A home in which to start, live and age well in Derbyshire

Housing and health joint needs assessment

June 2016

Contents

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1. Introduction

There is significant evidence that where you live – your home, housing circumstances and your neighbourhood – can affect your physical and mental health, and wellbeing.

The vision in Derbyshire is to reduce health inequalities and improve health and wellbeing across all stages of life, working in partnership with communities. To achieve this the County Council public health team commissioned a housing and health joint needs assessment to know more about the scale and nature of the problems faced, and what action can be taken. The intention is for this assessment to informing local commissioning by all organisations and individuals who are in a position to identify a risk to health from the home, and to take action.

The assessment aimed to provide Derbyshire with:

- Intelligence about the scale and nature of the 'homes and health relationship' to help inform targeted improvements
- An understanding of the national and local housing policy framework as it relates to homes and health, and how this could be changed to achieve better outcomes
- Knowledge of 'what works and for whom' that is relevant to Derbyshire's communities, drawing on local promising practice and evidence from elsewhere in the country
- Recommendations to inform local leadership and action

2. The approach

The assessment was completed by a secondment to Derbyshire County Council's public health team (DCC), Tessa Paul, working with Gill Leng (www.gillleng.co.uk), and with input from an oversight group.

Tasks included:

- Collection and analysis of intelligence on the scale and nature of the housing and health relationship in Derbyshire (DCC, Annex A)
- Health and social care performance relevant to housing (Annex B)
- A review of local housing strategies and policies (Annex C)
- Stakeholder engagement through interviews, a workshop and existing meetings (Annex D)
- Review of local promising housing and health practice (DCC, Annex E)
- Effective interventions recommended by NICE, Public Health England and other national bodies (Annex F)

This report brings together the learning from these tasks, and makes recommendations for action.

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3. The scale and nature of the homes and health relationship in Derbyshire

This section presents a summary of the content of Annex A.

3.1 The framework

The assessment considered the homes and health relationship using the framework adopted by Public Health England's national homes and health programme, drawn from evidence. Risks to health and wellbeing from the home and housing circumstances were broadly categorised under three headings:

1. **Unhealthy and unsafe homes**
   - Hazards associated with the 'bricks and mortar' impact e.g. cold, damp, and disrepair.

2. **Unsuitable homes**
   - The home environment does not meet the needs of a household or household member e.g. small or large households (under-occupation and overcrowding), disabled people, people whose health and care needs change, for example as they grow–up, and get older.

3. **Precarious housing and homelessness**
   - The household is living at risk of homelessness, or is homeless.

New housing supply, and the action of planning for new homes, is a means to enable people access to healthy homes, suitable for their needs and offering a secure place from which to live ie, it is route to reducing risks to health and wellbeing associated with existing poor housing conditions and unsuitability, and homelessness. The need for new housing, specifically affordable housing and specialist housing, is discussed within this assessment to some extent, as is the role of local authority planning services, but planning for healthy homes and neighbourhoods is a topic in it's own right and was not included specifically within the scope of the project. For more information on planning for healthy homes the TCPA provides a good source of information.

3.2 What have we learned? Use of intelligence

Understanding the scale and nature of the homes/health relationship in Derbyshire has been a challenging exercise, and one that hasn't been able to generate a complete picture. This is common to other local authority areas, including unitary councils where one may expect this process to be simpler. The underlying reason for difficulties in accessing useful data from housing services lies with government policy.

The housing 'system' is multi-faceted but, unlike health care or social care, successive governments have not provided clear outcomes and an associated framework. Also, although housing policy ostensibly lies with one government department (currently the Department for Communities and Local Government), in practice there are many other departments whose policies impact on housing, for example Treasury, DWP and BIS welfare and economic policies, Home Office and Ministry of Justice criminal justice policies, and Department of Health and social care policies. Without a clear outcomes based framework local areas have been – and still are - in the position where they must try to make sense of the multitude of national policies that influence housing-related activity, and make best use of associated resources, as and when they become available. Little information about this activity is collected and reported on nationally.

This is not the basis for effective strategic planning, and has not necessitated the development of information systems capable of informing this process. Instead housing services and interventions have collected the information they believe is necessary to satisfy requirements at the time – perhaps to meet legal requirements, or to justify input from an individual funding body.

This assessment is the first time the questions have been asked 'what do we know about the impact of the home or housing circumstances on health and wellbeing?' and 'are our housing services and interventions

effective in preventing and reducing risks, and improving health and wellbeing?' It is understandable that most services can't answer these when they were not originally conceived to contribute to this outcome. This is not just a 'housing' issue: it is also the case in the NHS in particular, where little intelligence is collected about the housing circumstances of those accessing health care.

Localism, and more recently devolution and integration, are believed to be the solution to meeting local needs more effectively – local organisations are felt best placed to understand these needs. These agendas are not going away and, although it may have been difficult to gather intelligence for this assessment, this should be viewed as just the start of generating better information about Derbyshire's communities, beginning with an agreement on local outcomes. The development of shared intelligence models is common to local areas that have already entered devolution agreements with the government: if Derbyshire follows suit then intelligence about homes and health must be within this.

3.3 What have we learned? Homes and health across the life course

Despite the challenges in gathering intelligence, there is 'good enough' information from which to draw the following.

All life courses

- Poor condition housing is known to have significant impact on physical and mental health and wellbeing, particularly people who spend a lot of time at home: children; disabled people and people with other long-term conditions; older people; carers.
- Nationally the evidence of the cost of poor condition to health and wellbeing is the most robust, with a recent figure of up to £2bn per annum to the NHS in England (BRE 2015) – cold is the biggest factor
- There are number of areas for improvement in health care and social care indicators that relate to poor housing conditions, including cold housing, across the life course
- In Derbyshire, some local authorities have very out-of-date information about housing conditions (they do not meet the statutory duty to understand housing conditions and to take these into consideration in assessments of housing need)
- Available evidence suggests that housing is in poorer condition in Derbyshire than for England.
    - The rate of fuel poverty (12.8%) is higher than the national average (10.4%)
- The lack of suitable accommodation for disabled people is problematic for people at all stages in life, likely affecting the life chances of children and young people, the ability of working age adults to contribute to the economy and the likelihood that people can live independently as they get older, instead requiring social care and health care at an earlier point in their lives. It is not evident that the findings from research completed on this topic in 2012 have been actioned.

Starting and developing well

- There is significant research evidence that a poor home environment and homelessness are particularly detrimental to children and young people, including that if this impact is not acted on, life chances are affected, and there's an increased likelihood of developing multiple and complex needs in adulthood.
- There is little specific data to inform an understanding of this relationship in Derbyshire, beyond within homeless families approaching district councils for housing advice/homelessness response. This is an issue in local authorities across England - adults are the client; it has not fallen under the remit of Children's Trusts/Boards
- There is enough evidence that children and young people are living in overcrowded and poor quality homes but little evidence that households are approaching services for assistance

Living and working well

- Research shows that not only are there health risks associated with the home and housing circumstances for this population, but that these risks also have the potential to impact on the individual's ability to access and sustain employment ie, the individual's or household's economic contribution
- In Derbyshire local evidence suggests that the health and wealth of these households may be at particular risk as a consequence of their home environment and/or housing circumstances:

- Those living in the private rented sector (this is main population in this tenure) and within this, shared accommodation – they may have no other needs but insecurity and high costs are risks to mental health in particular, as is sharing accommodation with other individuals who may present a risk
- Disabled working age adults – it is estimated that around 40% are living in unsuitable housing
- Individuals with a more than one of the following: experience of/actual homelessness; drug or alcohol use; mental health; criminal justice system

- The working age population is the largest group approaching district councils for housing advice (just over half did not have dependent children) but nothing known about their health and wellbeing and how their advice enquiry may mitigate any risks
- Working age households without dependent children are generally not owed a homeless duty but may still have health or care needs that are not met
- For adults experiencing multiple problems the picture is unclear but highly likely to under-represent the actual problem
    - Rough sleeping official figures suggest decrease but other services suggest otherwise (the national picture is that rough sleeping has significantly increased since 2010)
    - Drug and alcohol data for people with a housing risk, and offender data, is known to not adequately record housing circumstances (the author is working in PHE to update the recording systems)

