Mental Health Foundation have identified some common themes that represent elements of 'good supported housing'⁶⁶:

1. **Investment in quality.** This relates to both environments – which should accommodate physical access, promote positive wellbeing, and encourage social interactions – and services, which should deliver 'therapeutically innovative, responsive and dynamic care'.
2. **Co-production.** Tenants and other experts-by experience should be consulted in the design and development of buildings and services.
3. **Staff recruitment and training.** Investment is needed to recruit, train and motivate staff who are committed to creating safe, positive homes for people with mental health problems.
4. **Policy informed practice.** Staff should be supported to engage with and implement approaches in line with national policy.
5. **Appropriately resourced, suitable accommodation.** Housing for those who have additional support needs must be designed and resourced to meet their needs. In the climate of financial pressure across health and care systems, supported accommodation will only provide positive outcomes and cost-savings if it receives appropriate levels of investment.



Current Picture in Suffolk

5. Current picture in Suffolk

5.1 Housing stock

Overview

There were an estimated 335,370 dwellings in Suffolk in 2015⁷², 85% of which were privately owned, 9% were owned by housing associations and 6% were owned by local authorities. Overall, 36% of the dwellings were owned outright, 32% with a mortgage; 16% were privately rented; 15% (50,305) were social rented, compared to a national average of 18%⁷². Nearly 50% of the Suffolk housing stock is over 50 years old, with 18% pre-dating 1900. Only 15% has been built in the past 20 years⁷³.

According to the 2011 Census, 2% of Suffolk households were without central heating (ranging from 1.2% in St. Edmundsbury to 3% in Ipswich), rising to 2.5% in the over 65s (ranging from 1.4% in Forest Heath to 5.4% in Ipswich)⁷⁴.

Energy efficiency

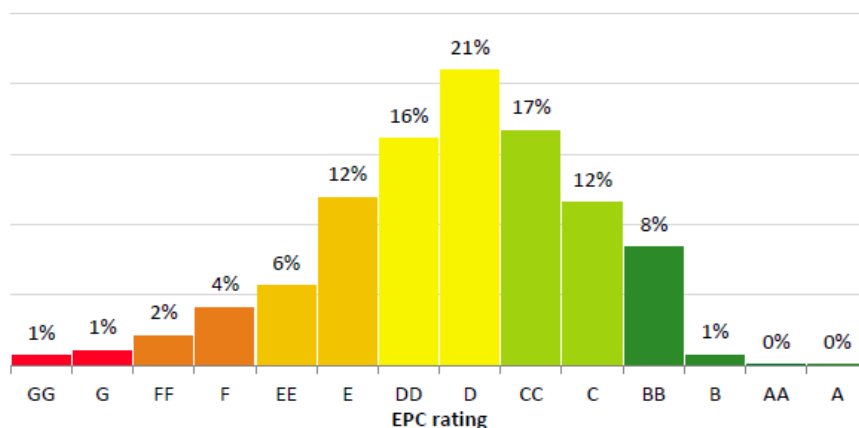
In 2015, the National Energy Foundation (NEF) was commissioned to develop a Suffolk Housing Stock database, compiling and modelling data on the county's housing stock to assess energy use and potential for improvement to reduce carbon emissions. Key points from the Suffolk Housing Stock database include:

- mains gas is the primary fuel in 65% of homes, electricity in 16% and oil in 15%⁷³.
- the most common heating system (61%), is a gas fired boiler and radiator system; 13% of properties are heated using an oil boiler and radiators; 11% are heated using electric storage heaters⁷³
- approximately 59% have cavity walls (of which 41% have been filled after construction); 21% of properties have solid walls; wall construction is unknown for 13%⁷³.

A cavity wall is made up of two walls with a gap in between, known as the cavity. A solid wall has no cavity; each wall is a single solid wall, usually made of brick or stone. Solid walls are common in houses build before 1920 and let out twice as much heat as cavity walls. Both types of wall can be improved by insulation: cavity walls through filling the cavity, solid walls from fitting insulation to either the inside or outside.

The energy performance of housing stock can be summarised using Energy Performance Certificate (EPC) ratings. EPC ratings are known for around 40% of homes in the database. Based on the Housing Stock database, the average EPC rating in Suffolk in 2015 was 62.1 Standard Assessment Procedure rating (SAP) (band D), slightly better/higher than the UK average of 58.5 SAP (lower band D) as reported by the English Housing Survey 2012-13. A breakdown of EPC bands is shown below:

Figure 4: Percentage of housing stock by EPC rating, Suffolk, 2015



Source: NEF Suffolk Housing Stock Database: Headline Energy Report⁷³

It is worth noting that this picture is likely skewed towards more positive ratings, as they are mandatory for new builds. However, the proportion of F/G rated properties is higher than the national average, perhaps reflecting challenges faced by the private rented sector, the age of the housing stock and the rurality of the county⁷³.

The modelling done using the 25 archetypes mapped to the entire housing stock estimates the total annual cost (in 2014 prices) of heating Suffolk homes as nearly £170 million. The standard energy efficiency improvements identified (e.g. insulation, draught-proofing, new heating system) as part of the archetype modelling provided estimates showing that a total annual fuel saving of £88 million would be possible, nearly half the amount spent annually on fuel bills, with savings (by archetype) ranging from £34 to £1,104 per household per year. The total cost of the identified improvements was £2.32 billion, ranging from £1,945 to £22,111 per household depending on the archetype. This equates to a payback period of 26 years.

5.2 Suffolk Housing Needs Survey

In 2014 a countywide housing survey was undertaken by Suffolk’s local authorities, led by the Suffolk Strategic Housing Partnership. Questionnaires were sent to 82,000 households (a random sample of 25% of households from the electoral register) of which there were 14,000 returns (a 17% response rate). The survey aimed to provide an overview of housing need in Suffolk, and it included a small number of options/questions relating to health, care and finances.

The headline findings of the survey were:

- 87% of respondents ‘love to live in Suffolk’ and 90% of households intend to continue to make their home here
- 40% of these households say their current home will not suit their needs in 10 years’ time, which could mean approximately 80,000 households living in housing unsuited to their needs by 2024
- 22% of those who replied to finance questions spend more than 35% of their monthly income on private rent or mortgage.
- 84% of people live about 10-20 minutes from their nearest leisure facility
- 22% of people responding to the survey have a disability or long-term illness and 54% of these people do not consider they receive sufficient support to meet their care needs
- 44% of respondents say the main barriers preventing a house move are personal finance considerations including being unable to afford a deposit, not being able to afford the cost of moving or the monthly cost of a mortgage

- 14% of respondents could afford to move, but cannot find the right property and 13% feel there is a lack of affordable private rented accommodation

Further analysis of questions and responses relating to housing and health highlighted the issues below. Not all respondents answered all of the questions, where percentages are given these are the proportion of the people out of the total number that answered that question.

Reasons for wanting to move

When asked for the main reason for wanting or needing to move, 15% (277) of respondents selected *“The property is affecting my/our health”*. This was ranked seventh out of 32 options, with the most common responses relating to larger home/garden, wanting to buy, or smaller/cheaper home. This was most common in the young age groups: 26% (29) of those in 16-24-year age category selected this response, with 20% (49) of those aged 65-74, 11% (nine) of those aged 75-84, and only 7% (two) of those aged 85 and over. The figure below shows that the answer was selected by a higher percentage of people renting in social housing than the other two sectors, there were 121 people who selected who rented social housing, 103 who rented privately and 50 owner-occupiers.

Figure 5: Percentage of people, by property tenure, who selected the answer *“This property is affecting my/our health”*



In terms of other responses that may have a direct bearing on the health and care of households, 9% (178) of responding households gave the *“Condition of current property”* as their main reason for wanting to move. There were 6% (111) who wanted to move because *“My home is difficult to access”*, with 5% (103) saying they wanted *“To make it easier to receive care/support”*, the latter being selected by 59% of over 75-year-olds.

Factors preventing people from moving

Four of the top five reasons preventing people from moving related to the costs involved (this was a multiple answer question): 34% (607) *“Cannot afford the deposit”*, 24% (429) *“Cannot afford moving costs”*, 22% (386) *“Cannot afford the monthly cost of a mortgage”*, and 24% (419) due to a *“Lack of affordable rented housing”*. This affordable renting factor was fairly consistent across districts/boroughs, and was more notable in the youngest age category (36% of those aged 16-24) compared to older. The second most common reason selected was *“can afford to move but can’t find right property”*, a response more common in the older age categories, reflecting both the ability to afford together with the likelihood of more specific needs. Other reasons reflecting financial considerations included *“Unable to sell”* (7%, 130), *“Negative equity”* (3%, 47) and *“Rent/mortgage arrears”* (2%, 43).

Support needs and disability

Of those households who responded to the question *“Has your home, or the access to it, been built or adapted to meet the needs of someone with a disability?”*, 21% (1,498) said *“Yes”* (of which 159 said it was *“No longer needed”*). 6% of people (460) replied *“No, but adaptations needed”*, and the

remaining 72% replied that no adaptations were needed. Response numbers were low to follow up questions about facilities already in the home, or that needed to be provided. Of the responses given, the highest proportion (higher than all the listed physical adaptations) was 3% (294) stating a need for “Assistance maintaining home/garden”. This links to a previous question about the needs of anyone not receiving sufficient support, to which 49% (442) stated “Looking after garden” and 39% (346) “Looking after the home”. The other main need identified by 40% (355) of households responding was for help “Claiming benefits or managing finances”.

Housing costs

Just under 50% of respondents to the survey also answered questions about housing costs. On estimating how much of their net household income was spent on rent or mortgage, 10% (613) said 45% or above, 12% (701) said 35-45% and 17% (993) said 25-35%. The figure below shows the percentage of each group of tenure that estimated they spent 45% or more of their income on rent or mortgage in the case of owner-occupiers, the actual numbers of respondents is given in brackets.

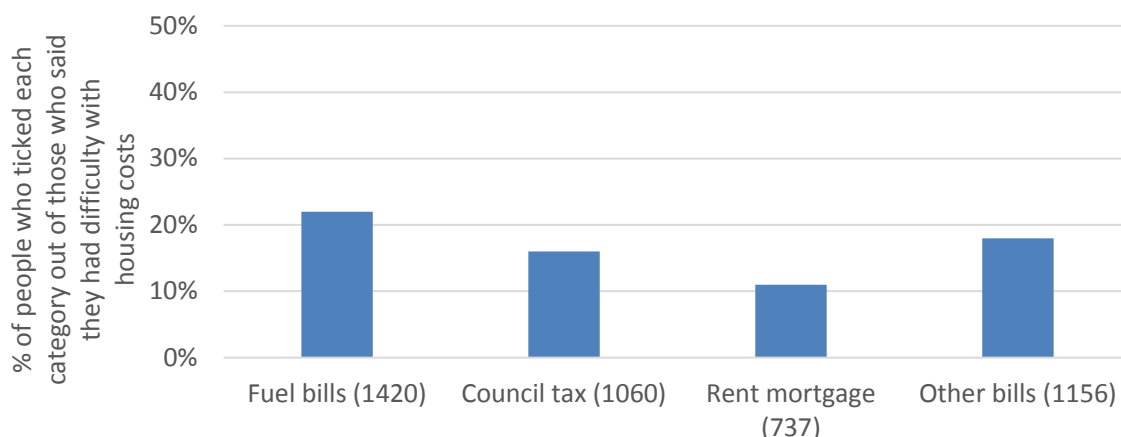
The Strategic Housing Market Assessments for Suffolk (SHMA) use an affordability test where the cost of housing can constitute up to 35% of gross income and still be affordable in the Ipswich housing market area and up to 30% of gross income and be affordable in the Waveney housing market area HMA⁷⁵.

Figure 6: Percentage of tenure type for people that estimate spending more than 45% of income on rent



The proportions above were similar for those who spent 35-45% of their income on renting or mortgage: 22% (251) of those renting privately, 12% (50) of those renting from a housing association, 10% (39) of those renting from the council and 13% (342) owner-occupiers with a loan/mortgage. The figure below shows those who responded to a question asking whether they experienced difficulty with any housing costs and which of the costs they identified as being problematic, actual numbers of each are given in brackets, multiple options were permitted, so these percentages overlap.

Figure 7: Types of costs found to be difficult for people answering that they experienced difficulty with housing costs



In total, 31% of respondents to the question had difficulty with one of the four options. 52% of those renting privately answered that they had difficulty with one of these housing costs, and 60% of those renting social housing, compared to 19% of owner-occupiers. In terms of fuel bills, 36% (420) of those renting privately had difficulty, 41% (363) of those renting social housing, and only 14% (609) of owner-occupiers.

5.3 Unhealthy housing

Cold

Fuel poverty has been defined nationally since 2014 using a low income high costs (LIHC) indicator. Under the LIHC indicator, the people in a household are considered to be fuel-poor if:

- the cost of fuel needed to keep their home warm, well-lit and with running appliances and hot water for everyday use is greater than the average for households across the country (the national median level)
- subtracting this amount of fuel costs, all their regular debt payments and expenses (including a mortgage) from their income results in an income below the official poverty line⁷⁶

Fuel poverty is closely linked to the thermal efficiency of a home. According to national data, 36.9% of fuel poor households are in households with a Fuel Poverty Energy Efficiency Rating (FPEER) of Band E or below, compared to only 7.8% in Band C or above⁷⁷. Age of dwelling and uninsulated solid walls are linked to increased likelihood of fuel poverty. The level is highest in the private rented sector (21.3% of households, compared to 7.4% in owner-occupied homes), and these households are in deeper fuel poverty than those in local authority housing, with an average fuel poverty gap of £410 compared to £175⁷⁷. The fuel poverty gap for each fuel-poor household is the amount that either the household's income would have to increase, or its fuel bill would have to decrease, so that the household would no longer be fuel-poor.

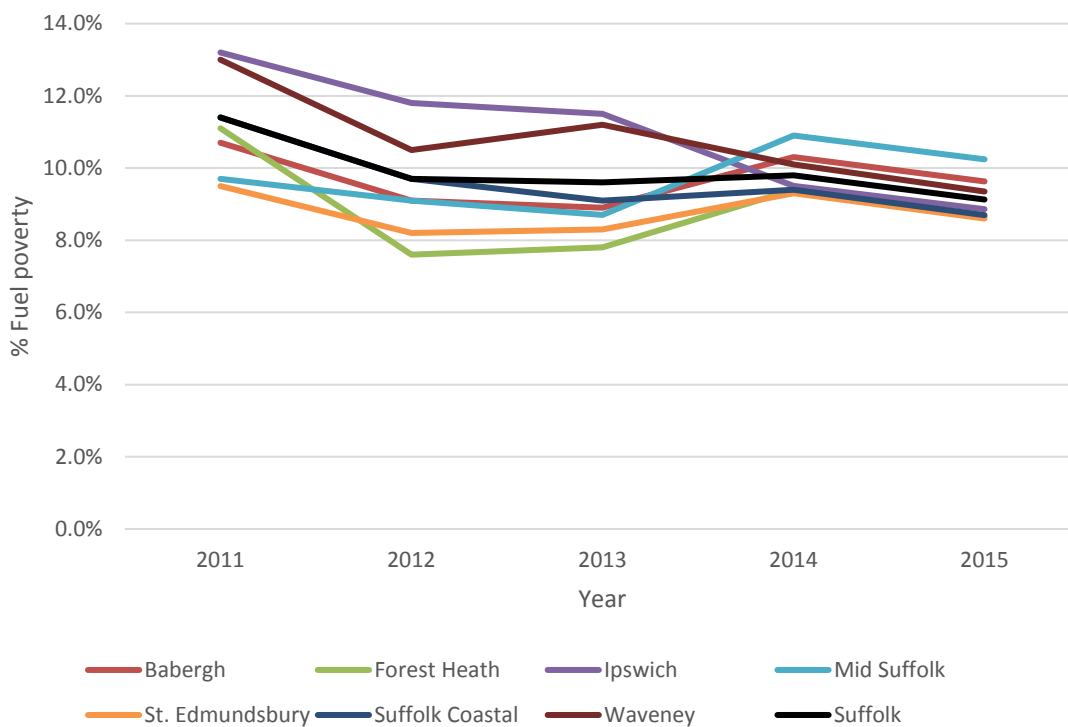
Fuel poverty, as would be expected, shows a social gradient whereby those on lower incomes are more likely to be at risk of fuel poverty, contributing to social and health inequalities¹⁴. The latest data (from 2015) shows an estimated total of 29,306 households in Suffolk are in fuel poverty, which represents 9.1% of all households in the county⁷⁸. This proportion ranges from 8.6% in Forest Heath and St Edmundsbury to 10.2% in Mid Suffolk. Nationally the estimate is 11%⁷⁸.

Table 1: Estimated number and proportion of households in fuel poverty, 2015, by district and borough, and Suffolk

District	Estimated number of households	Estimated number of households in fuel poverty	%
Babergh	38,826	3,737	9.6
Forest Heath	26,191	2,265	8.6
Ipswich	59,136	5,239	8.9
Mid Suffolk	41,582	4,258	10.2
St Edmundsbury	47,324	4,070	8.6
Suffolk Coastal	55,416	4,818	8.7
Waveney	52,617	4,919	9.3
<i>Suffolk County</i>	<i>321,092</i>	<i>29,306</i>	<i>9.1</i>

Source: Sub-regional fuel poverty data 2017, Department for Business, Energy and Industrial Strategy⁷⁸

Figure 8: Estimated proportion of households in fuel poverty, 2011-2015, by district and borough, and Suffolk



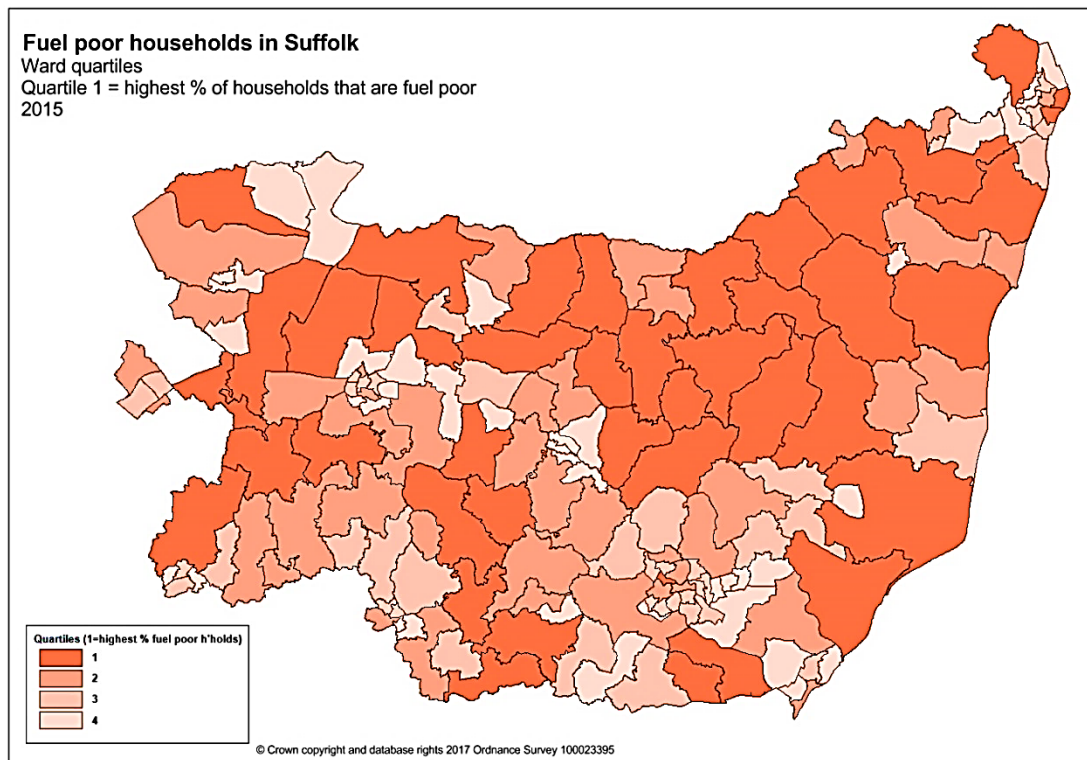
Source: Sub-regional fuel poverty data LIHC indicator, Department for Business, Energy and Industrial Strategy⁷⁸

Data using the LIHC indicator for fuel poverty is only available for the past five years. Overall the level of fuel poverty in Suffolk has dropped from 11.4% in 2011 to 9.1% in 2015. However, this still represents 29,306 households experiencing fuel poverty and therefore at risk of the (potentially severe) health impacts of a cold home. A drop from 2011 levels has been seen in all districts and boroughs except Mid Suffolk, which has seen a slight rise from 9.7% to 10.2%. Although Ipswich does

not have the highest percentage of households in fuel poverty it does have the highest absolute numbers of households in fuel poverty (5,2390).

Ward quartiles show how fuel poverty is distributed across the county by splitting the percentage of fuel poor households into four (quartiles) different colours. Looking at ward quartiles for the county in Map 1, there are clearly more wards in quartiles one and two (highest fuel poverty) than in the lower quartiles of three and four.

Map 1: Fuel poverty across Suffolk by ward



The appendix contains maps with further analysis of fuel poverty in Suffolk using a comparator of the national average, the regional average and Suffolk average. LSOAs are also presented for the whole county and for each of the districts and boroughs.

Excess winter deaths

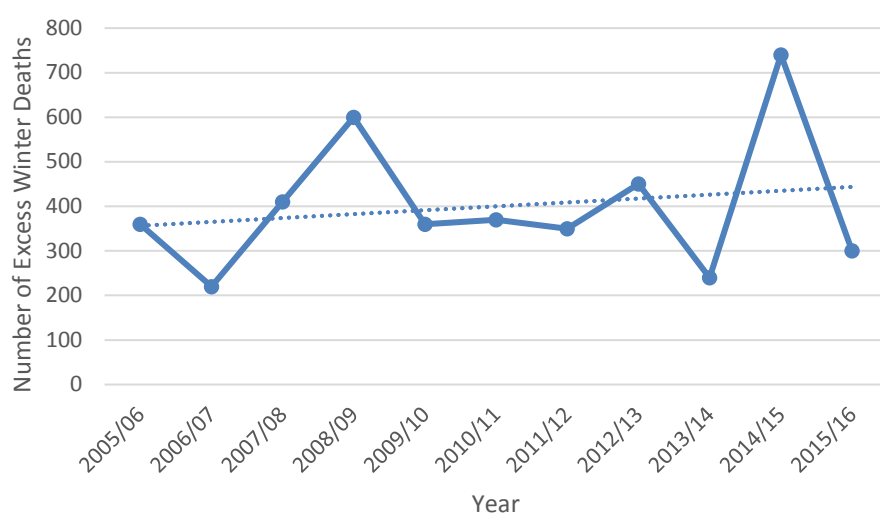
Excess winter deaths (EWD) are calculated by taking the number of deaths occurring in the winter months (December – March) and subtracting the average number of deaths from the four non-winter months either side of this period to give the excess. Although increased winter mortality is due to a number of causes of death, a WHO report has given an evidence-based estimate that 30% of EWDs can be attributed to the impact of cold housing¹⁸.

Combining the statistics on EWDs with the estimate that 30% are caused by cold homes (using methodology described in a WHO report¹⁸), suggests that there were 1,230 deaths in Suffolk due to cold homes in the 10-year period from 2005 to 2015. This is an average of 123 deaths per year (median 110), ranging from 66 in 2006/07 to 222 in 2014/15. It has been estimated that around 10% of excess winter deaths may be directly attributable to fuel poverty¹⁵; this would equate to an average of 41 deaths per year (median 37) due to fuel poverty.