Ageing well

- The health and wellbeing of the older population is particularly at risk from poor and unsuitable housing.
- Although the assessment wasn't able to identify the number of at risk households in Derbyshire, nationally it is known one in five of households aged 65 years lived in a home that failed to meet the Decent Homes standard in 2012. Also, that the vast majority (79%) living in a non-decent home were owner-occupiers. Derbyshire has a higher than average level of owner-occupation. Also, available information suggests that housing conditions in Derbyshire are worse than the England average.
- Far fewer older households approach housing advice services compared to other populations, but of those that have approached these services:
    - They have the most diverse range of needs of all populations
    - Financial matters are a greater proportion of reasons for the approach
    - A higher proportion of those approaching are homeless

  The lower number of approaches may be a consequence of more households accessing other services for housing advice and information, for example Call Derbyshire, or First Contact, although contacting these services suggests that the level of need may be higher than simply information and advice eg, there's a need for social care
- Although the private rented sector is commonly thought of as home to younger households, there's evidence that older households live here, and that some want to move (17% of older households on the Housing Register live in the private rented sector)
- There is evidence that the proportion of disabled people living in unsuitable homes increases with age

4. The framework for action

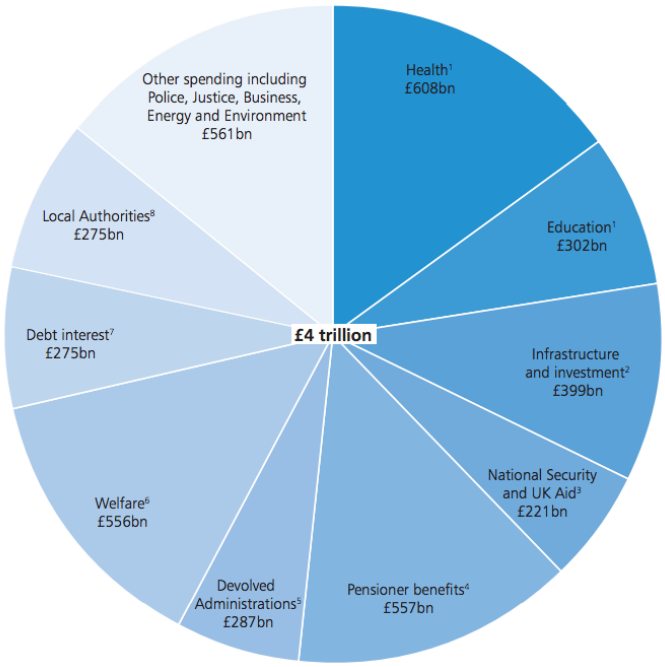
This section describes the framework for local action provided by the government in its strategies for homes, health care and social care. It also considers the findings of a review of current housing strategies and policies in Derbyshire.

4.1 The national context for action

The national context for action is derived from the government's Manifesto, the 2015 Autumn Spending Review, and March 2016 budget.

The primary aim of the government's housing strategy is to increase home ownership, mainly through the development of new homes (the recently published prospectus for affordable housing suggests that 88% of funding is intended for shared ownership, including for older people). This course of action is intended to

contribute to the government's overall vision of economic security: fixing public finance, returning the country to surplus and enabling the economy to pay its own debt. Investing in housing is itself is not a government priority – it is within other areas of spend: the following chart of national expenditure between 2016/17 and 2020/21 demonstrates this.



Source: HM Treasury 2016

On the topic of economic security and relevant to local planning for healthy homes, the government aims to increase opportunities for families through higher wages and lower welfare ie, get more people back into work, work will be better paid and there will be less need for welfare assistance. The government has also signified intentions to: improve education and increasing the number of available apprenticeships; introduce a work and health programme intended to enable people who are long term unemployed and with health conditions to return to work; extend Enterprise Zones.

Perhaps most significantly, the 'devolution revolution' is intended to 'rebalance the economy', with devolution of resources and powers to all local areas by 2020. The intention is also by this time for local government to be self sufficient: in practice this means that the government will no longer provide a 'core grant', but will give local authorities power over £26bn business rates and some control over setting local rates. It is not yet confirmed exactly what will be paid for through business rates, but it has been proposed that funding currently ring-fenced for public health until 2018 will be within this spend.

Integrating health care – the NHS – with social care by 2020, alongside the modernisation of other public services eg, criminal justice, is the final piece in the government's jigsaw. Within plans for integration is the Better Care Fund: the government recently announced additional funding specifically for the delivery of 70,000 additional home adaptations by 2020/21. The government's CASSH scheme for capital funding for specialist housing is also a means by which local areas could meet specific needs – the focus of this Department of Health programme to date has been older people and mental health.

There are a number of key dates associated with the government's plans – opportunities to ensure that thinking about homes for health is within the local response to these:

- All local authority areas must submit plans for devolution by 2017
- The NHS requires the completion and agreement of five-year Sustainability and Transformation Plans by end of June 2016, with implementation in October 2016
- Better Care Fund plans must include a plan to address Delayed Transfers of Care (by March 2016)

It is worth noting that the Coalition government ended significant capital investment in improving the private sector housing stock in 2010. The current government's plans are limited to energy efficiency: there is a goal of insulating a million more homes before 2020 but it is not known how this will be achieved yet; households will still be able to claim the Warm Home Discount and Cold Weather Payments, but neither of these address the root of the issue - energy inefficient homes. The Department for Energy and Climate Change (DECC) has recently published a resource to enable local areas to evaluate the impact of their interventions in this area, perhaps indicating that it will be up to local decision makers to invest in tackling cold homes through the resources they already have available.

Finally, the government's approach to social housing is important to acknowledge. This sector, offering the most affordable and secure form of accommodation, has reduced as a proportion of all tenures over time, linked to the right-to-buy policy and more recently to welfare and social housing policies. For example, social landlords have needed to review their stock, levels of affordability and length of tenure in light of the 'spare room subsidy' and more recently the Spending Review announcement to reduce social rents by 1% over the next four years (social landlords business plans were built on a rent increase). Also, government funding for new affordable housing has required greater investment from social landlords, and the number of social landlords developing new homes has decreased. The level of social housing is expected to continue to decrease.