National data from 2015 appears to show that excess winter deaths are almost three times higher in the coldest 25% of homes compared to the warmest 25%, and mostly occur among people aged over 75. It is estimated that 40% of excess winter deaths are attributable to cardiovascular disease; and 33% to respiratory disease.

The data shown in the figure below for the latest 10-year period, suggests a rising trend in EWDs in Suffolk, the solid line is the data from Suffolk and the dotted line is a trend line from the data points which rises over time. There is a pronounced spike in excess deaths of 740 in 2014/15. This is despite the near average temperature in the UK of 2014/15 compared to previous winters⁷⁹. Research to understand the causes of a spike in EWDs of 30,000 seen nationally has ruled out cold weather and 'flu, instead suggesting that the main cause may have been the health and social care system struggling to cope with demand⁸⁰.

Figure 9: Excess Winter Deaths in Suffolk, 2005/06 to 2015/16



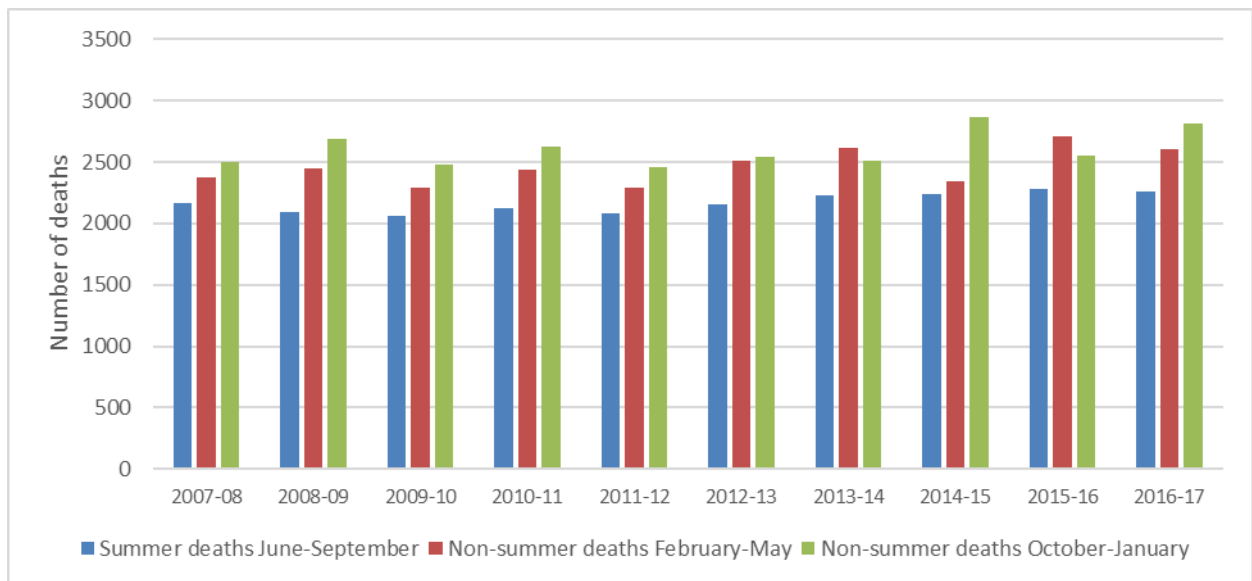
Source: ONS Excess winter mortality data, England and Wales⁸¹

Research that looked at the effect of colder winters on hospital admissions in Suffolk over a 10-year period (2003-2013), showed that overall admission rates for all ages were raised by 2%, and emergency admissions raised by 5%⁸². Although it is not possible to attribute a proportion of these to housing conditions, it is likely that some of these increased admissions could be averted if homes were sufficiently warm to protect against a colder winter.

Excess summer deaths

Sustained high temperatures (27°C or above) can contribute to excess mortality, especially in older people. This was observed during the 2003 summer heatwave in France⁸³, and is recognised in the England Heatwave Plan⁸⁴. The relationship between excess heat, housing and excess deaths is not as strong or direct as that with excess cold. The England Heatwave Plan focuses more on individual actions to keep cool rather than adaptations to housing, however it recommends loft and cavity wall insulation which protect against extremes of both heat and cold. Analysis of mortality in Suffolk during the period 2007 – 2017 shows during the summer months, June -Sept, there were consistently fewer deaths than during the rest of the year. Suffolk does not therefore appear show a pattern of excess mortality during the hottest part of the year.

Figure 10: Number of deaths from all causes in Suffolk occurring February 2007 – January 2017



Source: Primary Care Mortality Database

Damp

Local data is not available, but the English Housing Survey reports that in 2015 about 4% of homes in England had problems with damp, the most common problems being condensation and mould which affected 2% of homes⁸⁵. Damp problems were most likely to be found in private rented properties (9%) compared to social rented (5%) or owner-occupied (3%)⁸⁵.

Combining these national estimates for mould and damp with relative risk estimates for the onset of asthma in children related to mould⁸⁶ and damp⁸⁷ (using methodology described in a WHO report¹⁸) allows the calculation of an estimated range for the population attributable fraction. This is the proportion of a disease in the population that would be reduced if the exposure (e.g. to damp) was removed. Using these estimates, the population attributable fraction for asthma onset due to mould is 2.7% (95% confidence interval CI 0.2-8.4%) and due to damp is 4.6% (95% CI 1.2-10.7%). This suggests that nearly 5% of cases of asthma morbidity and mortality could be prevented if people were not exposed to damp homes, and nearly 3% could be prevented if people were not exposed to mould in their homes.

The estimated number of cases of asthma morbidity and mortality prevented in Suffolk's three CCGs can be calculated using the Office of National Statistics 2016 mid-year estimates of Suffolk, and the average asthma prevalence of 6.7% taken from the GP Quality and Outcomes Framework (QOF). Based on the WHO model of cases in children up to the age of 14 it can be estimated that a total of 622 cases of asthma morbidity and mortality would be averted if children in Suffolk CCGs were not exposed to damp or mould in their homes (232 from mould and 390 from damp).

5.4 Unsafe housing

English Housing Survey / HHSRS

The English Housing Survey is an annual survey of the national housing stock commissioned by the Department for Communities and Local Government that uses the Housing, Health and Safety Rating System (HHSRS), a system of assessing housing conditions designed to evaluate the effects of 29 potential hazards on the inhabitants of a property. This rating system contributes to the 'Decent Home Standard'. To reach a decent home standard a dwelling must meet the following criteria¹⁶:

- meet the statutory minimum standard for housing - dwellings posing a Category 1 hazard (e.g. excess cold, falls hazards) under the HHSRS are considered 'non-decent'
- be in a reasonable state of repair
- have reasonably modern facilities and services
- provide a reasonable degree of thermal comfort

The English Housing Survey produces weighted estimates of the prevalence of certain hazards/conditions from the HHSRS, broken down by different characteristics of the overall housing stock (e.g. age, type, tenure, urban/rural, deprivation). In undertaking this analysis, these national estimates have been applied to the Suffolk housing stock to produce modelled estimates of the number of properties affected in Suffolk, based on the address-level data held in the Suffolk Housing database.

The English Housing Survey 2015 shows different trends according to the characteristics of the property or the household in housing conditions/hazards which are of relevance to the health of households. In terms of excess cold, there is an expected gradient associated with the age of property, with 9.3% of properties from pre-1919 estimated to be excessively cold, reducing to 3.2% for those built in 1920-1944, reducing further down to 0.4% for those properties built after 1990⁸⁸. In terms of location, properties in 'rural' areas have the highest prevalence estimate for excess cold with 23.4%, followed by 11.9% in 'village centres', 5.6% in 'rural residential' and down to 1.5% in 'suburban residential'/'other urban centre'⁸⁸. In terms of tenure, excess cold is more common in private rented accommodation (4.8%) or owner-occupied (3.3%) than in social housing (0.5%)⁸⁸.

Data collected on decent homes in local authority owned housing stock shows that the proportion of non-decent homes in Suffolk local authorities' housing stock has dropped from 1.6% (313) in 2012 to 0.8% (147) in 2016⁸⁹. In 2015/16 in Suffolk, a total of 162 properties in the private rented sector were found to have one or more Category 1 hazards on inspection⁸⁹. In the same year, 238 private sector dwellings were made free from Category 1 hazards as a result of action by the local authority⁸⁹.

Hoarding

NHS Choices assert that hoarding disorders are often challenging to treat, many people who hoard frequently don't see it as a problem, or may be unaware of the impact upon their life or the lives of others³⁴.

The reasons as to why people hoard are not fully understood. However, there are certain types of mental ill health that are associated with hoarding including: severe [depression](#), psychotic disorders, such as [schizophrenia](#) and [obsessive compulsive disorder \(OCD\)](#)³⁴. Hoarding can also be an independent condition that is commonly associated with a wider self-neglect. Individuals affected are more likely to: live alone, be unmarried, have had a deprived childhood, have a family history of hoarding, have grown up in a cluttered home, and never learned to prioritise and sort items³⁴.

Accurate local statistics on the prevalence of hoarding are not routinely collected. The Royal College of Psychiatrists⁹⁰ estimates that about 1-2 people in every 100 have a hoarding problem that seriously affects their life. If this is applied to the adult (18+) population of Suffolk this equates to between 5,900-11,900 Suffolk residents.

Cognitive behavioural therapy (CBT) is a psychological treatment that can help to change the thoughts and feelings that drive people to hoard, in some instances antidepressant medication to help anxiety and obsessional problems may also be prescribed⁹⁰.

As well as the impact upon the individual, people who hoard can stop landlords from meeting their statutory duties- i.e. Gas safety checks and other certification required for registered Social Landlords⁹¹. The Suffolk Safeguarding Adults Board have developed multi-agency policy and practice guidance in relation to self-neglect and hoarding⁹². The purpose of the policy and practice guidance is to reduce risk, and where possible prevent serious injury or death of individuals who appear to be self-neglecting.

Costs to NHS/Society

Research undertaken by the Building Research Establishment (BRE) based on modelling of the most serious health hazards in homes, indicates that leaving vulnerable people in the poorest 15% of England's housing is costing the NHS £1.4 billion each year in first year treatment costs alone⁹³. This is comparable to the burden on the NHS of major public health priorities such as smoking and alcohol⁹³. Broadening the impact to look at the wider costs to society of leaving the nation's poor housing without improvement, the BRE model estimates the cost to society as £18.6 billion. Relating the cost of improving the poorest housing to the annual savings to the NHS, they estimate that the costs of repair would pay for themselves in just over seven years⁹³.

Looking specifically at the hazards associated with falls and excess cold, analysis was undertaken to apply prevalence estimates for hazards based on the latest English Housing Survey (2015) to Suffolk's housing stock, and combine with BRE's cost modelling to estimate the financial burden to the NHS in Suffolk of these hazards.

Applying the age category specific rates of excess cold, estimated in the latest English Household Survey, to the age structure of Suffolk's housing stock suggests a total of 10,687 properties with the Category 1 hazard of excess cold (under the HHSRS). Combining this total with the estimated costs to the NHS (in 2011 prices) modelled by BRE, suggests a potential average yearly saving to the NHS (in first year treatment costs) of £6.84 million if the hazard of excess cold was removed. The estimated cost of remedial work to remove the risk of excess cold (£48.9 million) would be paid back by only seven years of savings on NHS first year treatment costs alone.

Repeating this analysis with estimates for the prevalence of fall hazards, suggests a potential average yearly saving to the NHS (in first year treatment costs) of £5.3 million if these hazards were removed. The estimated cost of remedial work to remove these falls risks (£22.5 million) would be paid back by just over four years of savings on NHS first year treatment costs alone.

Repeating these estimates for the impact on the NHS of excess cold and falls but using estimates from the EHS based on urban/rural location of properties, and applying these to Suffolk's housing stock, suggests even higher potential savings: for excess cold there could be £9.3 million of potential yearly savings and for falls £6.3 million of yearly savings.

Cost estimates for hoarding cases indicate that there is large variability in total cost. However, Nottingham's Multi-Agency Hoarding Framework asserts that hoarding cases can cost up anywhere from £1,000 to £60,000⁹¹.

5.5 Unsuitable housing

Specialist housing needs – Older people

As people age, some people have specialist needs in terms of housing. Issues relating to mobility, dexterity and frailty, may all lead to needs for greater levels of care at home, or particular adaptations to the home.

In 2016 there were approximately 15,600 available places in specialist housing for older people (aged 75+) across Suffolk, yet some estimates of **need** were already higher than that, at almost 21,500 places, by 2015 (note: this figure is demand not actual provision) ^{94, 95}.

Table 2: Specialist housing requirements, 2015

Specialist Housing Requirements: All People Aged 75+	2015
Sheltered Housing	9,528
Extra Care Housing	3,431
Residential Care Home	4,955
Nursing Care Home	3,431
TOTALS	21,345

Specialist housing needs – Disabled people

The grant allocation available for disabled facilities grants (DFG) can give an indication of the level of need for housing adaptations because of disability. However, it should be noted that this does not provide a full and reflective position as the grant is means-tested and only available in specific circumstances. The grant has changed slightly in 2017/18, in that it has become part of the Better Care Fund (BCF) and so is jointly agreed with local clinical commissioning groups (CCGs) and the county council⁹⁶.

The table below provide the grant allocations available for Suffolk and its neighbouring counties and show the split between Suffolk’s district and borough councils for 2016/17 and 2017/18. A total of £166,055,714 was allocated to upper tier authorities for 2017/18, meaning Suffolk received around 3% of the total allocation. Of the Suffolk allocation, the table shows that by the district/borough split, nearly a quarter of the grant is allocated to Waveney, followed by nearly one fifth to Ipswich. Suffolk Coastal receives the next highest proportion, followed by St Edmundsbury. Babergh, Forest Heath and Mid Suffolk receive the lowest proportions, between 8% and 11%.

Table 3: Disabled facilities grant allocations 2016/17 and 2017/18

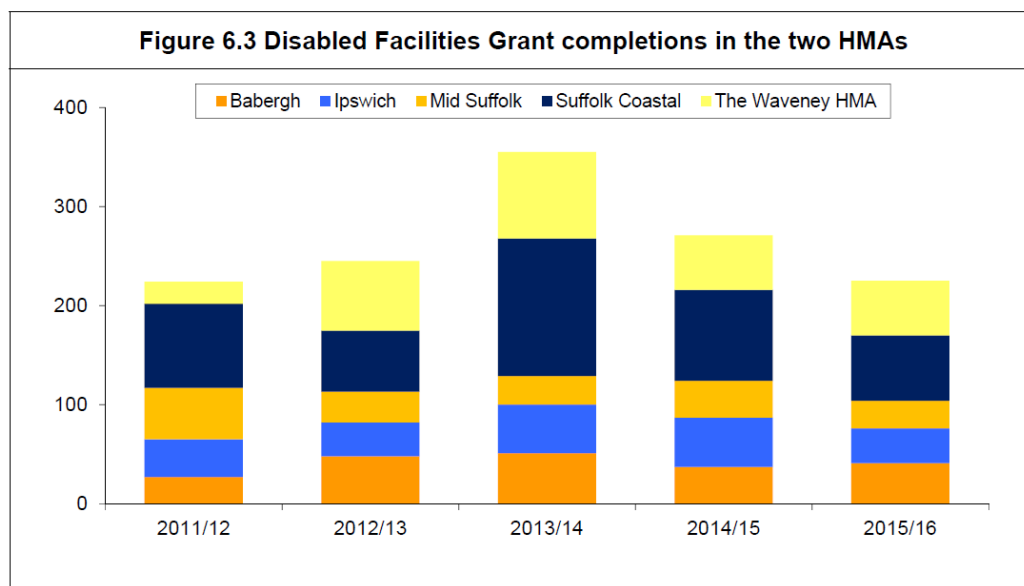
2016/17 Disabled facilities grant allocations		
County	£s	
Cambridgeshire	3,478,866	
Essex	8,217,306	
Norfolk	6,367,664	
Suffolk	4,824,576	
Suffolk district/borough	£s	% of Suffolk allocation
Babergh	522,743	11%
Forest Health	362,363	8%
Ipswich	934,117	19%
Mid Suffolk	480,275	10%
St Edmundsbury	635,439	13%
Suffolk Coastal	776,333	16%
Waveney	1,113,306	23%

2017/18 Disabled facilities grant allocations		
County	£s	
Cambridgeshire	3,809,721	
Essex	8,926,393	
Norfolk	6,923,659	
Suffolk	5,271,540	
Suffolk district/borough	£s	% of Suffolk allocation
Babergh	571,840	11%
Forest Health	397,748	8%
Ipswich	1,025,456	19%
Mid Suffolk	525,170	10%
St Edmundsbury	695,152	13%
Suffolk Coastal	847,104	16%
Waveney	1,209,068	23%

The Ipswich and Waveney Housing Market Areas Strategic Housing Market Assessment (SHMA), Volume 2 – May 2017 provides information on the DFG completions and from 2011 to 2016. The Ipswich Housing Market Area (HMA) contains the local authorities of Babergh, Ipswich, Mid Suffolk, Suffolk Coastal, and the Waveney HMA comprised the district of Waveney⁷⁵.

The figure below shows the number of Disabled Facilities Grants that have been completed between 2011/12 and 2015/16 in each authority within the two aforementioned HMAs. The SHMA notes “The figure shows that the requirement for these services has increased notably over this period in the Waveney HMA. Within the Ipswich HMA, the requirement for these services in Babergh has recorded an increase over the whole period, whilst in Ipswich it has fallen slightly and in Mid Suffolk and Suffolk Coastal it has decreased notably. It should be noted that the changes recorded are not linear and that the requirement can vary notably from year to year”⁷⁵. There has been a change in DFG completions over the last five years with the greatest in 2013/14 and least in 2015/16. Some of this will be due to changes and reductions in the grant allocations from central government since 2010⁹⁶.

Figure 11: Disabled Facilities Grant completions within the Ipswich Housing Market Area and the Waveney Housing Market Area, 2011-2016



Source: Babergh, Ipswich, Mid Suffolk, Suffolk Coastal and Waveney Councils, 2016

There are an estimated 1,750 residents with disabilities in need of significant care and support in Suffolk, of which a high proportion will have specialist housing needs, but only approximately 1,000 specialist housing places for disabled adults are currently available⁹⁷.

Individuals with learning disabilities

[Suffolk's Joint Learning and disability strategy](#) asserts that people with learning disabilities (aged 14 and over) and their families should be supported to live good ordinary lives in Suffolk, and that there is a need to ensure people can choose where they live, whom they live with and who supports them.

2017 estimates indicate that there are 13,900 Suffolk residents with a learning disability, with 26% of these (3,600) aged 65+. By 2035 the total number is expected to increase to 15,183, with 34% of these individuals (5,200) aged 65+⁹⁸.

People with learning disabilities are living longer⁹⁹. Research has suggested that this increase in life expectancy may be due to greater support for community lifestyles, improvements to person-centred care and support, and improved access to healthcare interventions such as anti-biotic treatment for chest infections and cardiac surgery for congenital heart disorders¹⁰⁰.

A 2014 learning disability needs assessment for Suffolk found that the use of day services, domiciliary care and specialist housing interventions has increased in Suffolk since 2009 in order to support the move from residential care to care in a community setting which is designed to facilitate maximisation of independence⁹⁹. However, Suffolk still does relatively poorly in comparison with the England average at ensuring residents with learning disabilities have stable and secure accommodation¹⁰¹, as shown in the figure overleaf.

Figure 12: Adults with learning disabilities living in settled accommodation, 2015/16

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Proportion of supported working age adults with learning disability living in settled accommodation (%)	2015/16	75.2	73.5	69.9	69.9	76.7	76.9	73.1	74.5	74.0	84.4	83.2	61.4	85.0
Proportion of supported working age adults with learning disability living in unsettled accommodation (%)	2015/16	19.8	22.0	22.6	19.0	21.8	23.1	26.7	15.7	25.6	15.6	14.7	14.9	13.3
Proportion of supported working age adults whose accommodation status is not known to LA (%)	2015/16	5.0	4.5	5.4	10.8	0.8	0.0	0.0	7.8	0.2	0.0	2.1	23.4	0.0

source: ¹⁰¹

Specialist needs – Other groups

There are a number of other groups in Suffolk who may be at greater risk of unsuitable housing. These include:

- Family carers
- Those affected by domestic abuse
- Transient populations (for example Gypsy, Roma and Traveller populations)
- Those experiencing dual diagnosis²
- Care leavers
- People that have served a custodial sentence
- Veterans

It is important to note that there are many crossovers between unhealthy, unsafe, unsuitable and insecure housing, and these groups could be affected by any of these issues. However, for the purpose of this needs assessment we have included specialist populations under the unsuitable housing section. This section provides a brief overview of scale and potential impact, and therefore it is recommended as a key area of future focus, so the complexities can be understood in more detail.

Family carers

The 2011 Census identified that 77,745 people (of all ages) in Suffolk provide at least one hour of unpaid care a week¹⁰², and data from the Department for Work and Pensions notes that in May 2017 there were 8,000 cases in payment for Carers Allowance in Suffolk¹⁰³. As the population of Suffolk ages, it is likely that the number of people providing unpaid care in Suffolk will rise.

² Individuals with substance misuse (drug, alcohol or both) problems and mental ill health together are referred to as having dual diagnosis.

A 2016 report by Carers UK¹⁰⁴ looked at the impact of inaccessible and unsuitable housing on carers and their families. The report found that for carers, there were very significant costs associated with higher utility bills which means many carers are living in fuel poverty. One of the fundamental reasons for higher energy costs was due to the person they care for needing a warmer home than average, and heating was used for more months in the year - because the person they care for is unable to regulate their body temperature, or because they were moving around less^{104, 105}.

Nationally, a key survey by Carers UK of over 5,000 carers (most of whom provide 50 hours or more of care a week), identified the following key issues for carers¹⁰⁴:

- 13% of carers said that as a result of caring there isn't enough space to live comfortably
- 15% of carers said that there isn't enough space for others to stay to provide support that they need (e.g. overnight care workers, family members who help with caring)
- Almost 1 in 5 (18%) carers are waiting for adaptations to be made
- Nearly 10% said that their home was in poor condition, from damp or disrepair

If these proportions were applied to the 2011 Census number of Suffolk carers, the following would apply:

- 10,100 Suffolk carers don't have enough space to live comfortably
- 11,700 Suffolk carers don't have enough space for others to stay to provide support
- 14,000 Suffolk carers are waiting for adaptations to be made
- 7,800 Suffolk carers homes would be in poor condition, from damp or disrepair

Young carers

The 'Young Carers and Young Adult Carers Supplementary Report' to the 'Suffolk Family Carers Needs Assessment'¹⁰⁶, highlighted that the identification of young carers and young adult carers can be difficult. There is generally a paucity of data on young carers and young adult carers in Suffolk. There is also a large gap between the number of carers identified through the census and those known to services.

According to the 2011 Census, 1,497 young people aged 0-15 identified themselves as unpaid carers, as did a further 3,216 young carers/young adult carers aged between 16-24. Of these, 495 reported that they were delivering 50 or more hours of unpaid care per week. The majority of young adult carers aged 16-24 years identified through the 2011 Census reside in Ipswich (5.6%), and the lowest proportion resides in Suffolk Coastal (3.2%). When considering young carers aged 0-15 years, the majority again reside in the Ipswich area (2.4%), whereas the smallest proportion resides in Mid-Suffolk (1.5%).

The impact of a young person's caring role on their health, education attainment, employment, personal and social lives can be great. For example, caring can lead to missing school, poorer attainment, and opportunity limitation later in life¹⁰⁶. The responsibility may make young people reluctant to move away from home, and if they want to they may not be able to find suitable, affordable housing¹⁰⁷.

Those affected by domestic abuse

1 in 4 women have been in an abusive relationship at some time in their lives; men can also be abused in a similar way. It can happen to anyone at any time of life regardless of age, race, gender, sexuality, disability, wealth, income, lifestyle or where a person lives¹⁰⁸. Abuse may occur in many forms and may include: physical, mental, psychological, financial or emotional abuse. There are certain populations that are disproportionately more likely to experience abuse, such as disabled people¹⁰⁹.

Disabled people are also more likely to experience domestic abuse for a longer period of time, and experience more severe and frequent abuse than non-disabled people¹⁰⁹.

Office for National Statistics data for the year ending March 2017 (most recent data available)¹¹⁰, indicates that in Suffolk there were 9,629 recorded domestic abuse related incidents and crimes, equivalent to 13 incidents for every 1,000 people in the population. 11% of all recorded crime was classified as domestic abuse related in Suffolk over the same period, this was the same proportion as England and Wales. The average number of new cases discussed at the Suffolk's Multi Agency Risk Assessment Conferences between December 2016 and December 2017 has increased by 19 % overall. In December 2016 the average was 109.6 cases over the 3 areas and in December 2017 the average rose to 130.5 cases.

People in abusive relationships may experience a multiplicity of issues in relation to housing. Living in an unsafe environment is a risk to physical and mental health. However, there may be significant barriers to leaving an abusive home, from the presence of children, an uncertainty or where to go, a lack of a long term living solution, and to fear of being found by the abuser – to name a few.

Citizen's Advice note that "local authorities have a legal duty to provide help to certain people who are homeless or threatened with homelessness. You will qualify for help if you are eligible for assistance, legally homeless or threatened with homelessness and not intentionally homeless. You must also be in priority need. The local authority may also investigate whether you have a local connection with the area. You will normally be considered to be legally homeless if it is not reasonable for you to occupy your home because of the risk or fear of domestic violence"¹¹¹.

A place in a women's refuge may be an option for some, or finding emergency accommodation. However, being able to leave the home is not always an option. As a recent news report highlights: "The lack of safe, affordable housing comes up again and again as the single biggest barrier to leaving abusive relationships: how can someone leave when there is nowhere to go?"¹¹².

Transient populations (for example Gypsy, Roma and Traveller populations)

Transient populations are people that move location frequently, as such they may not engage with the local community or services in the same way that permanent or longer-term residents would. For the purpose of this needs assessment Gypsy, Roma and Traveller (GRT) populations have been identified as a key transient population, however other transient populations may be students, migrants or seasonal workers, and this is an area that may need to be investigated more comprehensively going forward.

The 2015 GAROD needs assessment identified an estimated GRT population in Suffolk of approximately 1,500 individuals¹¹³. GRT groups are likely to experience poor health, and have a life expectancy that is 10 years lower than the general population. The GAROD needs assessment identified that although GRT populations who travelled had generally better health than those on static sites. Roma communities in Ipswich were live in generally poor quality housing, and tended to have large families. The needs assessment asserts that whether GRT populations travelled, were living on permanent sites, or in houses, the need for secure housing is as important to GRT communities as to others in the wider population.

In 2017, five Suffolk local authorities (Babergh District Council, Ipswich Borough Council, Mid Suffolk District Council, Suffolk Coastal District Council, and Waveney District Council) published a Gypsy, Traveller, Travelling Showpeople and Boat Dwellers Accommodation Needs Assessment (ANA). The purpose of the assessment was to quantify the accommodation and housing related support needs in terms of permanent and transit sites and moorings, for the period 2016-2036.

The research drew on a number of data sources including:

- Review of secondary information
- Consultation with organisations involved with Gypsy and Traveller and Travelling Showpeople
- Face-to-face surveys of Gypsies, Travellers and Travelling Showpeople covering a range of issues related to accommodation and service needs.
- Postal surveys of boat dwellers (followed by visits to each boat yard)

The ANA found that the density of authorised caravans varied widely amongst the local authorities:

Table 4: Numbers of caravans per 100,000 population amongst districts and boroughs

	Numbers of caravans per 100,000 population
Babergh	1
Ipswich	38
Waveney	42
Suffolk Coastal	60
Mid Suffolk	109
East of England average	81
England average	39

Source: GTTANA 2017

A similar assessment was carried out in 2016 for Cambridgeshire, Kings Lynn and West Norfolk, Peterborough and West Suffolk which showed very low numbers in Forest Health and St Edmundsbury (less than 5)¹¹⁴.

In August 2015 the Government published its amended Planning Policy for Traveller Sites, which replaced the previous guidance and circulars relating to Gypsies and Travellers and Travelling Showpeople. The guidance emphasised the need for local authorities to use evidence to plan positively and manage development. In March 2016, the Department of Communities and Local Government (DCLG) published its draft guidance to local housing authorities on the periodical review of housing needs for caravans and houseboats. It states that, when considering the need for caravans and houseboats, local authorities will need to include the needs of a variety of residents in differing circumstances including, for example, caravan and houseboat dwelling households and households residing in bricks and mortar dwelling households.

Those experiencing dual diagnosis

Individuals with substance misuse (drug, alcohol or both) and mental health problems together are referred to as having dual diagnosis. There is a strong association between poor mental health and health risk behaviours such as smoking, and alcohol and drug misuse¹¹⁵. The inter relationship between drug and alcohol misuse and mental health conditions is complex and has historically been widely debated.

The prevalence of dual diagnosis in Suffolk is difficult to quantify. In 2014/15, at least 202 individuals had a formal diagnosis of dual diagnosis, but this is an underestimate as not all those with dual diagnosis present for treatment, or are in treatment all the time.

It is estimated that 75% of those in drug treatment services have a concurrent mental health problem, with the estimate rising to 85% for those in alcohol treatment provision and up to 75% of all prisoners have dual diagnosis^{116, 117}.

Good practice guidance recommends that clients with dual diagnosis be managed within mental health provision with support from substance misuse teams¹¹⁸. A national review in 2008¹¹⁹ found that the recommendations were often not in place. In Suffolk, there is an agreement between providers about which service should lead for those with dual diagnosis. Ipswich Locality Homelessness Partnership have developed a joint protocol in 2016, to identify the Lead Agency – and clarify this role – for service users accessing Housing Related Support, Mental Health and Recovery services in Ipswich. The procedure aims to ensure that there will always be:

- Clear, action orientated and documented communication between providers
- An identified Lead Agency responsible for coordinating the actions relating to care and support for service users, and information sharing as appropriate, across partners
- Agreed escalation processes to raise concerns about coordination and/or joint working

There are plans to roll this protocol out across Suffolk through the recovery forums though the progress on this is not clear.

Mind¹²⁰ note that for people with dual diagnosis finding somewhere to live can be very difficult, and that many housing agencies and supported housing trusts will not accept drug users. Mind also note that housing and mental health are often linked, poor mental health may make coping with housing issues more difficult, and being homeless or having problems in your home can make mental health worse¹²¹.

Dual diagnosis may exacerbate housing issues further, and NICE guidance on co-existing severe mental illness and substance misuse¹²², highlights that services need to be aware that people's unmet needs may lead them to have a relapse, or may affect their physical health. This includes: social isolation, homelessness, poor or lack of stable housing, or problems obtaining benefits¹²².

Care leavers

The Government's Care Leavers Strategy identifies care leavers as a vulnerable group of young adults who have particular needs in relation to housing and homelessness¹²³. The strategy notes that the majority of care leavers leave care by the age of 18, and that rising demands on social housing and other accommodation is making it more difficult for young people to find suitable accommodation as they enter adulthood¹²³. It also notes that recurrent feedback from care leavers, is that they do not always feel safe in their accommodation¹²³.

For young care leavers, the Council has a legal duty to help make the move from care to independent living. However, the move to independent living can be extremely difficult for care leavers, and although support may be available the transition is often challenging. Money management, home maintenance and maintaining wellbeing may all be more of an issue for this population.

Data for Suffolk indicates that there were 292 care leavers in 2016/17, an increase from 279 in 2015/16¹²⁴. At the end of 2016/17 Suffolk data indicates that 90.0% of care leavers were in suitable accommodation, 60% of care leavers were in education, employment or training, and 87.0% of care leavers had up to date pathway plans¹²⁵.

Suffolk's [Leaving Care Service](#) works with young people in local authority care to help them to prepare for independent living from the age of 16 up to the age of 25. Most young people leave the care of

the local authority at the time of their 18th birthday, but will continue to receive support with accessing education, employment and housing beyond this age.

People that have served a custodial sentence

For the purpose of this needs assessment, we have not used the term ex-offender, as this can include anyone who has committed a criminal offence (for example a singular arrest).

Individuals entering prison have a range of complex needs for example these may include a lack of qualifications, or a learning or physical disability, and may leave prison with no fixed accommodation, no financial support and no prospect of finding work¹²⁶. This makes finding suitable and sustainable housing difficult upon release. Additionally, employment significantly reduces the chances of reoffending, as well as leading to other positive outcomes that have been shown to reduce reoffending, such as financial security and finding a safe and permanent home¹²⁶.

2015 data for England and Wales prison populations indicates that the total number of inmates (including pre-trial detainees) was 86,193 – equating to a rate of 148.3 people per 100,000 total population¹²⁷. If this rate is applied to the total Suffolk population (mid-2016 estimate), this could mean a potential ‘inmate’ population of approximately 1,105. This is very much a proxy of the total number, as it is for those with a custodial sentence.

It is difficult to find an accurate number of people that have been in prison, and are living in Suffolk. Information below provides an overview of prisons in Suffolk, however, upon release people may not necessarily reside in the area. Recent estimates indicate that approximately 30% of people in the housing related support system have a criminal conviction and that there are around 1,000 people currently on the case load for the national probation service across Suffolk.

There are several prisons within Suffolk, they are all trainer prisons and the nearest remand prison is Norwich. Prisons within Suffolk are:

- Warren Hill Prison – 232 operational capacity for Category C³ adult males (18+). This is distributed with 32 in the Democratic Therapeutic Community; 20 in Psychologically Informed Planned Environment. The majority of the prison population are within the Progression Regime or in transit from open conditions.
- Highpoint – c.1300 operational capacity for Category C adult males (18+). These are across two distinct sites, Highpoint North and South. This training prison is located near Newmarket, Suffolk.
- Hollesley Bay – 421 operational capacity for Category D⁴ adult males (18+). This is an Open prison in Woodbridge, Suffolk^{128, 129}.

As of October 2017, prison populations in Suffolk were at, or near to, operational capacity¹³⁰. The operational capacity refers to the number of inmates the prison can safely hold.

STARS (Supporting Treatment, Accommodation and Recovery in Suffolk), provides advice and support to those who are accessing treatment and who may be at risk of losing their tenancy. Data from STARS indicates that in January 2018, an estimated 30% all the currently supported STARS (intensive support) clients received a custodial sentence within the last five years.

³ Category C prisoners: Those who cannot be trusted in open conditions but who are unlikely to try to escape.

⁴ Those who can be reasonably trusted not to try to escape, and are given the privilege of an open prison.

Repeated studies have established that securing adequate housing reduces rates of reoffending¹³¹, and yet there remains concerns surrounding the level of statutory support available for those leaving prison as well as the availability of housing upon release¹³¹. Literature shows that the links between homelessness and offending are well established¹³². Although 2012/13 data highlights that 12% of prisoners released from custody had no settled accommodation¹³³, other data indicates that about a third of offenders are without a home either before or after imprisonment¹³².

In November 2016, the Government published its White Paper on [Prison Safety and Reform](#)¹³⁴, this identified access to stable accommodation as a key area in relation to preparing for life after release. A 2017 Parliament briefing paper notes: “Currently, if a prisoner is homeless on release a local authority may have a statutory duty to assist. Local authorities in England must secure accommodation if the ex-offender is in priority need (for instance if they are deemed vulnerable due to their custodial sentence). However, local authorities in England generally have regard to ‘intentionality’ and may judge an ex-offender to have made themselves homeless if losing their home was a likely outcome of committing a crime”¹³¹.

Finding suitable housing is only one element of successful transition back in to the community, and holistic support / wrap-around services are needed in relation to other areas – for example finding suitable education and/or employment.

Veterans

2016 estimates indicate that there are approximately 3,300 serving armed forces personnel in Suffolk and that the estimated size of the veterans/ex-forces community in Suffolk is between 33,000-37,000¹³⁵. A Service Leaver is a member of the UK Armed Forces who is preparing to leave the armed forces and transition to civilian life. Upon leaving the armed forces they become a veteran or member of the ex-Forces community. Veteran populations are those who have served for at least one day in HM Armed Forces, whether as a Regular or Reservist. The veteran population is getting older, with the national service cohort contributing to the large proportion of older veterans. This age cohort is also more likely to live alone.

For some Services Leavers/ veterans the transition from military life to ‘civvy street’ can be challenging, and this includes challenges with finding suitable, affordable housing upon leaving the military – especially those that are experiencing mental and/or physical ill health⁵.

Overcrowding

There are two measures of occupancy used in the 2011 Census to assess overcrowding and under-occupancy; one based on the total number of rooms in a household’s accommodation, and one based only on the number of bedrooms. The ages of the household members and their relationships to each other are used to derive the number of rooms/bedrooms they require, based on a standard formula. An occupancy rating of -1 implies that a household has one fewer room/bedroom than required, whereas +1 implies that they have one more room/bedroom than the standard requirement¹³⁶.

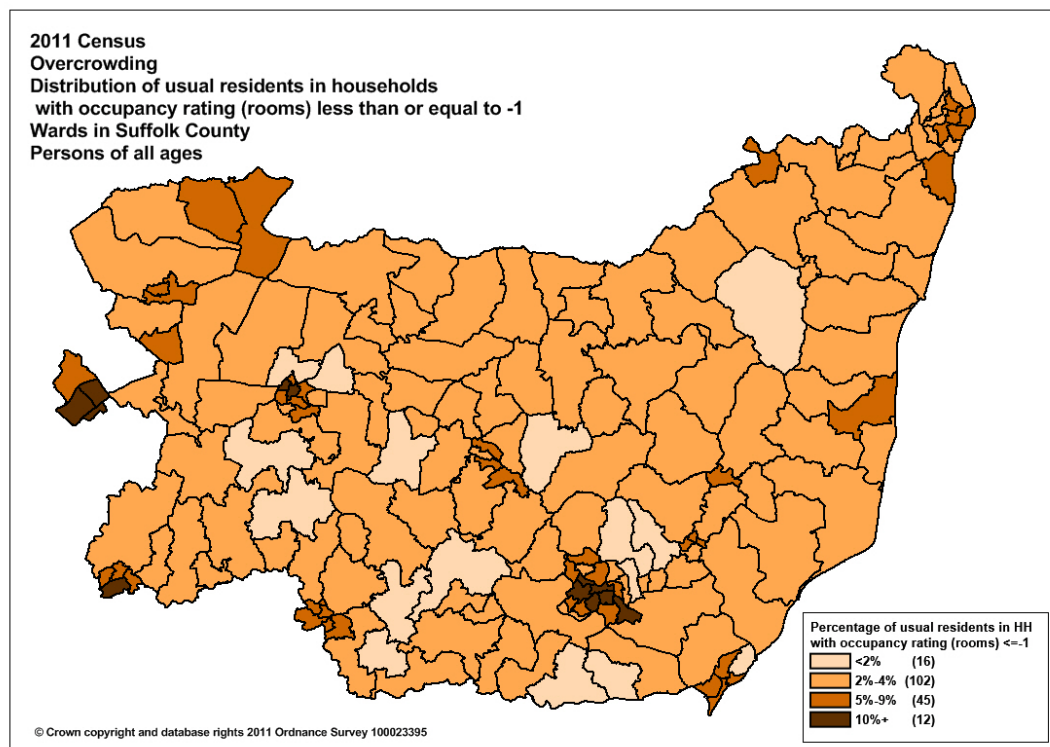
At the 2011 Census, 78.7% (562,000) of usual residents in households in Suffolk lived in under-occupied housing. Under-occupied housing is defined as that with an occupancy rating of +1 or more, this indicates that a household has one bedroom more than is recommended for the number and composition of people living in the household and is considered under-occupied by the bedroom standard¹³⁷. This compared with 74.5% in the East of England and 69.7% in England. The proportions

⁵ For information veterans can utilise: <https://www.veteransgateway.org.uk/>

ranged from 69.4% in Ipswich to 84.0% in Mid Suffolk. In the over 65 age group, this rose to 89.5%, compared with 87.4% in East of England and 85.3% in England living in under-occupied housing.

The Census showed that 5.7% (40,704) of usual residents in households in Suffolk lived in overcrowded housing. Overcrowded housing is defined as a house that has an occupancy rating of -1 or less, this indicates that a household has at least one bedroom too few for the number and composition of people living in the household and is considered overcrowded by the bedroom standard. This compared with 7.9% in East of England and 11.1% in England. In districts and boroughs, the percentages ranged from 3.6% in Mid Suffolk to 9.8% in Ipswich. In the over 65 age group, this fell to 2%, compared with 2.6% in East of England and 3.3% in England. At ward level, overcrowding ranged from 1.2% (Great Barton, St. Edmundsbury) to 18.5% (Westgate, Ipswich), with a median of 3.7%. As shown in the below map, overcrowding was most common in urban wards in Ipswich, Bury St. Edmunds, Haverhill and Newmarket. It is worth noting that the horse racing industry in Newmarket is likely to have an effect on the prevalence of overcrowding.

Map 2: Percentage of usual residents in overcrowded households, by ward



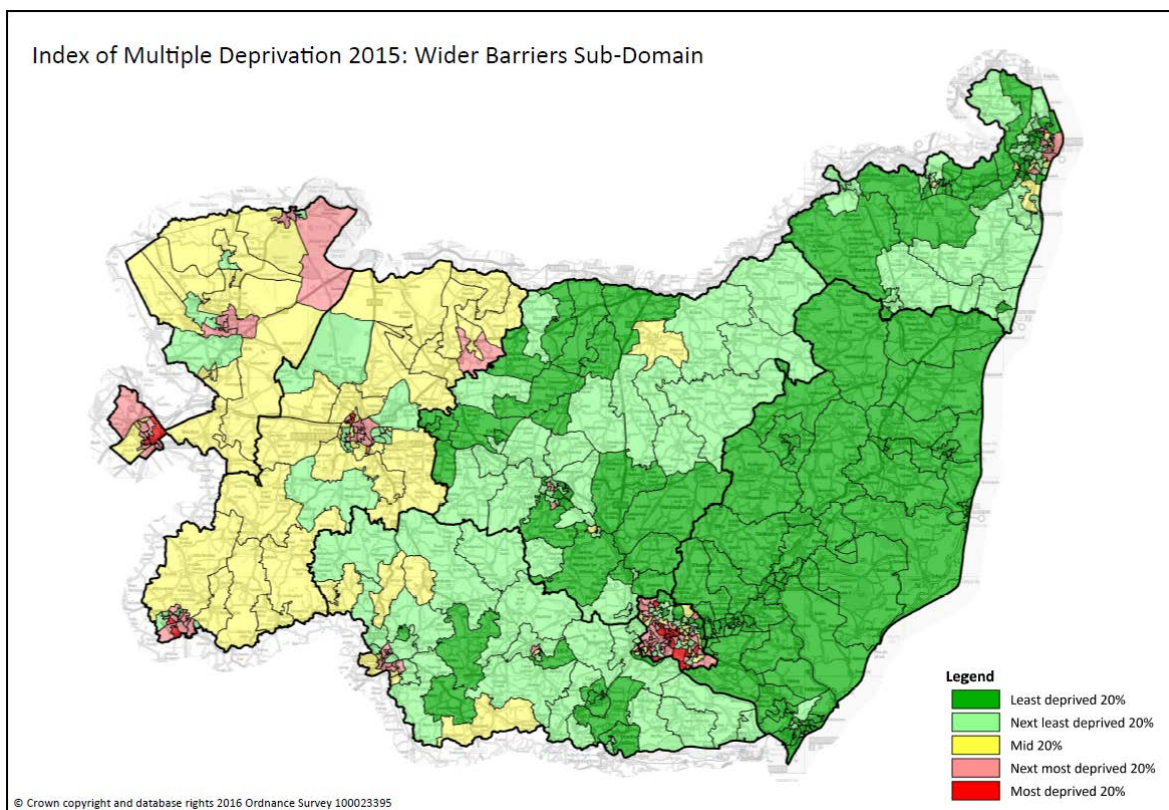
Source: 2011 Census Local Characteristics, ONS¹³⁷

5.6 Insecure housing

Index of Multiple Deprivation 2015

The Index of Multiple Deprivation (IMD) features a domain called 'Barriers to Housing and Services'. This combines two sub-domains: firstly, the geographical barriers (e.g. road distance to GP, schools, etc.), and secondly, the wider barriers to housing, which measures household overcrowding, homelessness and housing affordability (both in terms of access to home-ownership but also affordability levels in the private rented sector). The map below shows the distribution of the sub-domains "wider barriers" across Suffolk.

Map 3: Distribution of wider barriers from the Housing and Services Domain (Index of Multiple Deprivation 2015), by national deprivation quintile, by LSOA



Source: Index of Multiple Deprivation 2015

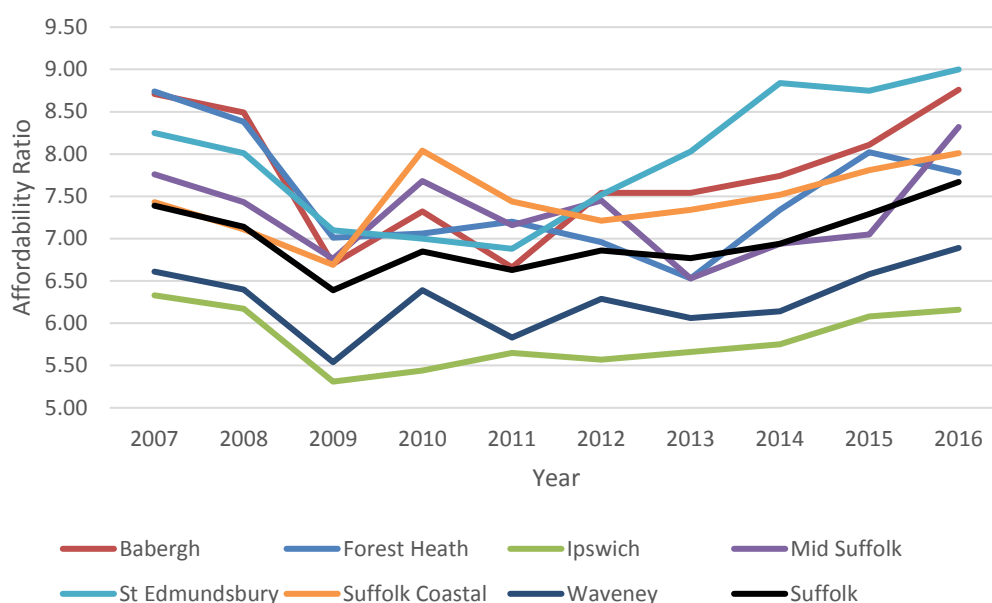
A total of 4% of LSOAs in Suffolk County (19/441) had estimated Indices of Deprivation 2015 Wider Barriers Domain scores in the most deprived 20% of national scores. These are concentrated in the most densely populated areas.

Affordability

House prices on average have increased by 25.7% over the last five years. Within this overall average, the lowest priced quartile of houses has increased in price even further, by an average of 30.9%, potentially making it harder for those on lower incomes to buy a home^{138, 139}.

The trend in the affordability ratio of median house price to median earnings in Suffolk over the past 10 years shows a pronounced sharp drop in the year following the 2008 financial crisis, followed by subsequent rises across the county. Most areas reached a higher ratio by 2016 than in 2007, except for Forest Heath and Ipswich. The biggest increase in the ratio (i.e. becoming less affordable) has been in St Edmundsbury. The latest ratio for Suffolk from 2016 shows that the average house price is just over 7.5 times the average gross annual earnings.