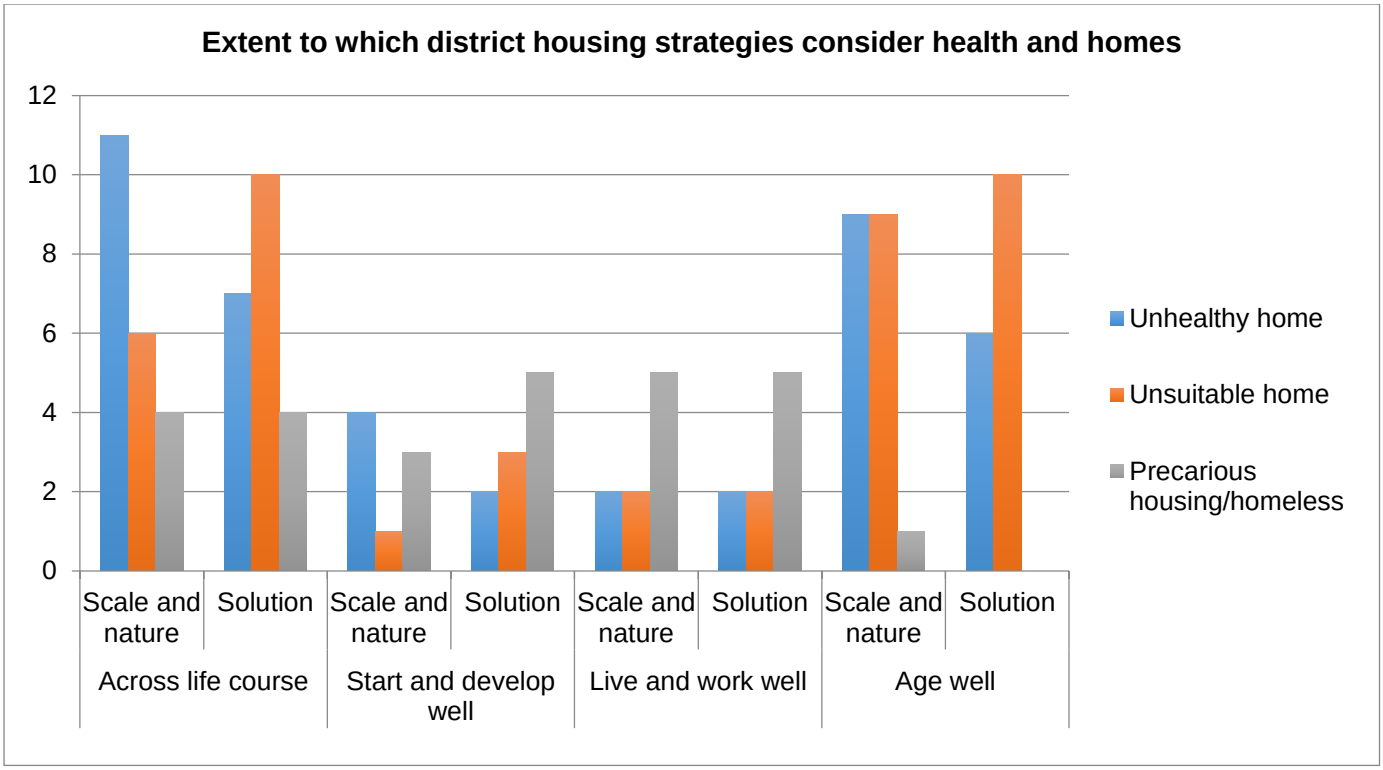
4.2 The local context for action

The local context for action is based on a desk-top review of 44 local housing strategies and policies to understand the extent to which these communicated a good understanding of the local homes and health relationship and that this understanding had evidently informed action to improve outcomes, supplemented by stakeholder views. The detail of this review can be found in Annex C, and relevant stakeholder feedback can be found in Annex D.

The review of local housing strategies found that:

- There are a number of legislative requirements on local housing authorities to understand their populations housing needs and to put plans in place to meet these. 30 of the 44 strategies reviewed were required by legislation. A small number of plans were cross-authority.
- An understanding of the scale and nature of the relationship between homes, housing circumstances, health and wellbeing, as experienced by different populations is not particularly evident in housing strategies.
- Where reference is made to health and wellbeing, housing strategies tend to do this in general terms, and mainly in reference to the intended outcome of a solution.
- The impact of the home or housing circumstances is, in the main, not evidence as a driver for strategic priorities or actions.

The chart on the following page depicts the extent to which housing strategies described the scale and nature of the homes and health relationship, and included relevant solutions, across the life course (the Y axis is the number of strategies).



Scale and nature in local housing strategies

The main focus of attention is on the relationship between unhealthy housing conditions, health and wellbeing for all households, with a particular focus on older households (much less attention has been paid to the relationship for other parts of the population). The aspect of 'unhealthy housing' described most is cold and energy inefficient homes, and related to this fuel poverty and excess winter deaths. However, not all areas have a specific strategy for affordable warmth/fuel poverty.

Problems of unsuitable housing, for example the home does not enable mobility or independence, and the associated impact on health and wellbeing, is considered primarily in relation to older people. A small number of plans recognise that people who have a long-term condition and/or disabled people may be adversely affected: the implication is that these individuals/households may be any age. Overcrowding is also referenced as a problem but not in specific population terms.

The relationship between precarious housing and homelessness, health and wellbeing, is explored in a very limited way, primarily in relation to adults with additional needs related to substance misuse or mental ill health. There is just one reference to homelessness in later life.

With very few exceptions, strategies do not reflect any depth of understanding of specific health impacts of the home environment or housing circumstances on health and wellbeing, on specific populations. This limits confidence in proposals to use resources.

Solutions in local housing strategies

The emphasis of solutions is on addressing unsuitability through: the allocation of social housing; interventions to improve the suitability of the existing home eg, home adaptations; alternative forms of accommodation to enable moves from unsuitable housing. Most attention is paid to the older population; the main solution specifically identified for other parts of the population eg, families with children, is the allocation of social housing.

Although unhealthy homes are recognised for their potential impact across the life course, solutions are mainly focused on the older population.

Solutions to homelessness are focused on 'starting and developing well' and 'living and working well', and these are targeted at meeting government targets, for example not using bed and breakfast accommodation to accommodate 16/17 year olds or families with dependent children for more than six weeks.

Derbyshire strategies for health care and social care

The scope of the assessment did not include a desktop review of strategies for health care and social care to understand the extent to which the home environment and housing circumstances are recognised and responded to, but this was a topic raised by stakeholders. In summary most stakeholders felt that there was considerable room for improvement, requiring systems leadership and a culture shift amongst professionals working in all sectors.

Particular barriers to embedding and integrating 'home' in health care and social care strategies included lack of capacity and capability in the workforce, and the unwillingness of some to engage with a topic that they did not understand as having relevance. This was felt to stem from a combination of lack of leadership and governance to the topic, for example it is perceived that the Health and Wellbeing Board does not have a strong understanding of the issues, and competing priorities/reducing resources that are in effect leading to increased silo working and protectiveness over budgets instead of the oft-spoken about integration.

The County Council's commissioning of this assessment should be recognised as a first step towards integrating 'home' in health and care commissioning, as should recent invitations to districts to participate in county commissioning arrangements eg, related to the Better Care Fund and transforming care. The test in the longer term will be that joint commissioning for better health outcomes incorporates action to improve the home and/or housing circumstances.

From a district perspective it is understood that only some are engaging Clinical Commissioning Groups on specific health and housing issues, and that this has been a challenge. Given that there was little input from CCGs in this assessment, and none from NHS providers, opportunities to integrate home and health should be explored further.

5. Interventions to improve health through the home

The assessment sought to understand 'what works and for whom' relevant to Derbyshire's communities, drawing on local promising practice and evidence from elsewhere. Given resource and time constraints, the approach was to:

- Identify local housing services/interventions that stakeholders felt were able to demonstrate a contribution to improve health and to describe these using a template drawn from Public Health England commissioned guidance on developing robust evidence of what works in housing (Annex E). It is worth noting that the assessment did not ask for a full review of the effectiveness of local services or interventions, for
- Describe housing services that exist primarily to enable local authorities to meet their statutory duties eg, around homelessness – there may be opportunities for these services to be more effective in the contribution they make to health and wellbeing (Annex E)
- Review evidence-based recommendations for housing services and interventions made by the National Institute for Health and Care Excellence (NICE), Public Health England and other national bodies that are relevant to Derbyshire (Annex F).

5.1 Evidence of 'what works' in housing

It is important to acknowledge that the national evidence base of 'what works, for whom and when' in relation to housing-related interventions is very limited in comparison with the available evidence for health care interventions. As an area of social and public policy, housing has not had the same level of investment

in research, and nor has the approach to research required the same degree of rigour (there are just two randomised control trials of housing interventions known to the author of this report: both very recent; one in the UK and one in New Zealand). The 'effectiveness' of housing interventions is typically described in case study form, and would usually include personal stories of beneficiaries. There has been little attempt to understand causality ie, did the intervention lead to the outcomes – the effect?

In the context of decreasing public resources, national ambitions and legislative requirements to shift public spending to preventive activity that will delay and reduce the demand for reactive and higher cost activity, in the last few years the lack of robust evidence of what works in housing to improve health and wellbeing has come to the fore. In 2015 Public Health England, with HACT and the support of five housing associations, commissioned the development of Standards of Evidence in Housing, intended to support the development of more robust evidence. Other national agencies are also working to improve the evidence base, for example the Centre for Ageing Better, part of the 'What Works' network, has recently launched a consultation on the scope of an evidence review of the role of home adaptations in improving later life.

It is because of the limitations of evidence of what works that this assessment has focussed on identifying those interventions that Derbyshire partners should be confident in commissioning ie, those that NICE – the source of national guidance and advice to improve health and social care – has made to date. However, NICE guidance does not cover every issue (the author of this report has recently worked with NICE to scope the development of housing-related guidance to address gaps). For this reason a number of additional interventions have been identified where there is other evidence-based guidance eg, from Public Health England, and/or there is general agreement across sectors nationally that it makes sense to implement. The detail of this review is found in Annex F.

5.2 Evidence based approaches and interventions in Derbyshire

It is evident from the review of services that are already contributing to improved health and wellbeing in the county that these are all at risk of becoming less effective as a consequence of reducing capacity and funding. Given this position, and in light of predicted reductions in public finance over the next few years, it simply does not make sense for there to be eight versions of the same service or intervention, in some cases with an added 'Derbyshire' level. It is likely that this doesn't make sense to Derbyshire communities either: the best route to achieving an outcome is less likely to be understood; effective working in one part of the county may not be on offer in another part, despite the need existing; health care and social care services do not operate on this geographical basis.