Figure 13: Ratio of median house price to median gross annual (where available) residence-based earnings, districts and boroughs and Suffolk, 2007-2016

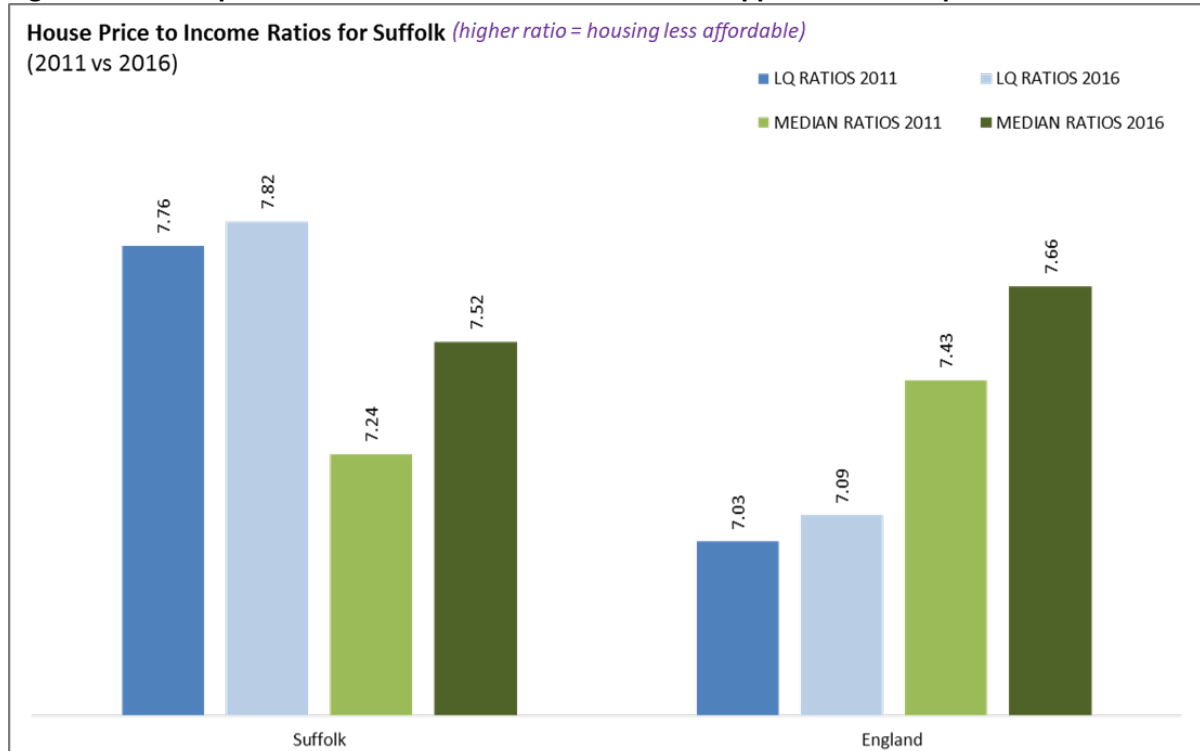


Source: Office for National Statistics¹⁴⁰

The figure below shows the house prices to income ratios for Suffolk. Higher ratios mean less affordable housing. In line with the national picture, housing affordability has declined over the last 5 years. In England as a whole, affordability is worse for the median house price to median income ratio. However, in Suffolk affordability is worse for the lower quartile house price to lower quartile income ratio. That is housing in Suffolk is least affordable for those residents in the lowest 25% income bracket, and this situation is worse than it is for the quarter of the population with the lowest incomes in the rest of the country.

Suffolk's low wage economy¹⁴¹ exacerbates affordability issues. As an example of this, data from Skills for Care indicates that in August 2017 in Suffolk there were an estimated 21,700 jobs in adult social care¹⁴². Estimates for the East of England predict that if the workforce grows proportionally to the projected number of people aged 65 and over, then the number of adult social care jobs will increase by 36% by 2030. However, average pay levels for adult social care workers in Suffolk are lower than regionally and nationally¹⁴². This could mean that working and living locally is particularly difficult for people working in the caring professions, who are vital in supporting our ageing and vulnerable populations.

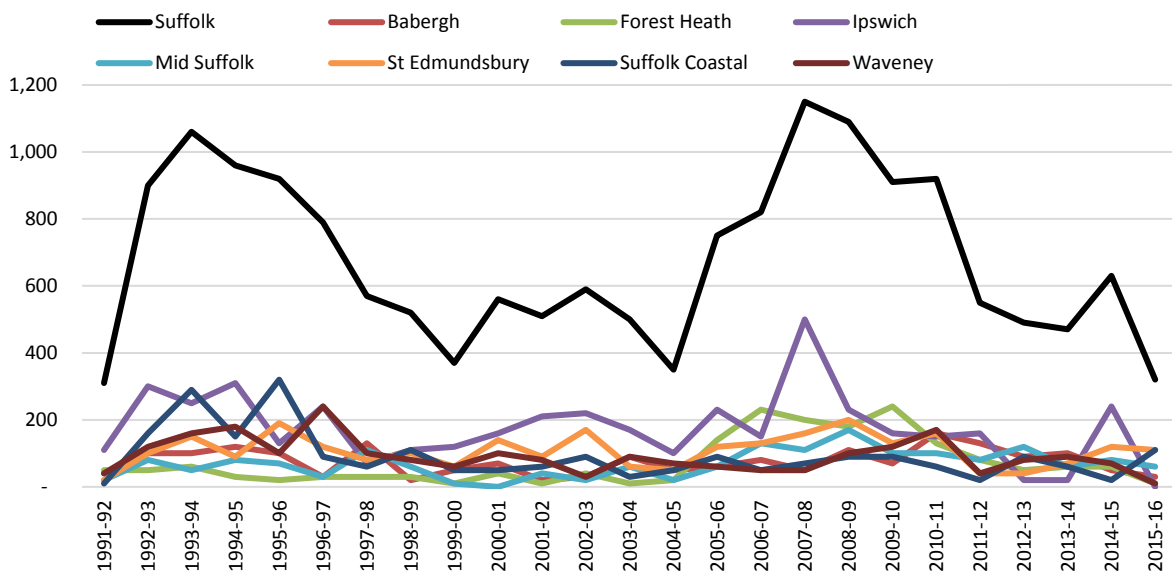
Figure 14: House prices to income ratios for Suffolk for the upper and lower quartiles



Source: Office for National Statistics; ¹⁴³

The figure below shows the volume of new affordable homes built over past years in Suffolk. There has been a large variability in numbers over the years, from a high of 1,150 in 2007/08 to a low of 320 in 2015/16. Numbers increased to above 600 in 2014/15, driven mainly by Ipswich. This picture, seen across much of the country, is of rising house prices relative to earnings, with fewer new affordable homes coming on the market each year.

Figure 15: Total additional affordable dwellings provided by local authority area- Completions



Source: Department for Communities and Local Government (Table 1008C)

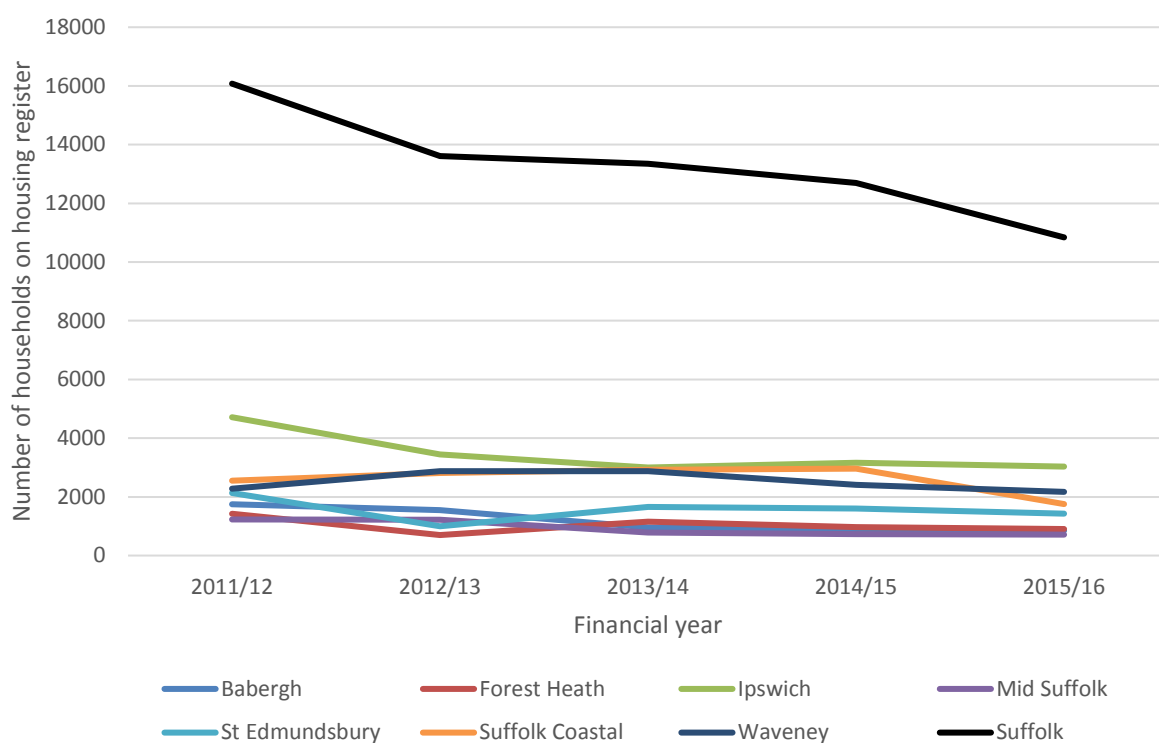
Other factors which may also be affecting the affordability of homes available include:

- Reduced numbers of social rented properties for example through private landlords converting social rented properties into affordable rental properties (80% of market rent levels in the local area).
- Freezing of local housing allowances. Local Housing Allowance (LHA) is the name given to housing benefit for private renters. LHA rates are calculated for every local area based on local rents. The maximum amount of support a household can claim will depend on where they live, the minimum number of bedrooms they need and their income. LHA has been frozen from 2016/17 to 2020/21, Shelter calculates that the freezing of LHA means that most private renters who need their income topped up by housing benefit will face a monthly shortfall between the actual cost of their rent, and the support available¹⁴⁴.
- Reduction in housing support for those under 35. The age under which claimants are only entitled to the shared accommodation rate of LHA (for a room in a shared house rather than a one bed flat) has been raised from 25 to 35 years.

Housing register

There has been a year on year drop in the number of households on the housing register waiting for a suitable property in Suffolk between 2012 and 2016, from 16,078 to 10,840. This reflects reductions across all districts and boroughs. It equates to a 33% reduction over five years in Suffolk, with the largest reductions seen in Babergh (51%) and Mid Suffolk (42%). There has been very little change in Waveney, with a 5% reduction over this period, during which time numbers rose in the intervening three years. It is unclear whether this is a real decrease in households in need or due to changes in eligibility criteria over time.

Figure 16: Number of households on the housing register, districts and boroughs and Suffolk, 2011/12 to 2015/16

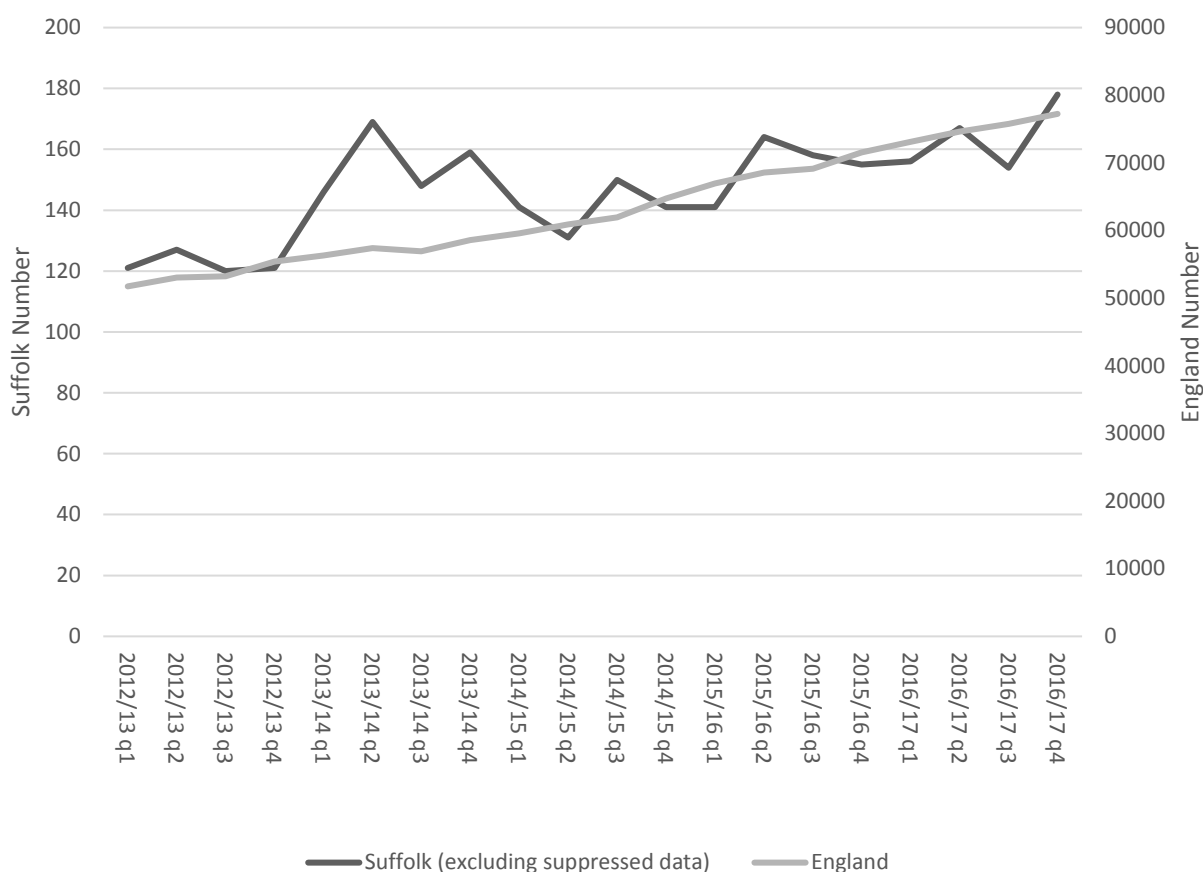


Source: Department for Communities and Local Government

Temporary accommodation

In the last 4.5 years, the number of households being housed in temporary accommodation in Suffolk has increased, as have England figures.

Figure 17: Number of households in temporary accommodation, Suffolk, by financial year/quarter, 2012/12 Q1 to 2016/17 Q2.



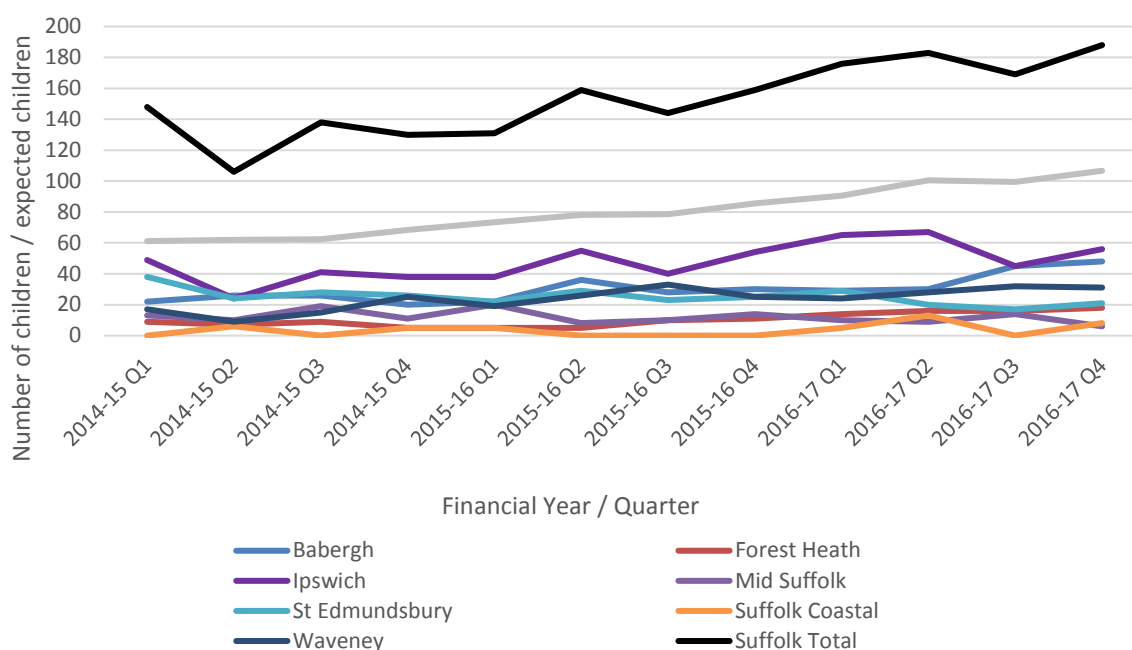
Source: Department for Communities and Local Government / Local Government Association

Values of less than five households have been suppressed. In addition, some values of five or greater have been suppressed to prevent other suppressed values being calculated

The literature review section highlighted that frequent moves are linked to long-term mental health problems and substance abuse. There are currently no estimates of the impact that the level of insecure housing is having on mental health outcomes for adults and children in Suffolk.

Temporary accommodation can have a particular impact on children, and the numbers of children believed to be affected has increased steadily over the past three years. This is a similar pattern to local authorities outside London, as can be seen in the figure below. The increase in Suffolk appears to be driven by numbers in Ipswich, Babergh and Waveney.

Figure 18: Total number of children / expected children in accommodation arranged by Local Authority at the end of each quarter, by district and borough, Suffolk County, and non-London LA average, 2014-15 to 2016-17



Source: Department for Communities and Local Government¹⁴⁵

Universal Credit

The Welfare Reform Act, introduced by the coalition government in 2010, consists of Universal Credit (UC) at its heart as well as a series of other initiatives and changes. Each part of the welfare reform programme has a distinct purpose with specific consequences and impacts; though the overall impact might be greater than the sum of its parts. The consequences and impacts of the various elements of the reforms can vary widely, and are often based on individual circumstances.

Universal Credit brings together six different benefits into a single payment, and represents a major welfare reform policy that is currently being rolled out nationally in a phased approach. Recent evidence, collected nationally by Citizens Advice (CA) from pilot sites, shows the impact of the rollout of Universal Credit (UC) on debt and housing: 1 in 4 people were not receiving their full payment within six weeks; of those helped by CA 14% were more likely to have problems with priority debts, like rent, if they were on UC versus the existing benefit system¹⁴⁶. The CA in Suffolk has reported issues with rent arrears and subsequent impact on housing where UC has started in Suffolk. Waveney was the first area in Suffolk to undergo rollout (in May 2016). In February 2017, Waveney District Council (DC) reported that 87% (255) of tenants on UC were in rent arrears, compared to 37% (1,508) of tenants not receiving UC. The average rent arrears were markedly different between these groups, with an average of £970 for those on UC compared to £300 for those not on UC. It is important to note that that this study was a snapshot in time, applying only to Waveney. The effect of UC on other localities in Suffolk has not yet been shown, though work looking into this is currently ongoing.

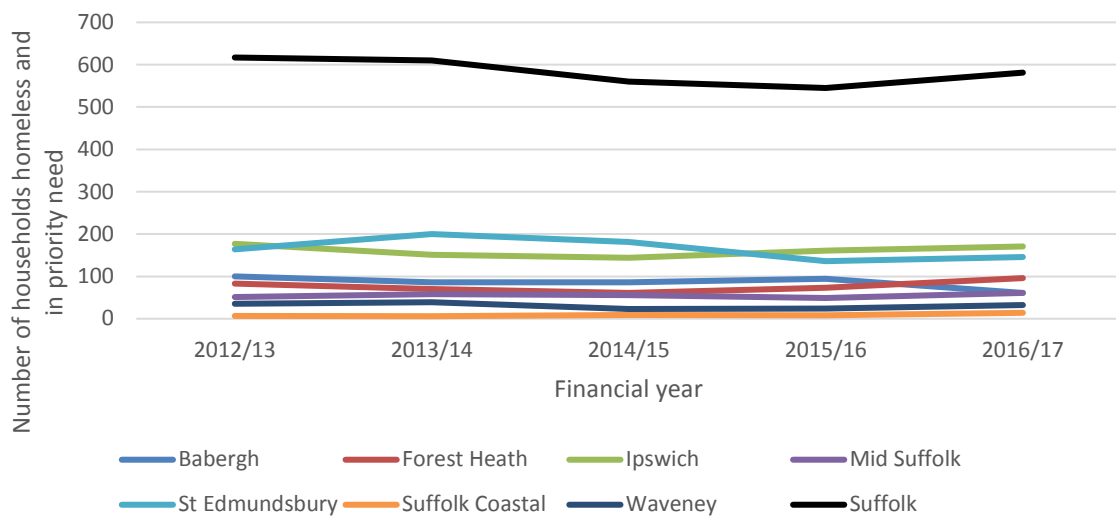
This shows a local experience of the difficulties reported nationally with the implementation of UC. The delays in payment can cause serious difficulties in meeting rent payments, jeopardising people's tenancies: Waveney DC noted that, despite preparing private landlords for the welfare changes, the delays incurred were making some landlords reluctant to accept UC claimants as tenants, putting additional pressure on the District Council's limited housing service provision. This is an area of policy change with the Autumn 2017 budget, announcing the end of the initial seven day waiting period,

meaning that the wait for Universal Credit should now be reduced to 5 weeks from February 2018. It is likely that despite this one week reduction, the 5-week wait will still have an effect on levels of debt and housing instability for those in receipt of UC.

Homelessness

The number of households recorded as homeless and in priority need has remained relatively stable over the past five years in Suffolk, with 581 households meeting these criteria in 2016/17 for statutory support. This number does not reflect all those in precarious housing situations who may have come close to homelessness during this time.

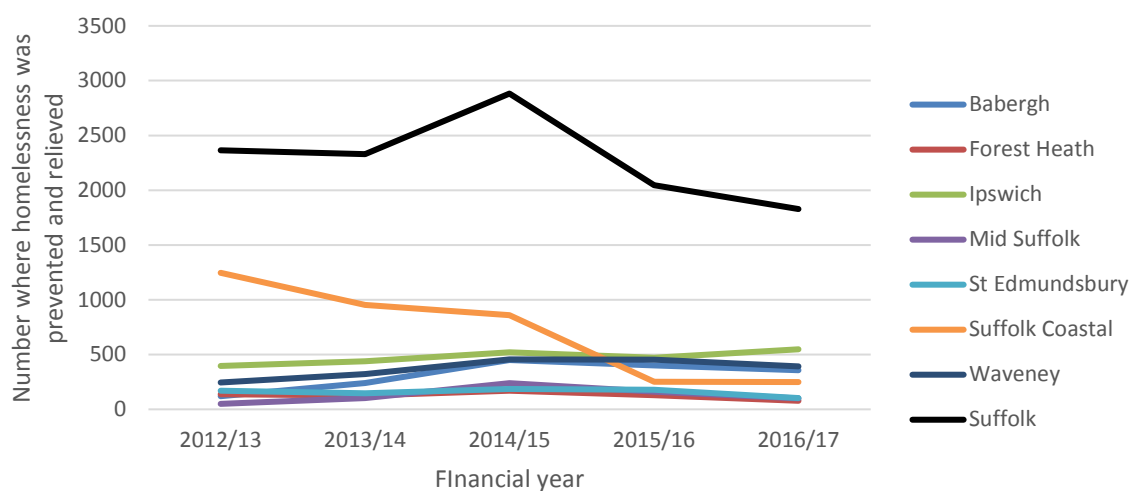
Figure 19: Number of households homeless and in priority need, districts and boroughs in Suffolk, 2012/13 to 2016/17



Source: Department for Communities and Local Government¹⁴⁵

The figure below shows the much larger number of those households where homelessness was successfully prevented and relieved, with 1,828 cases prevented in the past year.

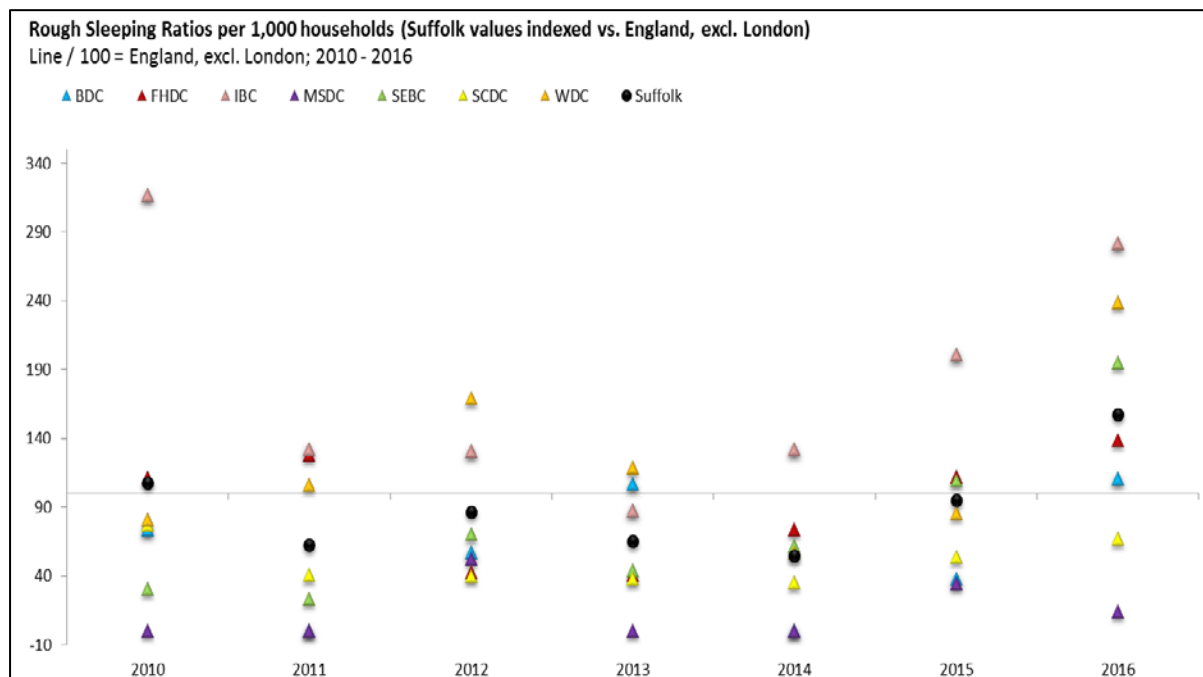
Figure 20: Number of cases where homelessness was prevented and relieved, districts and boroughs in Suffolk, 2012/13 to 2016/17



Source: Department for Communities and Local Government¹⁴⁵

The figure below shows the change in rough sleeping ratios in the districts and boroughs in Suffolk. The line is the England figure excluding London. Rough sleeping is gradually increasing across the country (excluding London) but increasing at a faster rate in Suffolk. The numbers of rough sleepers in Suffolk increased from 24 in 2010 to 82 in 2016 (+242%); while they grew by 134% across England (excl. London).

Figure 21: Rough sleeping ratios in districts and boroughs in Suffolk



Source: Department for Communities and Local Government¹⁴⁷

Acronyms: BDC Babergh District Council, FHDC Forest Heath District Council, IBC Ipswich Borough Council, MSDC Mid Suffolk District Council, SEBC St Edmundsbury Borough Council, SCDC Suffolk Coastal District Council, WDC Waveney District Council

A needs assessment for homelessness in Suffolk was carried out in 2015 as part of the ‘Groups at Risk of Disadvantage Health Needs Assessment’¹². More detail on homelessness in Suffolk, including exploration of the reasons for homelessness, services provided and national best practice on the issue can be found there. Across the Suffolk System, partners are working on the rollout of the Homelessness Reduction Act, which will commence in April 2018. This new legislation will have far reaching implications for local authorities; which are discussed outside of this report.

In December 2017, the House of Commons Committee of Public Accounts published a report on homeless households¹⁴⁸. The report asserts that since 2010 all homelessness measures in England have risen, with the number of children in temporary accommodation increasing by 73%, and the number of people counted as sleeping rough has more than doubled to 4,134. However, the report also notes that the true extent of homelessness is likely to be much higher with Crisis estimating that 9,100 people were sleeping rough at any one time in 2016¹⁴⁸.

Perhaps most tellingly, the report notes that local councils cannot solve homelessness alone, and working more closely with local authorities is no substitute for emphatic government action. They assert that the Department (for Communities and Local Government) needs to act now to bring together the stakeholders who can make a difference quickly. Suffolk County Council as well as

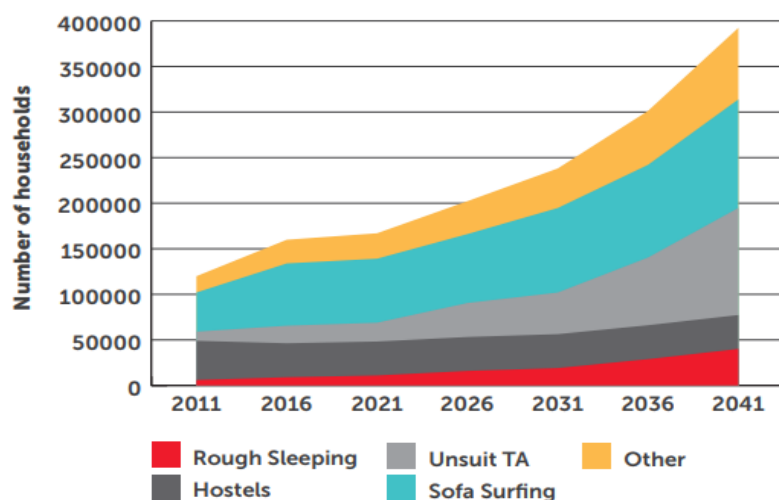
District and Borough councils, have an opportunity to lobby for change, to work together, and also work to provide wrap-around support for those who are most vulnerable.

Hidden homelessness and sofa surfing

The statutory homelessness definition takes in to account individuals or families who local authorities are obliged to assist¹⁴⁹. Therefore, people who are homeless (lacking their own secure, separate accommodation), but without formally applying or registering with a LA or applying to other homelessness agencies are omitted from official statistics. These people are often referred to as the 'hidden homeless'^{149, 150}.

- A 2011 report by Crisis found that the majority of single homeless people were hidden: 62% of those surveyed were hidden homeless according to the definition adopted for the study¹⁵¹.
- Research indicates an increasing number of people are sofa surfing (sleeping on floors/settees of a friend or relative). Crisis assert that there has been a 53% increase in sofa surfers in Great Britain from 2011-2016, with an estimated 68,300 households in Great Britain sofa surfing in 2016^{152, 153}.
- Projections data indicates that the number of rough sleepers alone in Great Britain could rise by 76% over the next 10 year (current figure 9,100)¹⁵³.
- Figure 21 highlights that at any one time, core levels of homelessness are around 160,000 households in Great Britain. Many of these households are single adults of working age, but there is a significant number of families and children within some of these groups¹⁵³.

Figure 22: Baseline forecasts of core homelessness main component, Great Britain, 2011-41



Category	2011	2016	2021	2026	2031	2036	2041
Rough Sleeping	6,100	9,100	11,000	16,000	19,100	28,900	40,100
Hostels	42,900	37,200	37,200	37,200	37,200	37,200	37,200
Unsuitable temporary accommodation	10,100	19,300	20,700	37,300	45,700	74,300	117,500
Sofa Surfing	42,900	68,300	70,200	75,600	92,700	101,700	119,100
Other	17,900	26,000	27,900	36,100	43,400	59,200	78,500
Total	119,900	159,900	167,000	202,200	238,100	301,300	392,400

Source: CRISIS. Homelessness projections: Core homelessness in Great Britain. (2017) ¹⁵³

Although a person of any age may sofa-surf, there is a particular focus on younger sofa-surfers, with some research indicating that one in five young people, aged 16 to 25, have sofa surfed in the past year because they had nowhere else to go^{154, 155}. If this statistic is applied to the 2016 population estimate of 16-25 year olds in Suffolk it equates to 15,600 young people.

Recent reporting indicates that a proportion of young sofa-surfers may be accepting offers from strangers in order to stay of the streets, putting them even more vulnerable situations and at risk of harm or exploitation¹⁵⁶.

Nationally, data on concealed households; households who are sharing accommodation; and overcrowded households can provide an estimate of hidden homeless populations. Data from 2016 indicates that there were 2.27 million households containing concealed single persons in England, in addition to 288,000 concealed couples and lone parents. The number of adults in these concealed household units is estimated at 3.34 million¹⁵⁰. These numbers represent broad stability alongside the estimates presented in the previous two Crisis Monitors, but a rise of one-third since 2008. Crisis asserts that being a concealed household can be quite a persistent state for both families and single people, with this persistence becoming more pronounced after the recent economic crisis¹⁵⁰.



Current Service Provision

6. Current service provision

This section covers **some** of the initiatives relating to housing and health that are currently in place in Suffolk. It is not a comprehensive review but highlights some of the good practice that is taking place across the county. The extent of the work that the voluntary, community sector, churches, district and borough councils are involved in with respect to housing is not explored in detail. For example, a significant proportion of the workload of Citizens Advice concerns housing. Brough and district councils cover, amongst other things:

- Advice and prevention work, including health and housing assessments
- Assessment of future demand, monitoring supply, including tenure and type of housing
- Inspection of properties through the housing standards teams, taking action with landlords when needed
- Supporting people with housing adaptations
- Outreach with marginalised vulnerable adults service
- Multi-agency working in the localities
- Joint partnership working regarding the implementation of Universal Credit
- Private Sector Landlord Forums
- Housing Related Support contracts

6.1 Suffolk Home Improvement Agency

The Suffolk Home Improvement Agency assists people living in Suffolk who are elderly or vulnerable, who have disability needs, or who are on a low income. The service provides advice, support and practical help to older home-owners, private tenants, and people of any age with a disability who could benefit from help to repair, improve or adapt their home so that they can continue to live comfortably, safely and independently. The service includes:

- arranging home visits to discuss the range of services provided
- help to identify what repairs, improvements or adaptations are needed
- providing information on the range of options available to fund work to the home
- help to complete grant application forms
- drawing of plans and preparation of specifications
- help to choose a builder from an approved list of contractors, obtaining estimates and organising the work
- dealing with payments
- referring as appropriate for other services

The advice service is free. The full service (including technical support) charges a fee of 12% of the cost of works. Individuals who are eligible for grants have the cost of the fees covered.

Individual councils and housing providers also deliver aids and adaptations within housing, based on needs with the aim of supporting vulnerable people to remain in their homes.

6.2 Warm Homes Healthy People

Warm Homes Healthy People is a non-statutory multi-agency partnership that offers a year-round service to those with health conditions who are struggling to adequately heat their homes. It aims to reduce health inequalities, pressure on health and social care, excess winter deaths and fuel poverty. In 2016/17, the service received nearly 5,000 calls, conducted 529 free home energy surveys, 570 heating installations or repairs and awarded £19,000 of fuel payments. Last winter the service worked closely with Ipswich Hospital Trust, and was able to reduce delayed transfers of care (DTCs) due to inadequate heating in patients' homes, saving an estimated 21 bed days. There are plans to repeat this exercise with Ipswich and West Suffolk Hospital this coming winter. At James Paget Hospital the service is linking up with the 'I'm Going Home' and 'Home from Hospital' service to extend these

services into the Waveney area, and add temporary heating for those patients for whom this is an issue.

The service faces the significant challenge of needing engagement from healthcare workers to identify vulnerable patients whose health may be suffering due to a cold home. Healthcare workers can make the connection, generate a referral to the service, and motivate the patient to take up the advice and support. More information on the service can be found online at www.healthysuffolk.org.uk/projects/warm-homes

The service has recently been successful in winning a £4.3 million bid with the Suffolk Climate Change Partnership, to provide assistance with first time central heating for households in fuel poverty. This fund will provide fully funded central heating systems⁶ to 514 fuel poor households in Suffolk over the next three years. The project will be managed by Suffolk County Council and administered by Suffolk Warm Homes Healthy People. Households will also be able to benefit from insulation measures and grants from the Suffolk Community Foundation's 'Surviving Winter Appeal' or from Suffolk's Warm Homes Healthy People where eligible. Suffolk's district and borough councils have committed to supporting the scheme with existing renovation grant budgets⁷.

Funding comes from a mixture of sources including £2.8 million from Affordable Warmth Solutions' Warm Homes, Energy Companies (as part of the obligations placed upon them to invest in energy efficiency by OfGEM) and Suffolk Community Foundation. District and borough councils have committed to supporting the scheme with existing renovation grant budgets should any match funding fall below the expected limits. The assistance will include making first time mains gas connections where gas is available, loft and cavity wall insulation and surviving winter payments towards fuel bills. The 3 year scope of the project will enable work to be done to build up networks to identify the most vulnerable which can be sustained after the end of the funding.

6.3 Warm Handovers

The Suffolk Information Partnership is a network of organisations supporting people in Suffolk with information and services around care, health and wellbeing (www.suffolkinformationpartnership.onesuffolk.net).

The Suffolk Information Partnership (SIP) was formed in 2010 and was made up of five key voluntary sector organisations in Suffolk and Suffolk County Council's Adult Social Care directorate. Now it has expanded to include nearly thirty statutory, voluntary and independent sector organisations all offering information and advice and delivering services to support people in Suffolk. The aim of the Partnership is to work together to provide clear, consistent, quality information to customers and a seamless journey for those needing to access services. Warm handovers is one of the services linking people up that is provided by the SIP.

The Suffolk Information Partnership manages a secure, online referral process to support vulnerable customers and clients and help them access services that they may not be able to on their own. With the client's consent their personal details and support needs can be passed on to other partner organisations who will get in touch with the client to offer support. The process is underpinned by a Data Exchange Agreement that outlines the responsibilities of each partner and means that the client

⁶ Subject to survey conditions

⁷ Anyone who does not have a central heating system and who has difficulty in paying their energy bills should contact Suffolk Warm Homes Healthy People on 03456 037686 quoting the Warm Homes Fund.

only needs to tell their story once. The warm handover currently has 19 partners organisations and around 80 referrals are made each month.

6.4 Suffolk Community Foundation – Surviving Winter campaign

For the past five years the Suffolk Community Foundation (supported by local press) has run the “Surviving Winter” campaign. Suffolk residents who are eligible for a winter fuel payment, but who do not need it (or anyone else who wants to make a donation), are asked to donate their payment to those who it could help. This has led to over £310,000 of donations, helping over 850 elderly residents to stay warmer during the winter.

In 2016/17, Citizens Advice administered the fund in partnership with Warm Homes Healthy People. This enabled £100,000 of donated funds to be allocated to some of the most vulnerable elderly residents via a fuel payment; the fund was also used to assist with small heating repairs.

6.5 Social prescribing

Social prescribing, sometimes referred to as community referral, enables GPs, nurses and other primary care practitioners to refer people to a range of local, non-clinical services (for example, housing) to help address social factors that may be affecting their health and wellbeing.

Two social prescribing schemes were launched in Suffolk in 2017, with three further schemes currently at different stages of development:

- ‘Solutions’ (based in Kirkley Mill, Lowestoft): the service is coordinated by Citizens Advice and offers support on general housing-related issues, benefits, heating, legal issues etc.
- ‘LifeLink’ (based in Haverhill) which covers all age groups and all health and wellbeing related issues
- Leiston - the scheme is not at ‘go live’ stage yet but similar provision to the Haverhill scheme is planned

In addition, there are two further potential schemes being considered/developed; one of these will cover the Shotley Peninsula area and the other will target two rural areas within Waveney/Suffolk coastal (precise locations yet to be determined). The former will be a generic scheme linking primarily to the Connect Health Social Care teams in the first instance but with the potential to work with district/borough colleagues to include housing related issues at a future point. The second scheme is to be targeted at the over-65 age group and detailed service provision is yet to be determined.

6.5 Domestic abuse

Suffolk has three Women’s Refuge in locations across the county offering 29 refuge bed spaces for adults (there are additional bed spaces for children) which has an average occupancy rate of 87%. Often victims will come from outside Suffolk with reciprocal arrangements across the country for victims fleeing an abusive relationship in Suffolk. It is important to recognise the importance of victim choice in supporting them with their options. With that in mind partners have pooled funding across the county to provide target hardening measures to help secure victim’s homes once the perpetrator has left.

Suffolk County Council along with partners have been awarded £516,244 over two years by the Department of Communities and Local Government in early 2017. The funding was to provide additional accommodation for victims of domestic abuse who are not eligible to be housed in refuge accommodation in Suffolk. It aimed to create a flexible, responsive alternative that also offered specialist support designed to meet the needs of victims, particularly those who have complex needs around substance misuse and mental health, as well as those with no recourse to public funds.

Suffolk County Council has working with district and borough councils to offer 22 bed spaces across the county for female victims of Domestic Abuse who are currently not eligible for support through the 3 women’s refuges in the county. This could be due to substance dependency, mental health issues or they may have a male child over the age of 16 which would prevent them from accessing refuge. The specialist refuge is offered alongside Domestic Abuse and Housing Options support. Victims of Domestic Abuse who require specialist support are being referred through local Housing Options Teams across the county.

There is also a bed space available for a female victim who has no recourse to public funds which is hosted by Lighthouse Women’s Aid in Ipswich. Additionally, following a successful application to the Migrant Mitigation Fund by Norfolk County Council, on behalf of both Norfolk and Suffolk, it is likely that bed space and support for victims with no recourse will increase over the next six months.

Suffolk County Council are applying to the Ministry of Housing, Communities and Local Government for £13,750 of ‘top-up’ funding to assist with move on accommodation. Often properties will not have essential furniture and white goods to enable victims to move in. If successful, this discretionary fund will be used to offer support for victims further assisting them on their cope and recovery journey.

6.6 Substance misuse

One of the key building blocks for recovery from substance misuse is the provision of suitable and stable housing. STARS (Supporting Treatment, Accommodation and Recovery in Suffolk), provides advice and support to those who are accessing treatment and who may be at risk of losing their tenancy. Alongside this, STARS also provides intensive support, where required, to those individuals who have repeatedly been unable to maintain a home. The support offered allows each client to acquire the skills necessary to be able to live independently.

Table 5: Services provided in 2016 and 2017 by STARS

	2016	2017
Unique contacts to the advocacy and support element of STARS	413	642
Applications made for housing	325	348
Cases of support provided to prevent loss of an existing tenancy	43	45
Tenancies secured for clients	271	179
Referrals to the intensive support element of STARS	52	50
Clients moved onto independent accommodation	16	13

Over 97.5% of clients engaged with STARS were continuing to engage in treatment for substance misuse either through the community treatment service or through mutual-aid groups

The STARS service is consulting on a revised service configuration due to a reduction in funding. The overall number of units of accommodation for the service will fall from 40 to 30 units as a result.

The Alcohol Recovery Project for Street Drinkers has enabled identification and support for street drinkers in Ipswich, assisting them to access mainstream services (including housing) to address their substance misuse issues. In 2016-17 a total number of 41 separate clients had contact with the service. Of the interventions delivered:

- 29% related to support to address addiction
- 18% related to improving health
- 17% related to accessing appropriate benefits/welfare
- 15% related to addressing accommodation issues
- 11% related to reducing offending behaviour
- 9% related to improving overall wellbeing

During 2016-17 the service secured nine people short-term temporary or hostel-type accommodation along with three secure tenancies, most of which have been sustained.

6.7 Homelessness

A dedicated needs assessment for homelessness in Suffolk was carried out in 2015 as part of the 'Groups at Risk of Disadvantage Health Needs Assessment'¹². See reference for further details. Homelessness is an area that is addressed by district and borough councils who prepare homelessness prevention strategies. Suffolk has several local multi-agency partnerships in place that work together to manage homelessness cases. For example in the west there is monthly Housing Forum which includes providers such as mental health, health outreach, voluntary sector, police. The group discuss homelessness cases to find joint solutions and progresses work such as discussing discharge protocols with the local hospital.

Rates of tuberculosis (TB) are high among the homeless and identification and treatment can be challenging¹⁵⁷. Across Suffolk, there are protocols and procedures in place between the councils and hospitals to ensure that homeless people receiving treatment for TB or TB-related conditions, or with medical needs are accommodated appropriately to allow them to successfully receive and complete treatment, in line with the NICE Quality Standard for Tuberculosis¹⁵⁷.

6.8 Mental health

There are currently 4 service providers working across Suffolk to support people with mental health issues under secondary mental health provision care to access housing: Home Group, Julian Support, Richmond Fellowship and Suffolk Mind. These are funded through the Mental Health Pooled Fund which is jointly commissioned by Suffolk County Council, Ipswich East and West Suffolk and Great Yarmouth and Waveney Clinical Commissioning Groups.

The organizations aim to:

- Support people who are referred with significant and complex needs to sustain a tenancy, be socially included and to recover
- Support service users to move in to supported housing from registered residential or nursing care or from an acute ward
- Support service users with a wide range of complex needs including personality disorder, physical disabilities, a dual diagnosis with substance misuse and people who challenge the service
- Support service users to prepare to move on to fully independent accommodation and to access move on accommodation
- Support service users to develop and maintain independent living skills, gain insight in to their choices, make and manage changes, manage physical and mental wellbeing, manage substance misuse, provide and promote recovery in every person supported

The 4 providers supply 214 supported accommodation units which are available for Mental Health Supported Housing Allocation Panels. There are 3 separate panels which each meet on a monthly basis. The purpose of the panel is to work with providers, discharge managers and members of the integrated delivery team to discuss referrals and placements. There have been 58 people moved from supported housing to the community between July 2016 and June 2017.

Table 6: Number of service users who moved from 24 hour supported housing to community provision July 2016 – 17, by provider

Provider	Number of service users
Stoneham Housing - East Ipswich	17
Julian Support – West Suffolk	16
Richmond Fellowship – Mid Suffolk	12
Suffolk Mind - Coastal	8
Julian Support – West Ipswich	3
Stoneham Housing - Waveney	2
TOTAL	58

A 12-week housing assessment placement pilot scheme was jointly commissioned in 2015 by Suffolk County Council and the Suffolk CCGs using Resilience Transition Funding. The aim of the pilot was to establish whether a 12-week placement in supported housing provided an opportunity for better understanding of a client’s needs before they committed to a longer term supported housing tenancy. The housing placements were for people requiring some level of support with mental health issues in addition to accommodation. The pilot was based in Eastwood Terrace in Woodbridge and provided one space to be used for this purpose. An evaluation of the pilot found that positive outcomes included identification of a suitable follow on destination and a thorough assessment of needs outside of a hospital or custodial setting but that the objectives could be achieved in a shorter time frame. The initial assessment period has been shortened subsequently to 6/8 weeks, the project is ongoing. To date there have been 10 people who have benefitted from the scheme.