An analysis of Annexes E and F suggests the following:

All life courses

- Tackling health risks from cold homes is one of only two housing specific NICE guidelines and quality standards ie, the issue is significant and there is 'good enough' evidence of 'what works'.
- The Derbyshire offer to residents does not meet the offer described in NICE guidelines eg, a strategy and a single point of access to information and advice and interventions
- There are a number of relevant services/interventions in Derbyshire but:
  - The impact of 'core' local authority services (private sector/environmental health/enforcement) is not measureable, and these services are limited in their capacity to be proactive
  - The Derbyshire Healthy Home project shows real promise but it is only funded until December 2016
  - The offer to residents is not consistent across the county: there is also a home improvement agency operating across six of the eight local areas, and a specific programme in Amber Valley
  - The Nottinghamshire and Derbyshire Local Authority Energy Partnership has been hugely effective in attracting external resources to the area but this appears to be in spite of a clear strategy, rather than because of – the potential for this Partnership to do more is considerable if it is supported appropriately in local commissioning

Starting and developing well

- Reducing health risks from home hazards to the health of children (injuries) is one of only two housing specific NICE guidelines ie, the issue is significant and there is evidence of 'what works'
- In Derbyshire this assessment did not identify any specific services to prevent and reduce injuries in the home. It may be that some existing services may meet this need but this is simply not evident in the data they collect, for example few outputs from home improvement agencies relate to children and young people
- Despite evidence of overcrowding in Derbyshire, and the known impact of this on the health and wellbeing of children in particular, the only solution on offer is a move into social rented housing. This is not a solution for children living in owner-occupied homes.

Living and working well

- The district authority housing advice/options services are the main contact point for this population but it is not known if these services are effective in improving health and wellbeing, and addressing issues which may be impacting on their ability to work
- Whilst there are some apparently good services in place for the working age population (without dependent children) who are at risk of/actually homelessness and may have other needs eg, (Healthy Futures and Pathways of Chesterfield), these are at the more 'acute' end of the problem. More preventive housing support services have been reduced: the impact of this is not known locally but evidence from similar decisions elsewhere suggests it will have a negative effect.
- The assessment didn't look in detail at the effectiveness of all services available to adults with multiple and complex needs commissioned outside 'housing' eg, treatment, offender resettlement etc. This is important – this population requires a systems- and outcomes-based approach.

Ageing well

- Given the demand for health care and social care from this population, it has been the focus of much recent NICE guidance, on topics such as falls, dementia, and hospital discharge.
- Common to this guidance is the need for:
  - Suitable housing – adapted or specifically designed for use
  - The use of technology
  - Information and advice to inform patient/customer choice
  - A frontline workforce that is able to recognise risks to health and wellbeing and take action
  - Partnership working across sectors, joint strategies and agreed pathways and protocols
- The provision of home adaptations is a mandatory requirement of local district authorities, Across the nine authorities are eight different district council services, plus two home improvement agencies, and two Derbyshire services: Call Derbyshire and social care. Compared to effective practice elsewhere this is an overly complicated and likely costly approach that does not provide a clear pathway to outcomes for customers. Derbyshire has recognised this an is in the early stages of reviewing and revising the model
- There is assistive technology service with potential for this to be scaled for use by other organisations, if this is not already the approach
- There appear to be multiple sources of information and advice, general or specifically for older or disabled people. There is only one specific housing options service for older people in Derbyshire Dales (this was a larger scheme but the funding ended). It isn't clear how effective any of this is in enabling better health outcomes through the home.

6. Recommendations for action

The following recommendations have been derived from an analysis of all the information presented in the Annexes, in light of the national context presented in section 4. Annex G presents this analysis in tabular form.

A note on definitions:

- If a recommendation refers to the development of a strategy, it should not be assumed that the output will be a strategy document. The process of developing a strategy is the important part: how this strategy is then communicated will be up to those involved (potential audiences will be identified through the process).
- A number of recommendations suggest taking a 'Derbyshire' approach but this is shorthand for the geographical area that makes most sense to achieving the desired outcomes; it is up to local leaders to agree what this area incorporates. This assessment was completed before the local arrangements for devolution had been agreed, but with the knowledge that Derbyshire has been identified as a single area for the development of a five-year Sustainability and Transformation Plan, and that social care and public health interventions are commissioned on this footprint.

6.1 Across the life course

Systems leadership and commissioning

In developing local 'homes for health' strategies Derbyshire partners should be thinking about what the local picture should look like by 2020/21:

- Devolution and integration will have been implemented, with a view to rebalancing the economy and improving public services
- Available resources for action will primarily be in the NHS or from local businesses, with the public having a say over how the latter income is spent to meet needs and, through their votes, influencing other remaining public spend. There will be very little national spend to local areas other than to 'top up' where business rates will not cover all costs.

To take the opportunities presented by the government's plans, and to mitigate any negative impacts, local 'housing for health' strategies must focus on:

- Demonstrating the contribution that action on this topic will make to other ambitions eg, economic security
- Embedding 'home' in all delivery mechanisms eg, health care and care integration, plans for devolution etc,
- Making it clear if the national framework is, or is not, useful to Derbyshire to address gaps, and including relevant 'asks' in agreements with the government eg, in relation to devolution so that action can be taken
- Understanding where local issues do not match current national policy, and what needs to be done, in order to take advantage of 'plugs': it is becoming evident that the government's plans are not addressing issues such as homelessness (this has continued to rise since 2010), and short term 'fixes' are usually announced in response to these.

Developing local 'homes for health' strategies will require Derbyshire to:

- Adopt systems leadership and invest in strategic enabling ie, for such a complex problem leadership is needed from different organisations to change different parts of the system but collaboration is key and this usually requires a recognised enabler. In theory the latter is a role that the Director of Public Health is ideally placed to deliver given that 'organising the efforts of society' to improve outcomes is the definition of public health.

- Make ‘homes for health’ everyone’s business so that the NHS, local businesses and communities consider it an important investment
- Ensure data about where people live and how this may impact on their health and wellbeing is collected across social care and health care services, and that housing services collect relevant health data, and enable shared access to this intelligence to inform commissioning (there is a move to requiring this, for example the Better Care Fund requires housing data to be collected and shared, and the Mental Health Taskforce also makes this recommendation)
- Invest in prevention to generate savings to the public purse (shifting attention from generating savings to specific organisations), and take a whole population approach, focussing not just on those who are immediately in need of a response but on those who may need assistance to prevent crisis. This approach has been recommended by both the Local Government Association and the King’s Fund, the latter making the point that it must be recognised that investing in housing benefits health and that health spend needs to shift to enable more prevention
- Think differently: engaging a wider range of interests eg, social, commercial, charitable in the process of developing plans; making the most of assets or ‘wealth’ in the area eg, in communities and individuals; co-produce plans and service re-design; invest in understanding the impact of interventions including social impact.

In developing local ‘homes for health’ strategies, Derbyshire should consider developing:

- Cross-authority housing strategies/a strategy that is more evidently focussed on the objectives of improved health and wellbeing for all populations, and economic ambitions (this will necessitate a new focus on younger populations) [this assessment was commissioned with a view to a cross-authority strategy]
- Aligned strategies for integrated health care and social care that recognise the risks to health and wellbeing from the home environment and/or housing circumstances and include action to address these
- Alternative solutions to preventing, delaying and reducing demand for housing, health and/or social care assistance – moving away from the reliance on social housing and public finance and recognising other ‘wealth’ in the local area
- Awareness and understanding of the risks to health and wellbeing from the home environment and housing circumstances amongst elected members and commissioners working in all sectors
- Leadership and governance for the development and delivery of a strategy/strategies that will result in ‘homes for health and wealth’, recognising that this requires input from a number of leaders in the system and an enabling role (see section on national context). It is likely that this will need to be supported by ‘task and finish’ groups, and/or other partnerships – there’s an opportunity to revise the multitude of existing Derbyshire housing groups
- A workforce strategy that will ultimately result in a shared understanding of the relationship between home, health and wellbeing amongst all professionals who are in a position to prevent or reduce risks through their commissioning and/or service delivery. This should be based on an audit of the housing, health and social care workforces, and should seek to develop capability on a cross-authority basis

In the short term:

- Members of existing health and wellbeing partnerships should receive training to develop their understanding of the impact of homes and housing circumstances on their objectives
- Existing arrangements eg, the Health and Wellbeing Board and core group should be adapted to include a member who is knowledgeable about the ‘home and health’ relationship (in its widest sense). The member should report back to relevant housing groups. Training and/or shadowing for an existing member would be one route to this, if additional members are not an option
- Existing Derbyshire-wide housing led groups should agree their ‘offer’ to improved health and wellbeing, and their ‘ask’ from health and social care organisations and partnerships to enable this to be more effective, and communicate this clearly

Underpinning action

No health without mental health

There is sufficient evidence to suggest that the home environment and housing circumstances can affect mental health and wellbeing, for example there are correlations between:

- Stress, anxiety, depression and other mental health problems and: cold homes; condensation, damp and mould; pests; noise; living in flats
- Overcrowding and mental health, particularly for children and young people (there is some evidence that suggests overcrowding impacts on development and behaviour)
- Financial problems and mental health

There is also evidence that interventions to improve housing conditions have a positive impact on wellbeing and mental health.