6.9 Localism

Suffolk County Council guidance on neighbourhood planning encourages communities to consider health and wellbeing in their policies and plans¹⁵⁸. Some communities in Suffolk are taking advantage of the opportunities offered by the 2011 Localism Act to develop their own Neighbourhood Development Plans to have a direct influence on local housing and growth. District and borough websites show there are approximately 50 neighbourhood plans in Suffolk that have either been adopted or are in development.

Examples of local work on housing include Community Land Trusts (Leiston) and the Community Right to Build (Somerleyton), where local communities are exploring models as a way of providing housing to meet local need and keep it within local ownership. Others, such as Southwold, are using their neighbourhood plans to explore whether they can develop policies which will prevent the conversion of an unbalanced number of properties into holiday lets or second homes, which affects the balance of the local community, provision of local services, and community cohesion.

A recent approach that builds upon history of localism in Suffolk, is the work being developed around community resilience. A Suffolk wide Communities Steering Group has been formed which brings together representatives from public sector organisation responsible for the communities or partnership agenda and those organisations which have a role in supporting the VCS. The purpose of the group is to develop and implement the community resilience programme on behalf of the Suffolk System, taking an integrated and co-ordinated approach which makes best use of the resources of the Suffolk System and shares good practice. The focus of the Communities Steering Group is developing its plans around four key enablers:

- Personal Responsibility
- Early Support
- Community Action
- Strong VCS

It is planned that the following guiding principles will inform the Suffolk system in relation to community resilience:

- Local Communities are key partners
- Respect the contributions that are already being made across Suffolk and learn from them
- Build on the success of those communities who already demonstrate high levels of resilience and proactively engage with those who are disadvantaged
- Respect the differences within and amongst communities whilst promoting a sense of cohesion, tolerance and respect
- Take an evidenced led approach in deciding how resources are used, to inform our dialogue with communities and when determining our impact
- Rather than taking a deficit approach, take an asset based approach when working with individuals and at a community level and with co-design as an accepted way of working

The community resilience plan aims to identify the enabling activity which is best delivered at a countywide level. However the expectation is that most of the activity in the plan will be delivered at a local level with local variation to reflect the unique circumstances of each community of place and interest. In developing the plans, time will be taken to understand what is already being delivered and working well and consider how this can be sustained and built upon before developing new interventions.

Sharing information and making links has been a priority for many local groups that include housing within their remit. For example, the Tackling Poverty Group (covering the Mid-Suffolk District) is a multi-agency group made up of statutory and voluntary organisations (Suffolk County Council Adult and Community Services, Health, Wellbeing and Children's Services, Mid Suffolk District Council Housing, Citizens Advice Mid-Suffolk, Foodbank, WHHP, Stonham Home Group, Realise Futures, Lions Club, ACE Anglia, The Forge Church, Tesco, Stowmarket Relief Trust, and OneLife Suffolk). The group has facilitated organisations working with people on their tenancies to access WHHP, linked support services with housing officers and housing support, and made referrals onto training/education programmes.



Future picture in Suffolk

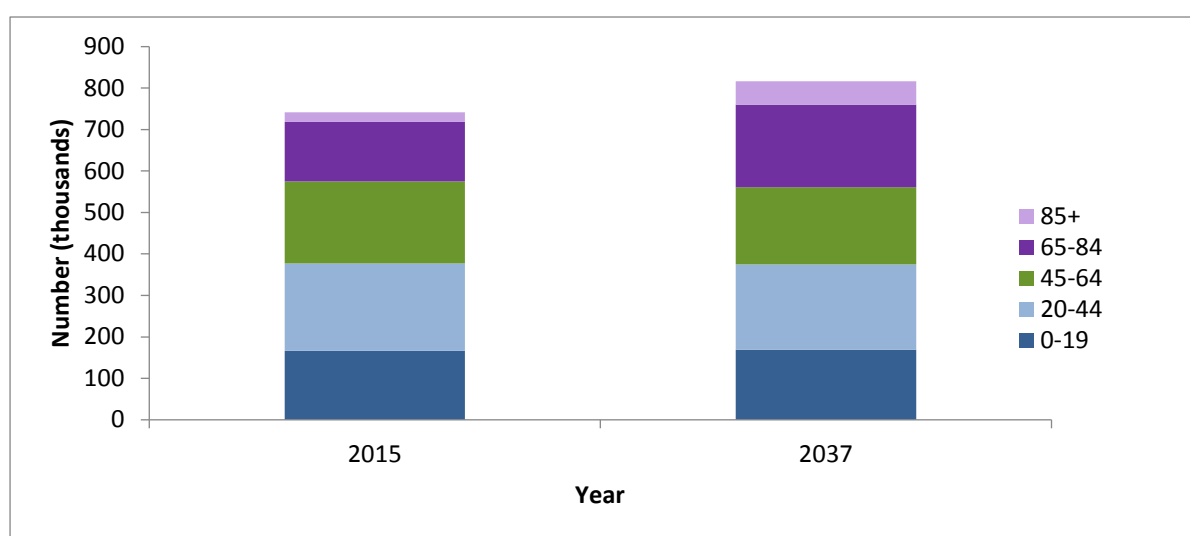
7. Future picture in Suffolk

Looking to the future means identifying factors we can predict will change, factors we can predict will not change, and the impact these different drivers may have on the relationship between housing and health in Suffolk.

7.1 Population projections

Population projections give us insight into what the demographic picture is expected to look like in 20 years, and therefore what demand this may place on a housing market that is already unable to meet current demand. The figure below shows how Suffolk's population is forecast to increase by 10% by 2037 (compared to 2015). This increase will be driven by older age groups, with a 54% increase in over 65s.

Figure 23: Age structure of Suffolk population, 2015 and 2037



Source: ONS sub-national population projections mid-year 2014

The challenge of meeting the needs of an ageing population are not unique to Suffolk. It is important to consider how the age, energy efficiency and rurality of Suffolk's housing stock in combination with larger cohorts of older people (including more with long-term conditions), will influence the numbers of vulnerable people at risk of the severe health impacts of cold homes. For example, in terms of housing hazards alone, the greater number of older people with mobility issues will increase the number at risk of falls.

Beyond the projected expansion in numbers in older age groups, there are predicted trends in health that will affect people housing needs. For examples, the number of people living with dementia in Suffolk is forecast to almost double to 24,300 by 2035, with 75% of the additional diagnoses being in over-85-year-olds¹⁵⁹. It is also estimated that there may be nearly 30,000 frail older people in Suffolk in 20 years⁹⁷.

7.2 Older people – specialist accommodation

Given the dramatic growth in the older population and the higher levels of disability and health problems among older people, there is likely to be an increased requirement for specialist housing options in the future¹⁶⁰.

Tables 7 and 8 taken from the Ipswich and Waveney Housing Market Areas SHMA¹⁶⁰ identify the additional impact that the increasing number of older people will have on specialist housing. It is

expected that an additional 3,476 units will be required in and around Ipswich (+75%) and 1,197 (+102%) in Waveney by 2036. Based on current population forecasts, the number of people within Forest Health and St Edmundsbury likely to require nursing and care home spaces is forecast to double. The Ipswich Housing Market Area (HMA) contains the Local Authorities of Babergh, Ipswich, Mid Suffolk, Suffolk Coastal, and the Waveney HMA area comprises the District of Waveney. Further breakdowns can be found in the Ipswich and Waveney Housing Market Areas SHMA¹⁶⁰.

Table 7: Specialist accommodation required in the Ipswich HMA over the next 22 years

Type of specialist accommodation	Current profile	Profile 2036	Additional units required
Sheltered housing	4,052	6,631	2,579
Enhanced sheltered housing	70	440	370
Extra care housing	508	1,035	527
Total	4,630	8,106	3,476

Source: ¹⁶⁰

Table 8: Specialist accommodation required in the Waveney HMA over the next 22 years

Type of specialist accommodation	Current profile	Profile 2036	Additional units required
Sheltered housing	1,045	1,905	860
Enhanced sheltered housing	0	173	173
Extra care housing	122	286	164
Total	1,167	2,364	1,197

Source: ¹⁶⁰

7.3 Existing housing stock

In 20 years' time most of the current housing stock will still be in use. The older the stock, the more likely it is to be inefficient to heat and prone to excess cold. Without substantial investment, predominantly at the level of individual owner-occupiers or private landlords, the burden of fuel costs, carbon emissions and poor health outcomes and the associated costs to the NHS and society continue to increase. This will be particularly in conjunction with the forecast increase in the proportion of older people in the population.

7.4 New housing supply

Local authorities across Suffolk prepare local plans and, combined, give an average annual target of 3,050 homes per annum to be delivered in Suffolk. Over the past five years, the best delivery rate has been 2,200 homes or 72% of current local plan targets. Local plans are based on Strategic Housing Market Assessments (SHMAs) that set an Objectively Assessed Need (OAN) which is based on population forecasts and accounts for affordability measures which can be defined as the housing that households are willing and able to buy or rent, either from their own resources or with assistance from the State¹⁶¹. Nationally in England, housebuilding has also been around half the level needed to match demand, this is likely to have an ongoing impact on keeping house prices high.

The following housing market trends can be identified:

- 1. Rising rents** - while mortgage costs have fallen, private rents have risen faster than earnings over the past 10 years. They are forecast to rise by around 90% in real terms between 2008 and 2040 – more than twice as fast as incomes⁹⁷.
- 2. Social housing** - reforms since 2010 have included the introduction of higher Affordable Rents for new homes and some re-lets set at up to 80% of market levels. Social landlords have also been given new freedoms to use fixed-term tenancies.

3. **Changing tenure** - the private rented sector expanded significantly from 10% to 18% between 2002 and 2012, with both home-ownership and social rented sector declining. It is estimated that 60,000 (70%) of 25-34-year-olds in Suffolk will be living in private rented sector accommodation by 2037⁹⁷.
4. **Failures in the credit market and housing market volatility** - have increased housing costs and the pressure on affordable housing. High house price to income ratios and mortgage regulation suggest housing will become less affordable over the next 20 years⁹⁷ for those on lower incomes. Welfare reform may have a significant impact on housing trends.

7.5 Household composition

The number of households and the demand for dwellings across the county are forecast to increase by 22% over the next 20 years⁹⁷, double the rate of population growth, as changes in the demographic structure of the population significantly change household composition.

Forecasts predict a significant shift in the proportion of older households with a greater number of couples aged 65 to 85 (and singles at age 85+). The largest proportional increases are forecast to be among singles and shared households (couples with other adults and 'other' household types)⁹⁷. The number of households with dependent children will grow less quickly (8%) compared to households with no dependent children (22%)⁹⁷. Rising private rent costs will likely affect the formation of younger households: by 2030, 40% or 132,000 of all under-40s in Suffolk are forecast to be living back at home with parents (vs. 14% today)⁹⁷.



Discussion

8. Discussion

Housing is recognised to be a key wider determinant of health. The right home helps to ensure health and wellbeing and enables people to keep well, live independently and participate in society. There are risks to individuals' health in homes that are unhealthy, unsafe, unsuitable for their needs, or insecure.

This HHNA has highlighted key themes in Suffolk around energy efficiency, housing stock, cost and the challenges of an ageing and predominantly rural population.

Action to reduce excess winter deaths and illness associated with cold homes in Suffolk has been highlighted as a priority for further work. A large number of households, the most vulnerable residents in Suffolk, experience fuel poverty and are at risk of the health impacts of a cold home. This is set to increase over the next twenty years without changes to the housing stock. There is good evidence for effective actions to prevent this and modelling suggests that the estimated costs would be paid back within seven years, in terms of savings to the system. Current housing stock in Suffolk is predominantly old and inefficient to heat. There are large savings to be gained from increasing energy efficiency, but these savings are at a high outlay. Long-term investment is needed in existing housing stock to mitigate the worst risks to health and the resultant costs.

The cost of housing is a significant factor for residents in Suffolk, particularly affecting people who rent privately. Most private and social renters have difficulty meeting current housing costs, including fuel bills, council tax and other bills. Private rents are forecast to rise twice as fast as incomes and affordable houses are not currently being built at a rate to meet demand. Forecasts in terms of population and market trends show ever expanding needs gaps and growing risks to health.

The Joseph Rowntree Foundation (JRF) argues that the availability and cost of housing will determine the degree to which growth can be considered inclusive, since high housing costs directly contribute to poverty, and the security and quality of housing impacts on health, children's development, and a family's long-term prospects¹⁶². Research they commissioned looking at strategic economic plans and devolution agreements found that housing elements only focussed on housing growth not inclusive growth or tackling poverty¹⁶³. They argue that plans for inclusive growth should address: the supply of affordable homes (defined according to local earnings); improving quality and energy efficiency to tackle fuel poverty; further regulation of the private rented sector¹⁶².

The shortage in supply of new homes contributes to rising housing costs. It is estimated that levels of poverty caused by housing costs can only be contained if the rate of housing supply nearly doubles, rent rises are limited and people continue to receive support with their housing costs¹⁶⁴. To tackle the availability of affordable rental property, the JRF argue that an increase in social rented housing is needed, as the market will not deliver this.¹⁶²

9. Strengths and limitations

This HHNA has benefited from the engagement of a range of stakeholders with cross-discipline awareness and expertise in the field of housing and health. The breadth of the scope developed with the guidance of the steering group sought to produce a report that gives a broad overview of the wide range of environmental, social and economic factors affecting the relationship between housing and health and wellbeing. However, ensuring its breadth has limited its depth in some areas.

The analysis has synthesised findings from a range of sources, including trends in routine data, as well as new analysis of the dataset from the 2014 Housing Needs Survey, and use of the innovative Housing Stock database. This latter data source enabled some modelled estimates of the prevalence and cost of housing hazards locally. Various assumptions had to be made in undertaking the modelling estimates, therefore the outputs are indicative only (and the costs featured have not been adjusted in line with inflation). The Housing Stock database offered a rich data source with scope to explore further. However, it is important to appreciate the timeliness and completeness of the data sources used to create it, along with the archetype-based modelling done to estimate energy efficiency costs and improvements. Other data sources used have also not been completely up to date, for example the EPC ratings were for 2015 as is the data on fuel poverty and the latest England Housing Survey. This HHNA will benefit from an update as these data sources are updated.

Although routine data sets allow comparison over time and across areas, they often rely on statutory reporting requirements, which in turn can be based on narrow definitions (e.g. of homelessness) which do not capture a wider picture of need. Much of the data has been presented at county or district/borough level, which can fail to capture the full range of values and pattern of distribution which may be more readily observed a lower geographical level, however the reliability of the statistical data becomes weaker. There was a lack of local data to meaningfully explore the 'external home environment' part of the framework introduced in the literature review section.

The Housing Needs Survey dataset was not fully explored when it was collected in 2014, so it has been a valuable exercise exploring the responses of local residents in areas relevant to this report. It is important to note that the survey itself does have limitations, the response rate in some areas was low with results skewed towards older respondents. Aside from the Housing Needs Survey, this HHNA does not otherwise capture the qualitative experience of local people in relation to the impact of their housing circumstances on their health, and their engagement with related services.

This report does not feature an exhaustive or in-depth assessment of all factors contributing to housing and health. Some areas, for example fuel poverty, are explored in more detail than others for example housing and crime. Future work may develop some of these topics further. It is worth highlighting that the description of local services in Suffolk is not complete, instead key services where the housing/health connection is most fundamental to their core offer have been highlighted. Furthermore, there would be scope to further explore local community assets that could be drawn upon to meet some of the needs identified, which has not been included here.

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Appendices

Appendix 1: Detailed methodology and evidence searches

The report starts by providing background information via a review of the national and local policy context. The literature in two areas has been reviewed: the literature on the links between housing and health, and the literature on the effectiveness of housing interventions that improve health.

There is then a large section both describing and analysing the current picture of housing and health in Suffolk. Information is taken from the Suffolk Housing Needs Survey and other databases to provide a description of housing need according to the framework of unhealthy, unsafe, unsuitable and insecure housing. The current level of service provision in Suffolk is then described, followed by a section where the future housing needs are projected. The report concludes with a summary of the key issues raised in the report and the areas to focus future work.

Aims and objectives

The aim of this housing and health needs assessment (HHNA) is to examine the evidence and relevant policy contexts, so that those working within the Suffolk System have a shared understanding and can co-produce a workable strategy to ensure more, and improved homes, which reduce health inequalities, and support people to live independent lives. The objectives are:

- to review the evidence for the relationship between housing and health
- to review key national and local policy relevant to housing and health
- to identify current and future need in Suffolk relating to housing and health
- to review the evidence and policy regarding how to improve health through a focus on housing

Methods

This housing and health needs assessment (HHNA) was undertaken by members of Public Health Suffolk guided by a steering group of key stakeholders with representation from district and borough housing departments, housing associations, council planning departments, Citizens Advice, a local housing charity, and Public Health.

Evidence reviews were undertaken with the support of the Aubrey Keep Library Service to review the relationship between housing and health, and evidence of interventions and best practice in this area. Analysis combined routine and local data sources, including the 2014 Suffolk Housing Needs Survey and the Suffolk Housing Stock database. Modelling and Strategic Housing Market Assessments were undertaken using data from the English Housing Survey, research quantifying the impact of housing

hazards on health, and cost modelling by the Building Research Establishment on costs to the NHS in terms of first year treatment resulting from housing hazards.

Housing and health

Housing is a prominent national and local policy area, not least due to the 'housing crisis' typified by issues with the availability and affordability of housing. The relationship between housing and health has risen up the policy agenda in recent years, exemplified by the 2014 'Memorandum of Understanding (MoU) to support joint action on improving health through the home'. This was signed by a wide range of national housing, health and care organisations and committed them to greater partnership working in this area. A local response to this came in the form of the Suffolk Housing and Health Charter, which this HHNA builds on.

This report explores the evidence and local needs in terms of the complex relationship between housing and health using the following framework (adapted from Public Health England):

- unhealthy housing – cold, damp, indoor air quality, noise
- unsafe housing – hazards associated with falls and injuries
- unsuitable housing – overcrowding, meeting needs of older and disabled people
- insecure housing – insecurity and stress, homelessness, affordability
- external home environment – gardens and green space, accessibility, active travel, safety

Methodology

Steering group

A steering group of key stakeholders was established to plan and agree the scope of this HHNA, and to provide subject matter expertise to help shape the direction and content of the housing and health needs assessment. Membership included representation from district and borough housing departments, housing associations, planning, Citizens Advice, Public Health and a local housing charity.

Literature reviews

Separate literature searches were conducted; two by the Aubrey Keep Library Service (AKLS) and two by Public Health Suffolk (PHS). The following search terms were included:

- interventions in housing - social determinants of health (AKLS)
- impact of housing on health (AKLS)
- housing and health (PHS)
- housing interventions and best practice to improve health (PHS)

The literature searches were performed using several databases and search engines. These included: NICE, PubMed, Trip database and Cochrane Library. The search included literature published from 2009 onwards. Further searches were conducted using Google to search for grey literature, as well as searching the websites of relevant policy/research organisations. Snowballing was used throughout to retrieve further evidence cited in published material.

Data sources used in the analysis

Analysis of the current picture in Suffolk was undertaken by members of the Public Health team, using a combination of routine and local data sources.

- routine statistics were all publicly available and have been downloaded from government departments or agencies.

- local data sources included:
 - 2014 Suffolk Housing Needs Survey - led by the Suffolk Strategic Housing Partnership and conducted by Snap Survey, who were commissioned to produce summary statistics of the data collected for this HHNA.
 - Suffolk Housing Stock database - commissioned by Suffolk County Council and created in 2015 by the National Energy Foundation (NEF), compiling a wide range of data sources on all properties in Suffolk. This featured extensive modelling to extrapolate data for all properties, using 25 detailed archetypes. Analysis was conducted by NEF. Housing archetypes are a way to categorise properties, they have been put together through analysis of the English housing stock to make up types of housing that are broadly representative of the homes that people live in e.g. in terms of floor area, storey height, construction age and fabric characteristic.

Analyses have combined data from both routine and local data sources. For example, modelled estimates of the prevalence of certain housing hazards in Suffolk have been produced by taking estimates from the latest English Housing Survey (routine statistics) which are broken down by certain characteristics of the housing stock or households. These estimates have then been applied to the distribution of Suffolk housing stock (taken from the local data source Housing Stock database) in the same or closely comparable category of that characteristic. This has been used to produce a weighted total, similar to the use of direct age standardisation in epidemiology (e.g. age-specific rates applied to known age structure of population). The resulting estimates have then been combined with cost modelling research undertaken by the Building Research Establishment (BRE) to estimate the cost to the NHS in first year treatment resulting from these hazards in Suffolk, and indicative costs of remediation of the hazards (using the 2014 reference costs used by BRE).

Some modelled estimates of health conditions or outcomes attributable to housing-related factors have been produced, for example, by applying a population attributable fraction (PAF) taken from research literature to local data on certain health conditions or outcomes. References and rationale are provided wherever this has been undertaken. Population attributable fractions are a way of quantifying the contribution of a risk factor to a disease. The PAF is the proportional reduction in the amount of disease in the population that would occur if there was no exposure to the risk factor.

Evidence search: The impact of housing on health. Natasha Howard. (8th February, 2017). ILFORD, UK: Aubrey Keep Library Service.

Sources searched

Google (2)
 Aubrey Keep Library (1)
 NICE Evidence Search (12)

Date range used (5 years, 10 years): 2009-2017

Limits used (gender, article/study type, etc.): LG=EN

Search terms and notes (full search strategy for database searches below):

NHS Evidence: housing and health Trip database: housing health, filtered by systematic review
 Evidence search: Interventions in Housing - social determinants of health. Barbara Norrey. (25th February, 2016). ILFORD, UK: Aubrey Keep Library Service.