For people who experience mental health problems the importance of safe, secure and affordable housing is well evidenced[1]:

- Their illness may lead to job loss or relationship breakdown, which in turn may lead to homelessness: common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high
- People with mental health conditions are one and a half times more likely to live in rented housing, with higher levels of uncertainty about their security of their home
- Mental ill-health is frequently cited as a reason for tenancy breakdown[i]

A lack of an appropriate housing response to the needs of people experiencing mental health problems can impact on demand for social care and health care, for example housing problems are frequently cited as a reason for a person being admitted or re-admitted to inpatient health care[ii]. Also, a lack of appropriate housing can contribute to delayed transfers of care into the community, the unnecessary use of residential care and out-of-area placements. These issues were raised in submissions to NHS England's Mental Health Taskforce, and acknowledged in their February 2016 report.

Consideration to housing, wellbeing and mental health is notable for its absence in Derbyshire's housing policy framework, and customer data (only housing register data and statutory homelessness data makes any attempt to identify a potential need). Whilst this is common in other local authorities, it is suggested that this must now be addressed both to achieve Derbyshire's ambitions and in light of the increasing focus nationally on this topic.

The Taskforce report included the following points of relevance to Derbyshire:

- There's a need for a better understanding of the mental health needs of the local population, bringing together local partners across health, social care, housing, education, criminal justice and other agencies – by 2020/21 NHS commissioning will be based on this understanding
- All Health and Wellbeing Boards (along with CCGs) should put in place updated Joint Strategic Needs Assessment (JSNA) and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing
- NHS England should address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models.

[1] This information was provided by the National Forum on Mental Health Housing as part of their and submission to the NHS England Mental Health Taskforce

- The NHS, local authorities, housing providers and other agencies should be working together locally to increase access to supported housing for vulnerable people with mental health problems. They should also be acting to share joint plans and information between local partners so that mainstream housing services play a more active role in preventing mental health problems arising.
- Local authorities should engage with national work to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

There are two actions Derbyshire should take:

- Ensure that housing, wellbeing and mental health is considered alongside physical health in all other recommended action
- Complete more detailed research into the needs of people experiencing mental health problems with a view to improving outcomes for this population through housing interventions, as part of a pathway

The role of local communities and service users

It was not within the scope of this project to engage with the community about their homes and health, their understanding of the relationship, what they felt the issues were and who they felt could and should take action. It is recommended that this is a piece of work that should be carried out, perhaps as part of the plan to deliver recommendations from a report on social capital in Derbyshire to Derbyshire's Health and Wellbeing Board in November 2015.

This suggestion is made for a number of reasons:

- There is strong evidence that connected and empowered communities are healthy communities, and that community mobilisation can lead to positive change in the physical and social environment, such as improved housing, and improvements in community infrastructure and increased funding[iii]
- Involvement in the community can increase personal resilience, enabling individuals to better manage crisis when this occurs
- There are examples, some of which are cited in this report, of individuals in the community playing an active part in supporting and enabling others to improve their housing circumstances as a means to benefit their health and wellbeing, for example: older people who have experienced a move supporting others to take informed decisions about their home (Silver Links); people who have experienced homelessness providing an advocacy role to other homeless people to improve outcomes from public services (Groundswell); members of the community playing an active part in identifying their neighbours housing improvement and other needs (Liverpool Healthy Homes); people with a spare room and a desire for support/company sharing their home with others (Shared Lives).
- With public finance reducing, the community's role could enable the remaining resource to focus on those who have no other safety net
- There's little evidence in the review of existing Derbyshire homes and health interventions that the views of service users or communities are informing the shape of these

The recommendations in the Social Capital report are highly relevant to enabling improved health and wellbeing outcomes through the home, for example (not exhaustive):

- Social prescribing: elsewhere in the country there are many examples of housing-related interventions being prescribed to improve health, from housing related information, advice and support to 'boilers on prescription'. There's relevant work already underway in Derbyshire eg, care co-ordinators within GP practices: if 'home and health' is not already part of their offer locally, there's an opportunity to enable this working with existing housing services
- Utilising public assets: there are examples of housing organisations eg, social landlords, making available their assets and/or making use of others' to deliver information and advice elsewhere in the country and it will undoubtedly be the case in Derbyshire, although this wasn't specifically identified

- The sharing economy: a number of examples have been provided above of housing related 'sharing' activity. Another example would be the use of community skills in home or garden improvement/maintenance – this is something that time banking typically offers already but would perhaps benefit from proactive effort to enable people to understand the impact this type of offer could have
- Participatory and co-design: the overall challenge of improving health through the home is one that would benefit considerably from the participation of the community and service users, as would the more specific recommendations to change service delivery
- A trusted workforce: examples of the role of community members in homes and health have been provided above eg, peers, as have suggestions to develop the housing, health care and social care workforce. Developing healthy home community 'connectors' or 'champions' could be an effective means to a number of improved outcomes.

Defining the role of social housing

The assessment suggests that social housing does provide a role in improving health and wellbeing but it is isn't possible to determine whether it is as effective as it could be.

In light of the multitude of national policies that have and will continue to affect the level of social housing provision, it is recommended that Derbyshire takes a pro-active approach to working with registered providers and council landlord services to define the role of social housing in relation to health and wellbeing, and wealth. Having done this, revisions to how this is used are likely to be necessary ie, the local authority allocation schemes that provide the framework for access.

A Derbyshire approach will be challenging - there are individual allocation policies and practices, although there is a common lettings system in some areas, and political perspectives on the purpose of social housing differ - the risk to current levels of social housing, and how this contributes to health and wellbeing, is significantly high.

This work would also inform future development of housing, and the role of the proposed Derbyshire County Council Development Company: it would enable greater clarity about the type of homes needed in the locality and enable local leaders to feel more confident about the use of public land to develop homes.

This exercise is in the early stages of being undertaken in other devolved areas eg, Greater Manchester.

To address specific housing and health issues

Develop a Derbyshire strategy to tackle the issue of cold and poor condition homes that:

- Recognises that households across all life courses, and in all tenures, may be affected
- Draws on intelligence from health care and social care sources to inform targeting
- Is based on an option appraisal of a Derbyshire version of the 'single point of access' to advice and interventions described by NICE
- Maximises the potential of local authority private sector housing/environmental health services and professionals to provide expertise and be proactive in their approach
- Applies the DECC evaluation tool to assessing the effectiveness of the existing models in Derbyshire, and the Derby Hub, to inform a decision on their inclusion, and potential extension, in a Derbyshire model

Commission the use of the BRE cost calculator across Derbyshire to enable up-to-date information about the private sector and to inform targeted interventions. This should be done in partnership with the CCGs to ensure it able to inform their commissioning.

6.2 Specific life course recommendations

Starting and developing well

At this point in life the home environment can make the difference between being healthy and doing well in adulthood, or the development of poor mental and physical health, dependency and limited ability to contribute to the economy or society. Poor condition homes and housing circumstances affect life chances. Surprisingly then, across England this population is rarely the focus of commissioning for housing. To inform commissioning for this life course:

- Revise the local collection of housing service data to ensure that children within households are identifiable
- Conduct in-depth research into the impact of the home and housing circumstances on health and wellbeing, particularly as evidenced in the health care system, through the frontline workforce eg, health visitors, and in the education system.
- Within research particular, attention should be paid to:
  - Families with children on the housing register who are currently living
    - in the private rented sector (to understand impact of conditions and security)
    - in overcrowded circumstances
    - in a home unsuitable for a disabled child or child with a long term condition
  - Overcrowded families with children living in owner-occupied and private rented housing
  - The low number of applications for home adaptations relating to disabled children, compared to local estimates of need
- Review the approach taken by district housing option services to households with dependent children/young people to ensure that opportunities to mitigate the impact of a poor home environment, precarious housing circumstances or homelessness on the child's health and wellbeing are identified and responded to
- Review supply and effectiveness of mediation and other available services to prevent homelessness and improve health and wellbeing amongst young people and others in the household who approach the local authorities as a consequence of relationship breakdown
- Develop an agreed pathway, and supporting protocols, for households identified as at risk of injury from the home to access a home safety assessment and the installation of preventive safety measures (the recommended research and reviews of existing services and their contacts with this population may establish the need for a specific service)

Living and working well

The home environment and housing circumstances of this population have the potential to impact on health and wellbeing, and wealth. With economic sustainability and growth a priority nationally and locally, it is important that this relationship is understood locally and action taken to address risks. Supporting this population is also desirable from the perspective of preventing demand for social care and health care, as people get older. Action is needed to:

- Work with private sector landlords and lettings agents – part of the local economy – to enable a healthier private rented sector (healthy homes; security of tenure; affordable). It may be necessary to work with any major local employers (including local authority and NHS) to understand where their workforce lives, and if this is in the private rented sector, can joint action be taken?
- Integrate 'home' into local conversations about education, training, employment and welfare, ensuring that relevant workforces assist households to understand the connection between income and housing choices, but also to identify the challenges to achieving the right home environment to inform commissioning eg, for affordable homes provision
- Take an outcomes and systems-based approach to adults with multiple and complex needs, including homelessness ie, recognise that this population experiences many services, operating in different systems eg, health care, social care, housing, criminal justice, and that unless these services and systems collaborate to improve outcomes, this experience is unlikely to be a positive one. In addition to

reviewing the provision of housing support (including use of 'supported' accommodation paid for through Housing Benefit), this must include a review of existing approaches/interventions of treatment providers, mental health provision and provision for offenders.

Ageing well

Although the main focus of much housing activity across Derbyshire already, it is difficult to be confident that resources are being used to best effect when there is no evident strategy and a patchwork of services. Commissioning the right home environment for this population is essential to improve outcomes and quality of life for people, and to prevent, delay and reduce the need for social care and health care. In particular action is needed to:

- Review and revise information and advice provision across Derbyshire, particularly to enable people to make informed choices about their housing options before crisis (the low number of approaches from older people to housing advice services suggests they are going elsewhere and may have a need for a higher level of support that could have been prevented). This provision must involve older people in its delivery.
- Complete the review of home adaptations access and delivery so that there are clear and timely pathways to improved outcomes: the end result should also include information and advice for potential self-funders [this is also relevant to other life courses]
- Review existing hospital discharge services with a view to understanding a) if this could have been prevented through a home-related intervention b) what housing needs exist and c) whether the current process is effective in enabling a timely transfer of care.
- Understand if the home environment or housing circumstances are a contributory factor to the high level of admissions of over 65s to residential and nursing care, and if so, what interventions are needed, for whom and when, to delay and reduce the need in the future

7. ANNEXES

Annex A Scale and nature of the home and health relationship in Derbyshire

Information compiled and collated by Tessa Paul for Derbyshire County Council Public Health, with support from Gill Leng from GLHS

Table of Contents

Note: There are additional tables and charts, collated as part of this project, in a separate document.

Introduction to the scale and nature of the housing and health relationship in Derbyshire

This section draws primarily on local intelligence to understand the housing and health relationship in Derbyshire.

As introduced in the main report, the relationship between homes and health has used the following three headings, and sub-headings:

Precarious housing and homelessness	• Insecurity in the private rented sector • Homelessness, risk of homelessness and rough sleeping
Unsuitable housing	• Housing which is unsuitable to meet the needs of physically disabled people • Overcrowding
Unhealthy and unsafe housing	• Disrepair, unhealthy and unsafe housing, including hoarding • Cold and damp homes and fuel poverty

Each section describes:

- The housing issue and the main risks to health and wellbeing
- What this relationship looks like in Derbyshire including, where possible, breakdowns by age group; household type; tenure etc,
- Issues of significance faced in particular districts or communities

There are a number of populations for whom their home environment is particularly important to protecting and improving their health and wellbeing, and reducing health inequalities. There are specific sections for:

- Offenders
- People with learning disabilities
- People with drug and/or alcohol problems
- People with mental health problems
- Gypsies and Travellers

Availability of local intelligence

This section describes the availability of local intelligence to inform understanding the scale and nature of housing and related health issues.

It has been quite difficult to extract robust intelligence from local sources of information. There are many reasons for this, ranging from customer information not being asked for in the first place, or incomplete records; information being recorded on a system that does not easily allow interrogation; services being unable to provide detailed information within the timescales required.

The number of different access points into the 'system' is also problematic: all services have their own mechanisms for collecting and recording information (and there can be differences in what is asked of customers to the same service); signposting and referrals from one organisation to another are not always captured by either organisation; there are no unique identifiers in use between services so it isn't possible to identify duplication or pathways. To

understand the picture across the life course requires household type and age data: only some services have been able to provide these in any sufficient quantity.

The difficulty in collating accurate, up-to-date and consistent data, highlights a need to reconsider the value of data: what do we want to know and how can we best answer these questions? It may be that some data currently collected is not needed, and/or there might be alternatives. Such an example would be the commissioning of private sector stock condition surveys – it is a statutory requirement to understand the condition of homes in a locality but surveys are cost-prohibitive in the current climate. Alternative methods of understanding conditions and their health impact may be available eg, the BRE Domestic Energy Model or Cost Calculator, supplemented by better local recording when customers are in contact with services.

The following table describes the availability and limitations of the data made available as part of this review: -

Table 1: Sources of information for the HHJNA, availability and limitations

Source of information	Purpose	Primary customer group	Comment

Housing Registers	To enable households to access Social Rented and Affordable Rented housing	Households seeking to improve their housing situation through a move into a social rented or Affordable Rented home through a housing association or local authority.	• There will be some duplication with data provided by local authority housing options/housing advice services.
			• There are some restrictions to joining the Housing Register ie, not everyone in housing need will be registered.
			• There are normally two sources of information within the system:
			  ○ Self-reported circumstances – with possibilities that people do not fully understand the questions
			  ○ Priority band based on an assessment of circumstances. It is not always easy to understand what circumstances are from the banding
			• It has not been possible to analyse detailed priority by life course
			• Licensing agreements with systems providers, complexity of extracting reports and capacity issues for staff, made it very difficult to extract a full range of information
			• Some information is collected in text format: it is not possible to extract data from it
			• Housing Register reviews, and the frequency with which these are carried out, can affect the number of applications held

Housing Standards and Environmental Health Team	To improve the environment, health and housing of the residents	Anyone facing a risks to their health and wellbeing from poor housing or environmental conditions	• Qualified professionals apply the Housing Health and Safety Rating System to understand risks to health and wellbeing; • Records of hazards do not provide sufficient information to understand the presenting problem e.g. excess cold may or may not correlate to fuel poverty • Record keeping is solely based on the property and presenting issues, and rarely are any householder details such as age, health issues are recorded • Each local authority keeps records in a different format – making it very difficult to collate and compare information
Local authority housing options/	To meet housing needs	Households in precarious housing	• There will be some duplication with data provided by the Housing Registers on Choice Based Lettings Schemes, and on