Sources searched

Google (10)

Date range used (5 years, 10 years): >2005

Limits used (gender, article/study type, etc.): LG=EN

Search terms and notes (full search strategy for database searches below):

There is some crossover between this search and the environmental determinants of health - if this is the case the reference will appear in one or the other search request results. Search Engine: health / housing / interventions / social determinants Medline health / housing / intervention* / social AND determinant* ab.ti

For more information about the resources please go to: <http://www.nelft.nhs.uk/library>

Appendix 2: Evidence for housing interventions and best practice to improve health

Title	Summary	Findings
<i>The Health Impacts of Housing Improvement: A Systematic Review of Intervention Studies From 1887 to 2007.</i> ¹⁶⁵	This systematic review considered the health impacts as a result of housing improvements. Over 40 databases were searched, and 45 relevant studies were identified for the period specified in the title.	This review found that housing warmth improvements can generate health improvements. The baseline housing conditions and targeted interventions will affect the extent of health gains. More research is required to investigate the potential for longer-term health impacts.
<i>Housing and health inequalities: a synthesis of systematic reviews of interventions aimed at different pathways linking housing and health.</i> ¹⁶⁶	This systematic overview is review available literature and provide an overview of the evidence and impact of housing and neighbourhood interventions on health and health inequalities.	There is evidence supporting interventions aimed at improving area characteristics. Further evidence supports targeted warmth and energy efficiency interventions. The health impacts of internal housing improvement interventions and housing tenure are unclear.
<i>Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews.</i> ¹⁶⁷	This synthesis of 30 systematic reviews between 2000 and 2007 from developed countries only. Interventions based on wider social determinants of health, including housing and living environment were considered.	There is suggestive evidence that some interventions may impact positively on inequalities or on the health of specific groups, particularly housing and the work environment interventions.
<i>Spatial Planning for Health: An evidence resource for planning and designing healthier places.</i> ⁵⁶	This report uses diagrams to illustrate the findings from an umbrella literature review (evidence and case studies) of the impacts of the built environment on health. One area of concentration was housing. The quality and strength of the evidence was appraised using an agreed grading system.	The report sets out three basic principles for healthy housing: 1. Improve quality of housing There is reasonable evidence that energy efficiency, removal of hazards, refurbishment and fuel poverty interventions have positive health outcomes. The evidence is strongest for energy efficiency and positive health outcomes in relation to asthma. 2. Increase provision of affordable and diverse housing

		<p>There is little conclusive evidence in this area for positive health outcomes.</p> <p>3. Increase provision of affordable housing for groups with specific needs.</p> <p>There is reasonable evidence to suggest that housing for specific vulnerable groups has positive health outcomes, for example better substance misuse or co-occurring mental health disorders.</p>
<p><i>Housing improvements for health and associated socio-economic outcomes.</i>¹⁶⁸</p>	<p>This study searched 27 databases for housing intervention studies from 1887 to 2012. Then assessed the health and social impacts on residents following improvements to the physical fabric of housing.</p>	<p>The study concluded that improvement in thermal comfort, appropriate size for occupants and adequate and affordable heating can lead to health improvements. Targeted interventions are most effective, especially for warmth and respiratory diseases.</p>
<p><i>Effective Strategies and Interventions: environmental health and the private housing sector.</i>¹⁶⁹</p>	<p>This report considers the links between environmental health and health improvement and wellbeing, specifically around housing.</p>	<p>The report focuses on four sections:</p> <p>4. Tackling poor housing conditions This section looks at case studies and evidence in areas such as the impact of poor housing on children and overcrowding and tuberculosis.</p> <p>5. Regeneration strategies: area approaches and empty homes This section considers interventions such as area renewal and regeneration and delivering housing enforcement and family support in a seaside town.</p> <p>6. Effective working for health improvement This section concentrates on the links between housing conditions and health, affordable warmth projects and tackling energy efficiency in hard to heat areas.</p> <p>7. Working more effectively together This section gives examples of where joint working can be effective in the areas of tackling health inequalities, health and wellbeing boards and across health, housing and social care.</p>
<p><i>A Memorandum of Understanding (MoU) to support joint action on improving health through the home.</i>¹</p>	<p>This MoU is between various interested parties in health, housing and government departments to place emphasis on integration between health and housing services.</p>	<p>The MoU sets out the commitment in this area and identifies that the right home environment can:</p> <p>Protect and improve health and wellbeing and prevent physical and mental ill-health, which in turn can</p>

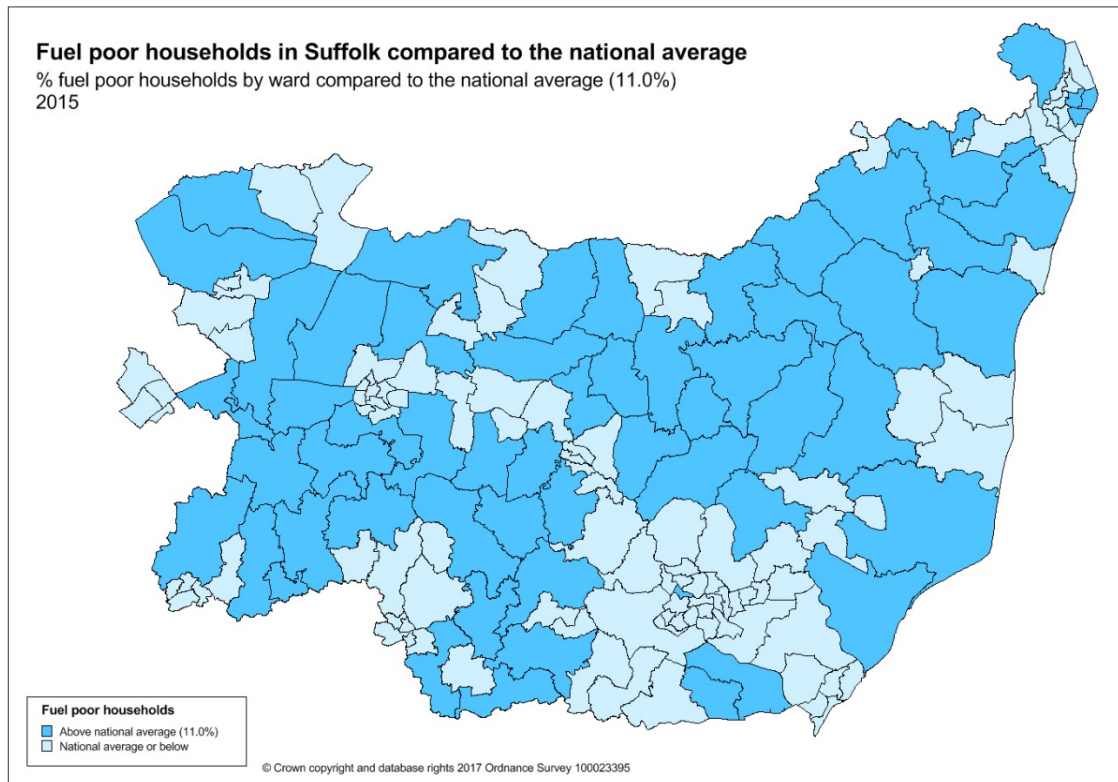
		prevent pressure on health and care services.
<i>Closing the health gap – a gap worth closing: How housing can play its part in reducing health inequalities.</i> ¹⁷⁰	This report provides ideas and practical actions that housing, care, support and public health teams can take to reduce health inequalities. Among other suggestions, it identifies three steps that can be taken: Step 1 - Develop a more relational approach to the housing management service Step 2 - Adopt new 'health creating' practices Step 3 - Undertake special projects and programmes	This report recognises the importance of gathering and using good quality evidence to demonstrate impact. It recognises that housing organisations can help to prevent illness by improving energy efficiency, aids and adaptations in the home.
<i>Excess winter deaths and illness and the health risks associated with cold homes [NG6]</i> ¹⁷¹	This guideline covers reducing the health risks (including preventable deaths) associated with living in a cold home.	The guidance makes the following recommendations: 1. developing a strategy for people living in cold homes 2. identifying people at risk from cold homes 3. training practitioners to help people with cold homes 4. raising awareness of how to keep warm at home 5. ensuring buildings meet required standards
<i>Preventing excess winter deaths and illness associated with cold homes [QS117]</i> ¹⁷²	This quality standard covers reducing the health risks (including preventable deaths) associated with living in a cold home.	The standards provided include: 1. Year-round planning to identify vulnerable local populations 2. Identifying people vulnerable to health problems associated with a cold home 3. Single-point-of-contact health and housing referral service 4. Asking people about keeping warm at home 5. Identifying people vulnerable to health problems associated with cold homes on admission 6. Discharge plan
<i>NICE quality and productivity: Proven case study. Liverpool Healthy Homes: Delivering sustainable health and housing improvements</i> ¹⁷³	This initiative aims to deliver sustainable health and housing improvements and targeting the improvements at those that cause or worsen disease and early death.	The case study shows evidence of improvements in savings, quality and evidence of change all between 70 and 90% of the maximum score possible.

<i>Integrating housing, health and care.</i> ¹⁷⁴	This blog considers the importance of health services being involved in housing related health improvement initiatives and building developments at the start.	The blog indicates that there are substantial savings (£315.2m) to the health service in engaging in this area of work. It goes on further to give examples of housing providers and health care services working together to improve both physical and mental health.
<i>Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review</i> ¹⁷⁵ .	This rapid systematic review identified over 1500 articles for review. It included articles from 2004 to 2009 that examined the effectiveness of interventions to improve the health of those who are homeless, marginally housed or at risk of homelessness.	The review concludes that there is evidence of interventions to improve health, housing and access to health services for homeless people.
<i>Developing empirically supported theories of change for housing investment and health.</i> ¹⁷⁶	This paper describes how to use logic models to illustrate the theories of change in health due to housing.	The paper concludes that this might be a useful evaluation and evidence approach in the future to inform research on housing and health.

Appendix 3: Fuel poverty –maps

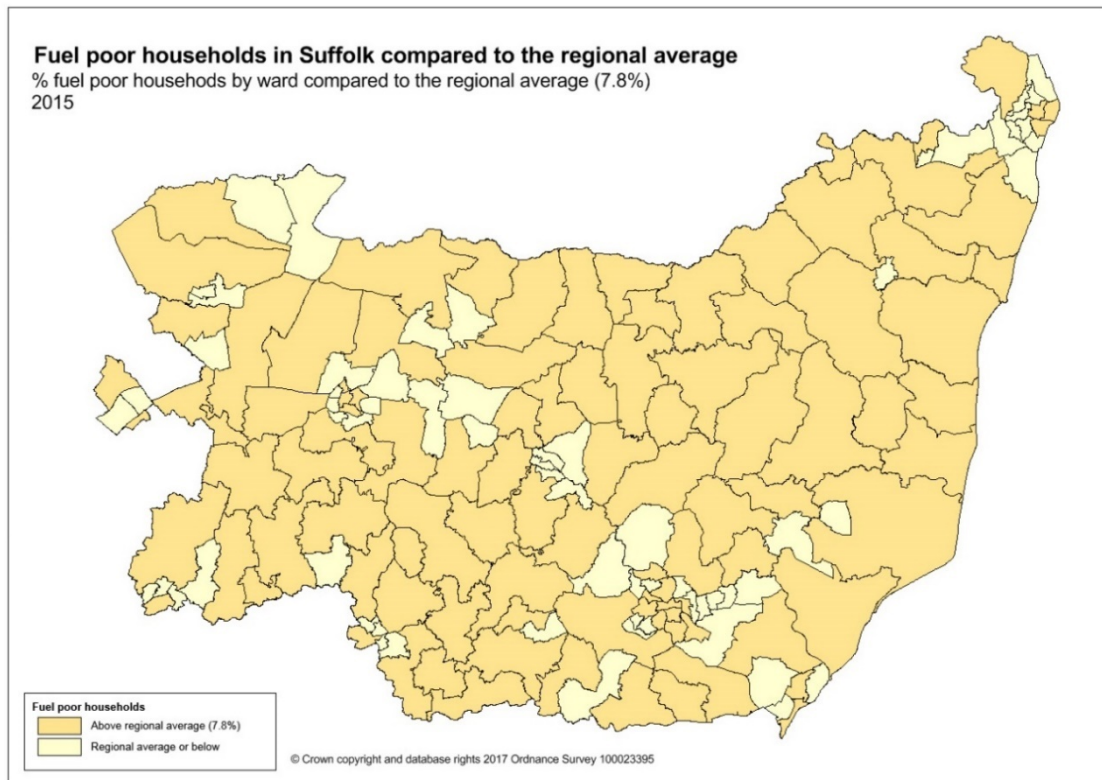
Map 4 shows the level of fuel poor households in Suffolk compared to the national average of 11%. The darker blue represents where a ward is above the national average of 11% and the lighter blue is below the average. There is a mix of above and below across the county with clear clusters which are below the national average. This could be explained as areas where mains gas is available, which are in and around the main towns in the county.

Map 4: Fuel poverty in Suffolk compared to the national average



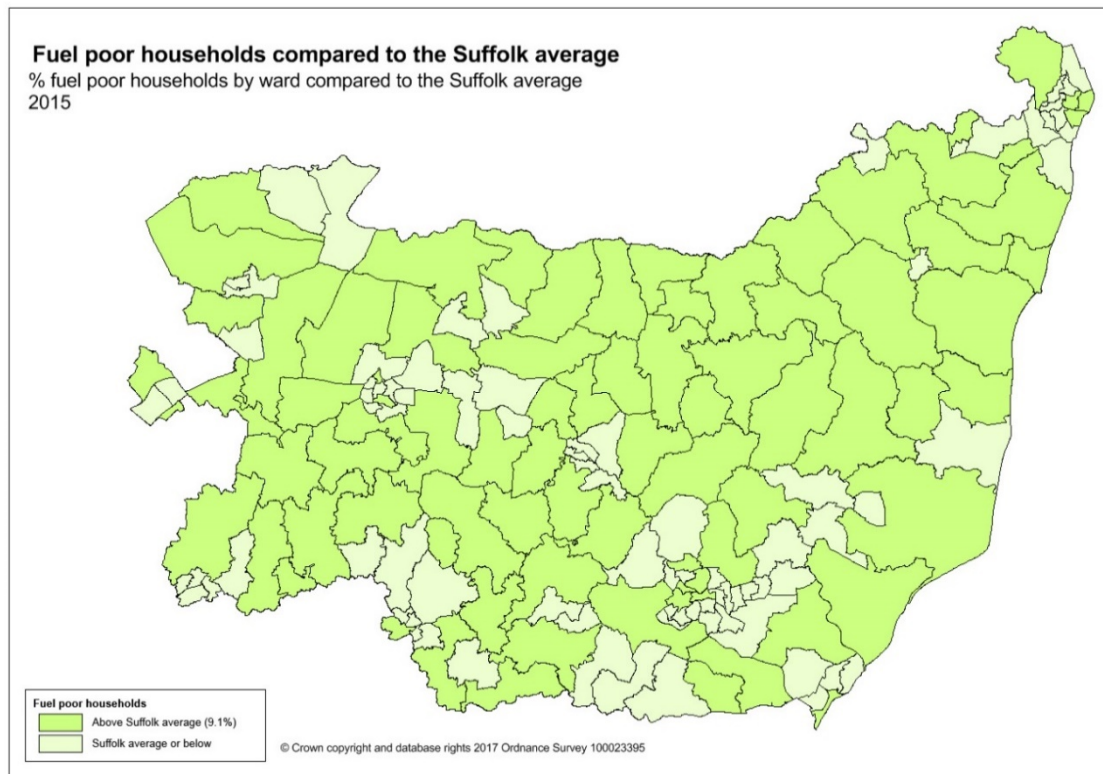
When looking at the proportion of fuel poor households in Suffolk compared to the regional average in Map 5, there is a very different picture to the national comparison. Most of the county is above the regional average of 7.8%, i.e. there are higher levels of fuel poverty. Areas which appear better than the regional average are likely to have access to mains gas.

Map 5: Fuel poverty in Suffolk compared to the regional average



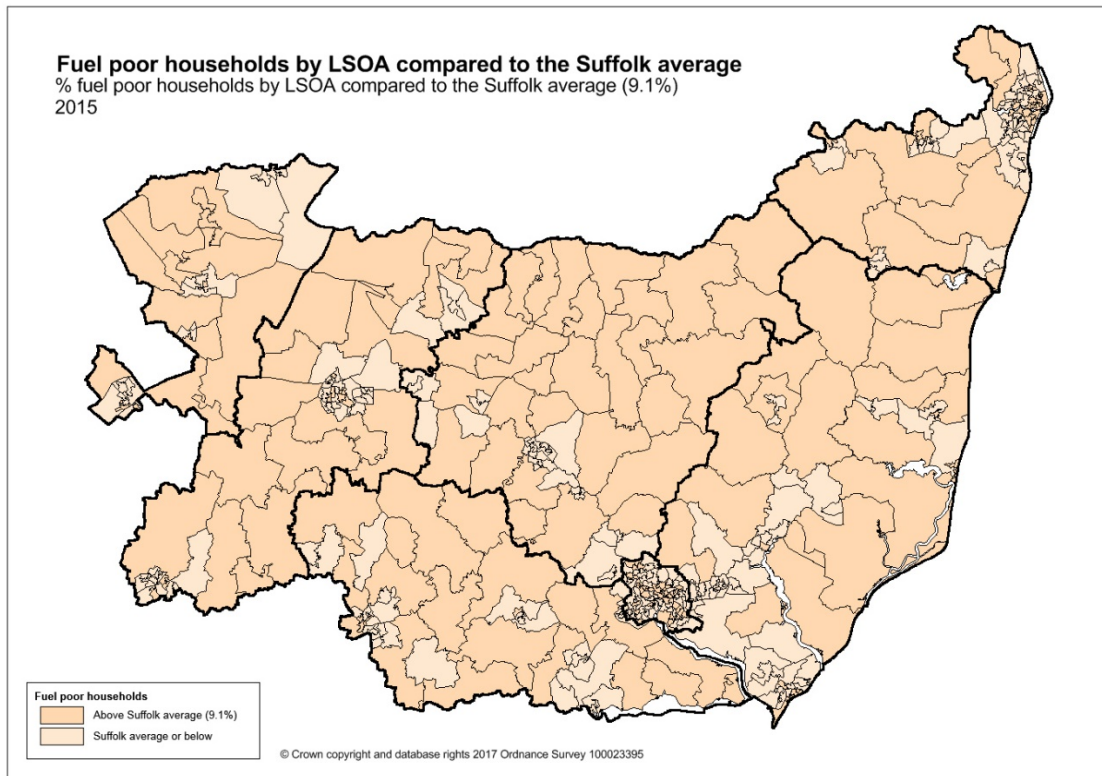
Map 6 compares the wards in Suffolk to the Suffolk average (9.1%) of fuel poor households. Darker green areas are those that are above the levels of fuel poverty and light green are below the Suffolk average. There is a similar picture to that in Map 5 of the regional average (7.8%) comparison. However, there are a few more wards which are below the Suffolk average for fuel poverty and they tend to be next to those that were lower than the regional average.

Map 6: Fuel poverty in Suffolk compared to the Suffolk average

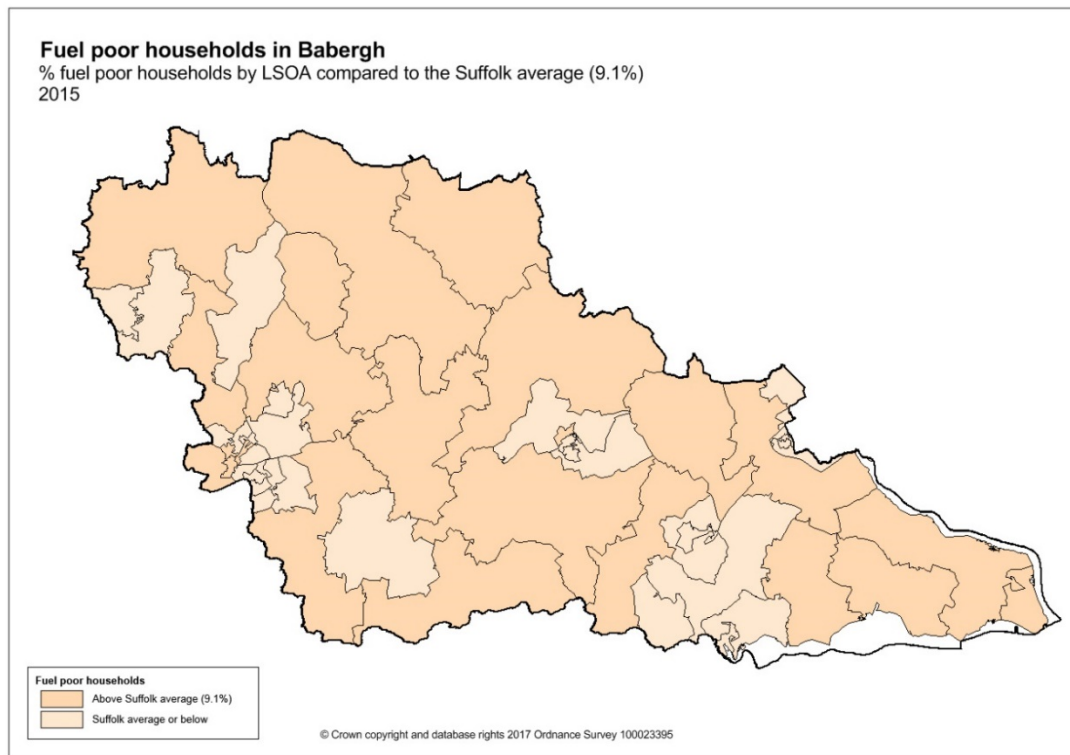


Map 7 allows a closer look at where fuel poverty is on a lower geographic level within the wards in each of the boroughs and districts. The map shows where the level of fuel poverty in each LSOA is above (shaded darker) or below (shaded lighter) the Suffolk average of 9.1%. Many of the LSOAs across the county are above the Suffolk average which is in line with the observations in the previous maps. Each of the boroughs and districts has a similar split of fuel poor households above and below the Suffolk average. Those that are below the Suffolk average of percentage of fuel poor households tend to be in small clusters. Detailed maps of each borough and district are available in the maps following.

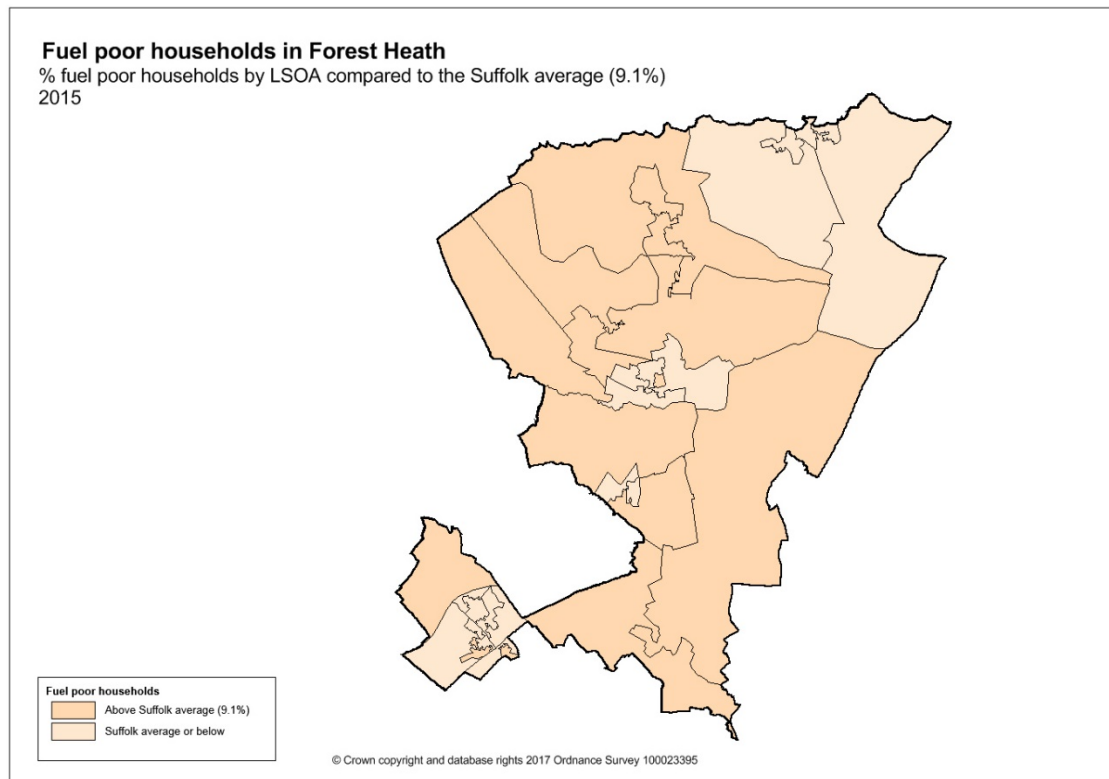
Map 7: Fuel poverty across Suffolk by Lower Layer Super Output Area (LSOA)



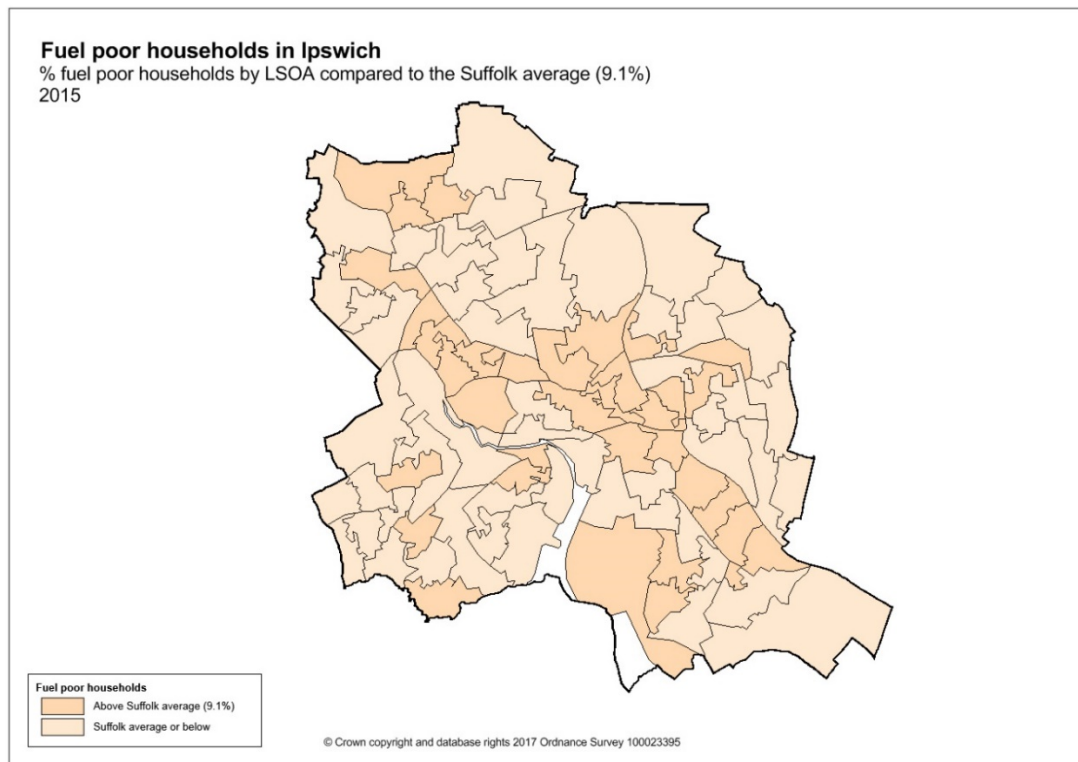
Babergh



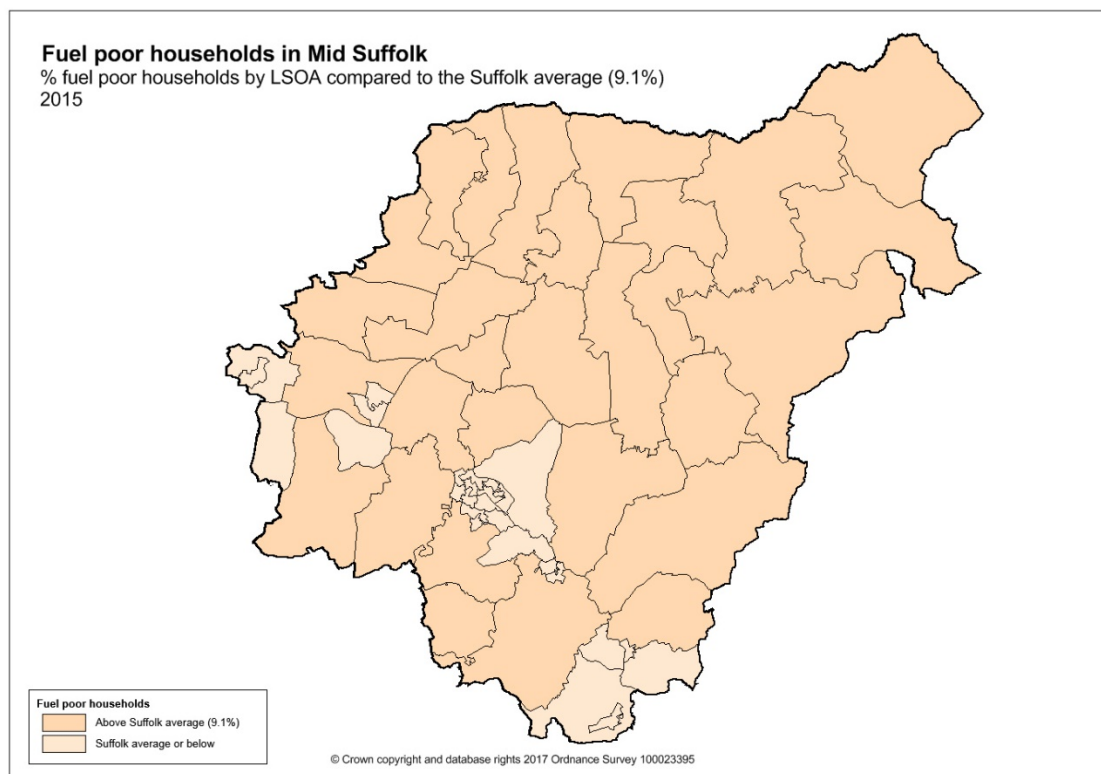
Forest Heath



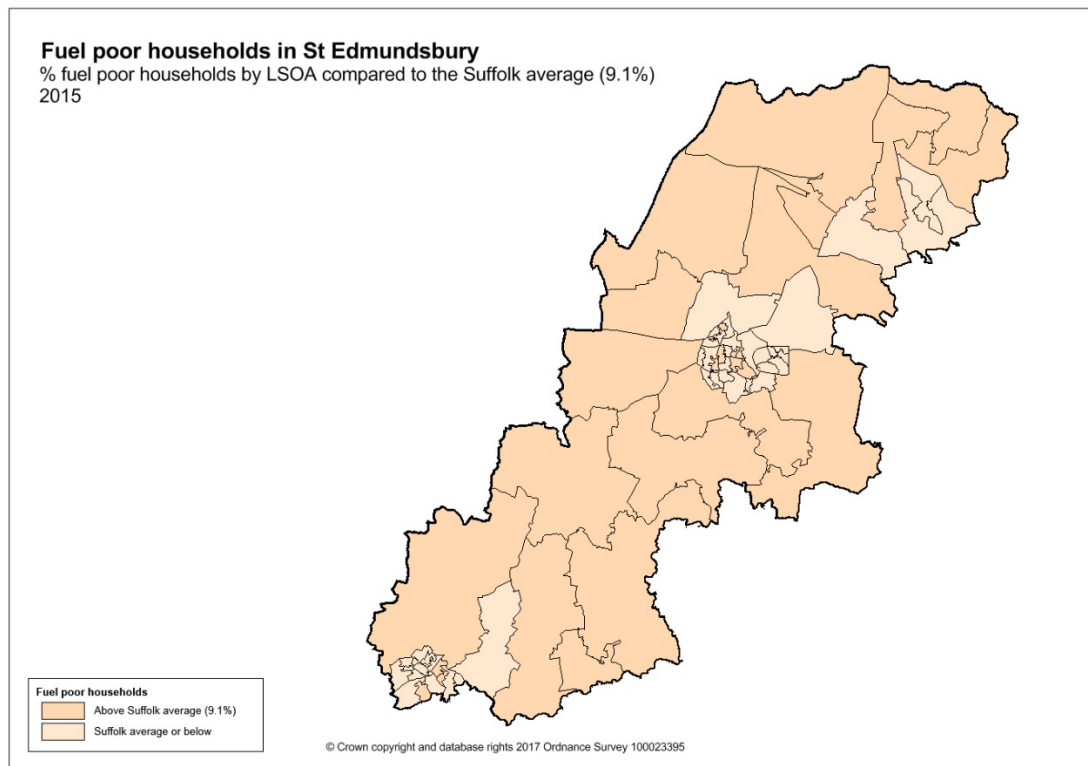
Ipswich



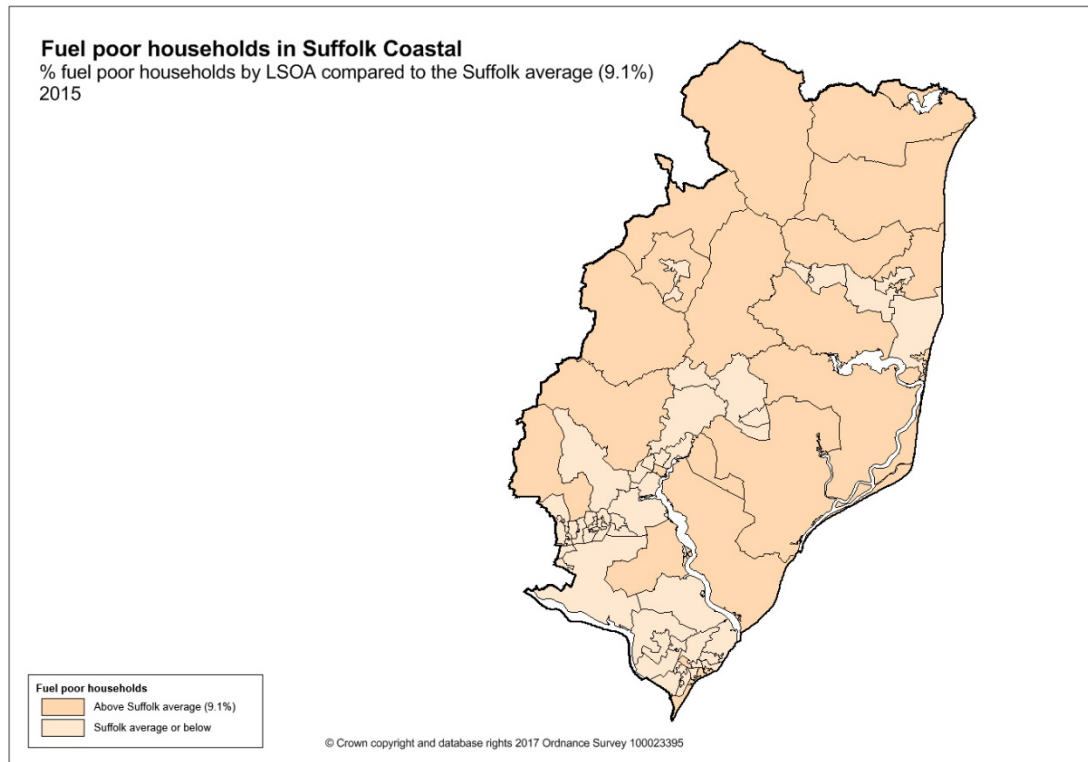
Mid Suffolk



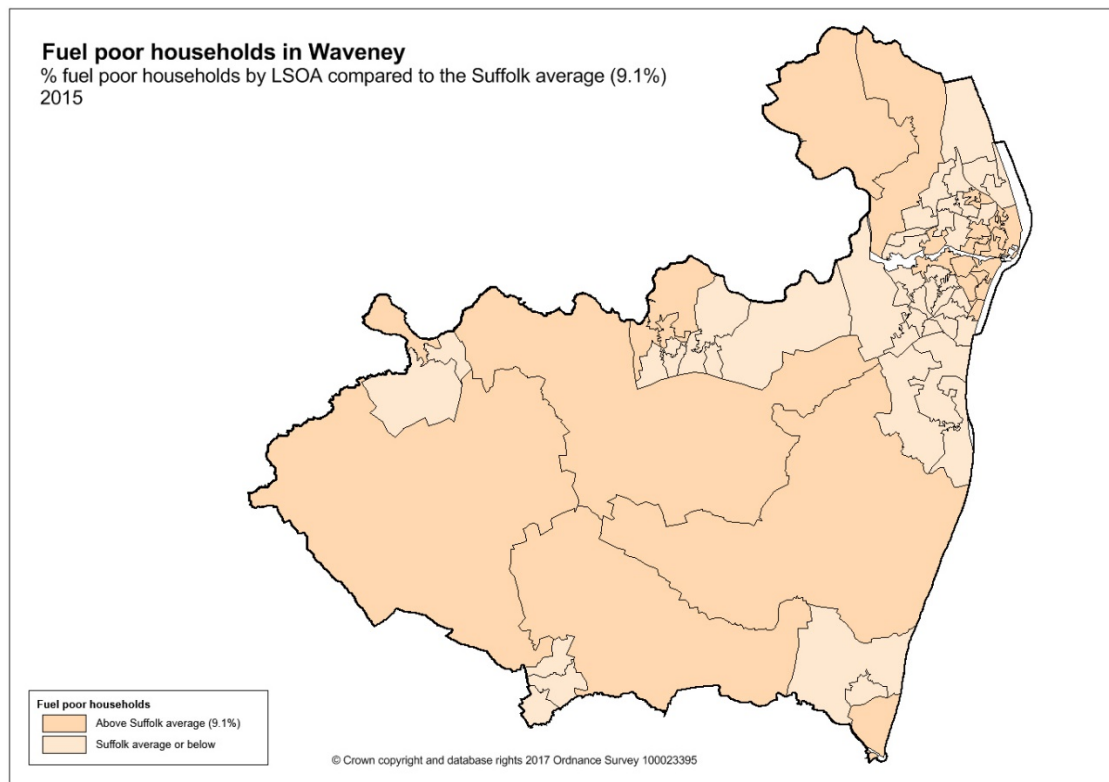
St Edmundsbury



Suffolk Coastal



Waveney



Appendix 4: Case studies

Warm Homes Healthy People (WHHP)

The following is an example of how this project works with health staff to reduce delayed transfer of care and hospital re-admission.

Mrs A is 85 years old with numerous health conditions and was admitted to hospital after having a stroke. She was unable to be discharged due to inadequate heating at home, as well as a gas leak. Ipswich Hospitals Crisis Action Team (CAT) made a referral to Warm Homes Healthy People. The project arranged a quick home survey via Mrs A's son, and arranged for the gas leak to be fixed. Loan heaters were provided which meant that Mrs A could be discharged for care in her home rather than a community hospital, which she was much happier with.

Mrs A received a new, fully funded central heating system and cavity wall insulation free of charge.

Her son had the following to say:

"Mum was so happy to be able to come home and be cared for here rather than be in hospital. It also gives us both peace of mind that she has a heating system that's reliable and we don't have to worry about. It used to be freezing upstairs as there weren't any radiators. But now mum has a portable thermostat she can carry around the house with her. We couldn't be happier."

Wheelchair accessible new council property

The following case study was provided by a Housing Enabling Officer from Mid Suffolk and Babergh District Council:

- A garage review and appraisal identified the disused play area and garage site as suitable for housing development to meet the registered housing need. There is a shortage of suitable wheelchair accessible homes and it was agreed that an affordable rental, three-bed, wheelchair-accessible bungalow would be suitable on this site. In addition, nine parking spaces were created for other residents bordering the development (replacing five under used garages and creating four new additional parking spaces).
- This property had been specifically designed around the family's current and future needs. In general, there is always greater need than supply within Mid Suffolk District (ref. Mid Suffolk Disability Forum Access Group notes) for family properties which are fully accessible to one or more people within the household who have additional mobility issues.
- The Occupational Therapy team identified the prospective tenants as having an urgent need for adapted accommodation and were on the Council's Housing Register.
- The family of three were living in private rental sector accommodation in a small two-bedroom terraced house (climbing stairs was difficult for two members of the family) and no wheelchair access which was unsuitable for their current needs. Two members of the family have mobility impairment and further deterioration is likely.
- The property is more spacious and user friendly for their health needs both now and in the future. The property is future-proofed for hoisting equipment thus avoiding costly adaptations. It has provided a secure environment and a more suitable tenancy for their needs. The new home has provided level access wheelchair accessible accommodation with space to move around in a wheelchair with no obstacles. There is a wet room and a low-level bath. Off street private parking and a carport are provided at the property.
- The family have expressed how happy they are with their new home (and able to have a pet) which has had a positive impact on their mental wellbeing. From conversations with the family we are aware that their previous cramped accommodation was impacting on their mental and physical wellbeing. The move also enabled a change of school which was more accessible and closer to home.

Appendix 5: Stakeholder group

The following people were part of the stakeholder group or gave their comments on earlier drafts of this report:

John Pitchford: Head of Planning, Suffolk County Council
Ian Blofield: Head of Housing and Communities, Ipswich Borough Council
Julia Vernon: Business and Partnership Manager, West Suffolk Councils
Gillian Cook: Housing Strategy Officer, Babergh and Mid Suffolk District Council
Justin Hunt: Head of Housing Services, East Suffolk Councils
Andrew Regent: Supported Housing and Care Manager, Orwell Housing
Carol Eagles: Mid Suffolk Citizens Advice Manager
Stephen Watt: Head of Service Development & Contracting (MHL), Adult and Community Services, Suffolk County Council
Stephen Javes: Chief Executive, Orwell Housing
Jane Ballard: Suffolk West Citizens Advice Manager
Rodney Back: Housing Manager, Genesis Housing
Giles Cresswell: Housing Services Manager.
Rob Longfoot: Housing Services Manager, Suffolk Housing
Sarah Norman: Housing Officer, Suffolk Housing
Jonathon Seed: Corporate Manager, Babergh and Mid Suffolk District Council
James Cutting: Planning Strategy Manager, Suffolk County Council
Anna Crispe: Head of Knowledge and Intelligence, Public Health, Suffolk County Council
Natacha Bines: Joint Strategic Needs Assessment Programme Manager, Public Health, Suffolk County Council
Alison Amstutz: Public Health, Suffolk County Council
Kit Day: Public Health, Suffolk County Council
Jodie Rendell: Public Health, Suffolk County Council
Michaela Breilmann: Insight and Data Manager, Suffolk System
Mary Orhewere: Public Health consultant, Suffolk County Council

Appendix 6: Suffolk wide progress in meeting the NICE quality standards on cold homes and excess winter deaths

NICE Quality Standard QS 117 - Preventing Excess Winter Deaths and Illness Associated with Cold Homes			
	Evidence Required for QS	Current situation	Suggested Actions required
QS 1 –Year-round Planning to identify vulnerable local populations	- Evidence of local arrangements for multi-stakeholder winter planning meetings for collaboration on year-round planning to identify local populations who are vulnerable to health problems associated with a cold home	- There have been multi-stakeholder winter planning meetings in the past coordinated by the CCGs, but there have not been any this year to date or any planned. No known lead for this in the CCGs. - Lack of data identifying where vulnerable populations are situated	- Need to identify which agency will facilitate multi-stakeholder planning meetings throughout the year and resume holding them - Need a more proactive approach to identifying local populations vulnerable to health problems associated with a cold home. What scale should this take? Is it something to be held at a Town/Parish level rather than more strategically?
	- Evidence of a local winter plan	- Winter Escalation Plan for the whole Suffolk System is in progress but currently not signed off (Nicola Roper SCC link) - some individual communities have developed their own - Business Continuity Plans i.e social workers, Home First, and commissioned domiciliary care providers	
	- Evidence of local action to support Public Health England's Cold Weather Plan for England	- Cold Watch System operates in Suffolk November to March which ensures Radio Adverts and Alerts are activated in times of severe cold weather -Severe Weather Response Plan drawn up by the Local Resilience Partnership	
QS2- Identifying people vulnerable to health problems associated with a cold home	- Evidence of local arrangements for multi-stakeholder winter planning meetings for collaboration on year-round planning to identify local populations who are vulnerable to health problems associated with a cold home	- As QS1 above - Currently identification is ad hoc and reactive i.e health visitors, social care etc will identify service users vulnerable to issues related to a cold home when known to them	- As QS1 above
	- Evidence of local data-sharing arrangements and analysis to enable identification of people who are vulnerable to the health problems associated with a cold home	-None evident - Warm Homes/Healthy People (Suffolk's Single Point of Contact Referral System) has requested from CCGs and GP Federation lists of those vulnerable to the health problems associated with a cold home to date 15 practices have sent out letters to patients who have COPD or risk of falls	-Need to develop local data-sharing arrangements and analysis to enable identification of people who are vulnerable to the health problems associated with a cold home
QS3- Single-Point of –Contact health	-Evidence of local arrangements to ensure that people who are	- Warm Homes Healthy People is the Single Point of Contact	- Promotion and awareness raising on

and housing referral service	vulnerable to health problems associated with a cold home receive tailored support with help from a single-point-of-contact health and housing referral service.	Health and Referral Housing Service - ACS and Health Visitors are main referral source. Very few referrals from GPs and Hospital -E-click now available on Ipswich Hospital's intranet-but very low referrals from this (if any)	going particularly target GPs and NHS staff - Ensure WHHP is publicised regularly in the newsletters put out by the respective CCGs to the GPs in their areas. - ensure WHHP referrals are part of the Suffolk Information Partnership - Share good practice-CAB at Kiky Mill in Lowestoft
	-NICE QS specifies local data collection that should be used as evidence	- A range of data is kept but not as much as specified due to lack of data related to total identifiable (QS2)	
QS4- Asking people about keeping warm at home	- Evidence of local protocols to define people who are vulnerable to the health problems associated with a cold home	- Not aware of such a protocol except with "Homeshield"	- Further research to see if there is- something to establish if not. Establishment of such a protocol could be an objective of the multi-stakeholder planning meetings.
	-Evidence of a local protocol for primary health care professionals to ask people who are vulnerable to the health problems associated with a cold home at least once a year whether they have difficulty keeping warm	- It may be asked but no evidence it is asked as a matter of course	- Primary Health Care providers to establish a protocol for asking the question
	-Evidence of local protocols for community healthcare practitioners to ask people who are vulnerable to the health problems associated with a cold home at least once a year whether they have difficulty keeping warm at home	- It may be asked but no evidence it is asked as a matter of course from referral evidence	- as above
	-Evidence of local protocols for home care practitioners to ask people they visit at home who are vulnerable to the health problems associated with a cold home at least once a year if they have difficulty keeping warm.	- It may be asked but no evidence it is asked as a matter of course from referrals	-Establish if this a protocol for Home First? -Is it a requirement for care providers commissioned by SCC? If it is not part of a formal protocol then it should be made so-such as in the Homeshield assessment
QS5- Identifying people vulnerable to health problems associated with cold homes on admission	-Evidence that care settings (hospitals, mental health services and social care services) have arrangements to identify people who are vulnerable to the health problem associated with a cold home as part of the admission process.	- Not sure if this is being done as its primarily a Health service QS. Currently "Warm Homes Healthy People" do not have any evidence that any referrals are made as part of an admission process. - WHHP has approach A and E who haven't the capacity to do this as a matter of course.	- Suggest Approaching Therapy Team, the Fragility Assessment base and Health Outreach from hospitals. - GP's could include this as part of their admission

<p>QS6- People, who are vulnerable to health problems associated with a cold home who will be discharge to their own home from hospital, or mental health or social care setting having a discharge plan that includes ensuring their home is warm enough.</p>	<p>- evidence that people who are vulnerable to the health problems associated with a cold home have a discharge plan that includes actions to ensure that their home is warm enough. -This applies to any time of year - It should include referral to services that provide help to reduce risks as well as any immediate practical needs such as ensuring the heating is switched on before they are discharged.</p>	<p>- There is evidence that the HomeFirst Team and Discharge social care team, based at the hospital do ask friends/relatives/social care to ensure that heating is put on at home for when someone is discharged -The very low incidences of referrals to Warm Homes initiative from discharge teams/plans would suggest however, that consideration as to the efficiency and affordability of heating for a vulnerable individual is not part of the plan</p>	<p>- Discharge Social Care Team and Homefirst to ensure an individual who is identified as being vulnerable to health problems associated with a cold home is referred to Warm Homes for assessment as part of the discharge plan, in order that affordable, efficient, adequate heating is available to people vulnerable to health problems associated with a cold home. - Ask if Red Cross and Suffolk Family carers are aware of WHHP to support their work in rehabilitating people into their own homes.</p>
	<p>-Data collected should include proportion of people identified as vulnerable who do require actions to ensure that their home is warm enough as a total of those that are discharged</p>	<p>- This data is not known</p>	<p>- As with QS2 data sharing arrangements need to be put in place.</p>