Source of information	Purpose	Primary customer group	Comment
housing advice services – approaches for advice/assistance		circumstances or homeless	homelessness returns (P1E data) • Each local authority keeps records in a different format, and in different levels of detail, making very difficult to collate and compare information
Offender information from probation services	To assist offenders on probation, under supervision with access suitable housing and support	People on probation, under supervision, having left prison, under community orders	• Data does not allow us to correlate housing with health issues. • Data is described in broad issues, such as “housing”, which can mean many things, including homelessness, a home in disrepair, needing to avoid certain locations.
Statutory homelessness data (through quarterly P1E returns)	Extent of access to local housing authority homelessness services where LA has recorded a homeless prevention, relief or statutory homeless intervention.	Households who are homeless or at risk of homeless	Only those full details of households where there is a statutory duty on local authorities to provide assistance has to be reported. The number of households recorded in detail is very low, in comparison to the number of households approaching local authorities for advice or assistance.
Home Energy Conservation Act (HECA) reporting	Scale of households in fuel poverty, and interventions to address this	Households experiencing Fuel Poverty	Website data is not detailed, although local authorities sometimes keep more detailed information in Affordable Warmth Strategies etc.
Planning monitoring data	Data about new planning applications, decision making, types of development, enforcement action	Any household accessing new homes	Future predictions of likely homes to be completed over the next few years, can be difficult in some local authority areas Detailed information such as sites with Lifetime Homes properties, larger homes, disabled people’s housing is not easily retrievable from some databases.
Stock Condition Survey	Sample survey of private sector properties to assess condition of the properties and characteristics of households	Households in private sector homes (owner-occupied and private rented)	Some stock condition surveys were completed many years ago (range from 2003 to 2014). The number of private sector homes in poor condition may have altered significantly due to investment in improvements between 2005 to 2010, for example South Derbyshire reports a 50% reduction in non-decent homes between 2005 and 2014.
Disabled Housing Research Data	Collation of data, and sample survey of people with physical disabilities	People with physical disabilities of all ages	Wide range of data, but from 2012 and earlier, although did have some predictive information for 2015, to 2025.
Home Improvement	Requests for assistance and	Disabled people, older	Databases are mainly held to record the progress of any work, and

Source of information	Purpose	Primary customer group	Comment
Agencies	advice regarding disrepair, cold, damp, energy efficiency, and access to adaptations for disabled people	people, other vulnerable people	tasks completed. Minimal or no information held on databases about the characteristics or health issues of households.
Housing Options Service(s) for Older People	Advice or assistance for Older People on a wide range of housing issues	Older People	One of the services has now closed, so we only have access to monitoring information which is not highly detailed for the purposes of the HHJNA
Hospital episode statistics	Data on people who are admitted to hospital or who are unable to leave when clinically able to do so, due to housing issues	People admitted to/to be discharged from hospital	No information available on those admitted to hospital due to housing related issues. NHS information on "delayed days" includes 'awaiting community equipment/adaptations' and 'housing' (typically homeless However, no further detail could be obtained from either Adult Care or CCGs on the full nature of the housing issues. Information has been collected from local hospital discharge interventions, on the details of the clients they assisted.
Care Co-ordinators at GP surgeries	Data on people who are identified as at high risk of unplanned and inappropriate hospital admissions, where tackling housing issues could help to reduce the risk	People who are at risk of unplanned and inappropriate hospital admissions because their home is unsuitable/ in disrepair, or insecure.	No information available. The information and detail is not recorded by the Care Co-ordinators.
Learning Disabilities information from Adult Care teams	Anonymised data on people with Learning Disabilities needing accommodation	People with Learning Disabilities	There will be some duplication with data provided by local authority housing options/housing advice services. Information supplied did not always give a reason for needing to move.
General	Local authority capacity to fulfill information requests was very limited. Whilst staff recognised the need for this type of work, their focus on delivering frontline services took priority.		

Summary of the main housing issues affecting populations in each stage of the life course

This is a summary of information presented on subsequent pages:

Table 2: Summary of health and housing issues by life course stage

Life Course		Main issues	Other issues affecting significant numbers
Starting & developing well	Young people up to the age of 25	• Homelessness – due to relatives/friends asking to leave & other relationship breakdowns; end of Assured Shorthold Tenancy (AST) tenancy in the Private Rented Sector (PRS); • Fuel poverty • Cold, damp, disrepair	Unsuitable for households with a disabled child: although numbers may be low, but needs are high and if unmet have implications for the rest of life Rough sleeping amongst single young people/couples
	Families with dependent children	• Insecurity of PRS • Risk of homelessness due to end of PRS tenancy; relatives/friends asking to leave & other relationship breakdowns; • Overcrowding • Fuel poverty • Cold, damp, disrepair	Unsuitable for households with a disabled child: although numbers may be low, but needs are high and if unmet have implications for the rest of life
Living & working well	Working age households without dependent children	• Insecurity of PRS • Homelessness due to end of PRS tenancy; relatives/ friends asking to leave & other relationship breakdowns; • Cold, damp, disrepair	• Overcrowding • Fuel Poverty • Rough Sleeping • Financial – mortgage arrears
Ageing well	Older people *assumed 60+ but agencies collect by other ages ie, 50+; 55+; 60+; or 65+	• Unsuitable for disabled people and/or other long term conditions • Fuel poverty • Cold, damp, disrepair	• Homelessness due to mortgage arrears

Precarious housing and homelessness

This section covers homelessness, and insecurity in the private rented sector.

Homelessness

There is no single, simple or agreed definition of homelessness. The definition of homelessness is not limited to those households who are owed a statutory duty to settled accommodation by a local housing authority. It includes[iv]:

- People sleeping rough (this population is considered the 'tip of the iceberg');
- Single homeless people living in hostels, shelters and temporary supported accommodation;
- Statutorily homeless households – that is, households who seek housing assistance from local housing authorities on grounds of their being currently or imminently without accommodation. This covers all household types, including families with children and single people;
- 'Hidden homeless' households – that is, people who may be considered homeless but whose situation is not 'visible' either on the streets or in official statistics. Classic examples would include households living in severely overcrowded conditions, squatters, people 'sofa-surfing' around friends' or relatives' houses, those involuntarily sharing with other households on a long-term basis, and people sleeping rough in hidden locations. [Overcrowding is considered under 'unsuitable housing'].

Homelessness as experienced by all populations and reported in official government figures has been rising since 2010: rough sleeping has increased by 102%; statutory homelessness has increased by 10%. This trend is predicted to continue alongside ongoing reforms to the welfare system and social housing, and other austerity measures.

Ill health is both a cause and consequence of homelessness. It is difficult to disentangle the impact of simply not having a home on health and wellbeing when the circumstances leading to homelessness are also likely to have had an effect eg, loss of employment, relationship breakdown, abuse or other trauma.

People who experience of homelessness are a heterogeneous group with a range of needs: their homelessness is rarely just a housing problem or indeed a consequence of something that they have immediate control of (fire, flood, redundancy, for example). All populations can be expected to experience a negative effect on their health and wellbeing, not just those rough sleeping or for households with multiple or complex needs. This is particularly true of the impact of homelessness on mental health and wellbeing. Physical health impacts can be related to the quality of the accommodation/environment within which the homeless household is residing.

This section concentrates on relevant information to health and wellbeing. Each local housing authority has a duty to complete a homelessness review at least every five years: other information about homelessness should be found there.

What are the main risks to health and wellbeing from homelessness or being at risk of homelessness?

Dependent on the events that lead to homelessness and the assistance received, homelessness affects household members in different ways.

Families with children, and young people
Homelessness may mean that parents are unable to provide the quality of care needed during pregnancy and infancy, and the quality of temporary home environment can impact on a baby's physical development[v]. Children are at greater risk of infection, especially gastroenteritis, skin disorders and chest infections[vi], and their mental health is affected, contributing to development problems[vii].

Shelter research reports that:

- 58 per cent of families in temporary accommodation (other than bed and breakfast) said their health had suffered as a result of where they were living[viii]
- Almost half of parents with children said they were depressed[ix].
- Nearly half of respondents described their children as 'often unhappy or depressed'.[x]

Homelessness leaves parents at breaking point and children's lives in chaos. Stress and anxiety is related to the lack of control over their housing situation, combined with high levels of poverty and often poor living conditions. Families often also feel very isolated, especially when temporary accommodation is provided at a distance from the household's local community and friends. The effect of homelessness on children can be long-lasting. A study undertaken in Birmingham found that 40 per cent of the homeless children studied were still suffering mental and developmental problems one year after being rehoused[xi].

Many young homeless people experience mental health problems, are drug dependent, have self-harmed. [xiixiii]

Adults

The health and wellbeing of single homeless people is significantly worse than that of the general population.

Table 3: Health issues of single homeless people in comparison to general population

Health issue	Homeless population	General population
Long-term physical health problems	41%	28%
Diagnosed mental health problem	45%	25%
Taken drugs in the past month	36%	5%

Source: The unhealthy state of homelessness, Homeless Link 2014

Research suggests that single people who are homeless, including rough sleepers, have an average age of death of just 47 years. [xiv]

Homelessness amongst single people has a particular impact on health services and the criminal justice system, a fact acknowledged by the government in 2012:

'*Most of the additional financial costs of homelessness to health and support services and the police and justice system are attributable to the most vulnerable and hardest to help, including in particular those with multiple needs*.'

The number of accident and emergency (A&E) visits and hospital admissions per homeless person is four times higher than for the general public, and research also suggests that A&E is accessed by people simply seeking a roof over their head. The cost of single homeless people using inpatient, outpatient and accident and emergency services was estimated in 2010 to be £85m a year.[xv] This form of homelessness increased by 102% between 2010 and 2015.[xvi]

The single homeless population is much less able to contribute to the local economy. 80% of single people experiencing homelessness want to work, but only 10% are in paid employment. Many people face significant barriers to work, despite considerable effort by hostels and day centres to improve employability; these barriers relate to ill health and/or a history of anti-social or offending behaviour. The isolation and exclusion experienced by single homeless people often affects their ability to engage with, and contribute to, society in general.

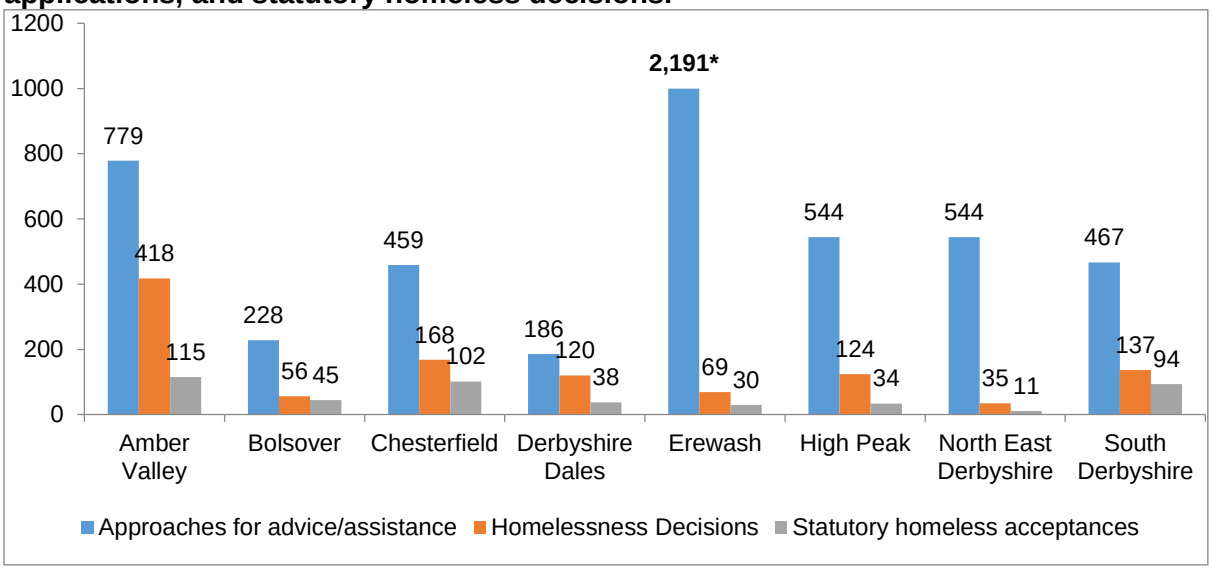
The scale and nature of households at risk of homelessness or homeless in Derbyshire

Intelligence has been drawn from information collected by local housing authorities, and related services. Sources include:

- Local housing authority housing advice and assistance
- Local housing authority homelessness services
    - Decisions made on homelessness applications by local authorities
    - Statutory homelessness decisions
- Healthy Futures hospital discharge service
- No Second Night Out rough sleeper initiative

The manner and extent to which data is reported can vary between local housing authorities. For example, Chesterfield Borough Council only recorded 459 approaches, but took over 6,000 calls with regard to homelessness and housing queries; Derbyshire Dales gave face to face housing advice to 940 people, but not all were opened as cases on the system; Erewash record most of their approaches. Direct comparisons should not be made, but it is still of value in understanding the scale of the problem.

Figure 1: Number of approaches for housing advice and assistance; decisions on homelessness applications, and statutory homeless decisions.

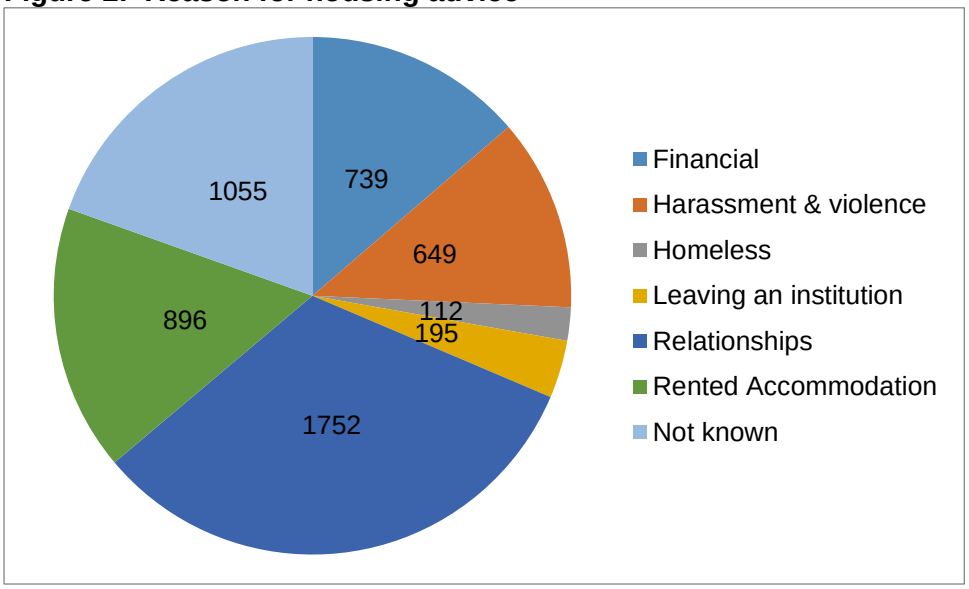


** Erewash approaches are 2,191 – graph altered for purpose of presentation*

Sources: Derbyshire Local Authority approaches for homelessness and housing advice information 1.4.14 to 31.3.15; P1E quarterly data returns re homelessness decisions October 2014 to September 2015

The reasons why people approach local housing authorities for housing advice and assistance are wide ranging, and are in some cases are unlikely to reflect the trigger for the housing need eg, 'relationships' or could refer to breakdown as a consequence of financial issues. The main reported reasons for approaching for assistance are parents/family/friends or ex-partners asking households to leave, and relationship breakdown. Again, this could be for a number of reasons, including overcrowding (there are risks to health associated with these circumstances – see the section on Overcrowding below)), behaviour, harassment, abuse, financial etc.

Figure 2: Reason for housing advice



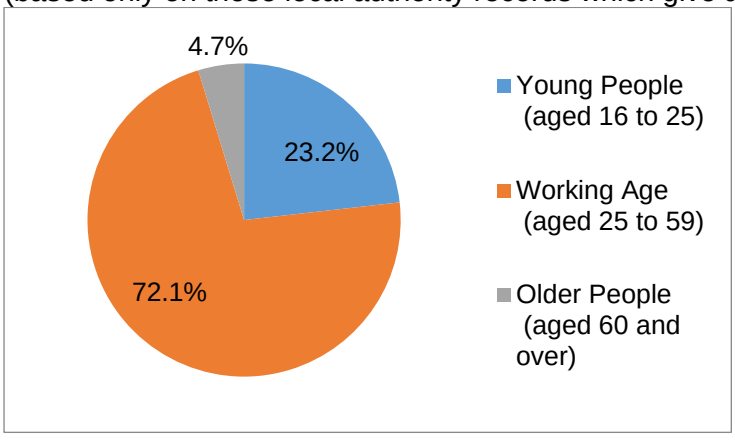
Source: Derbyshire Local Authority approaches for homelessness and housing advice information 1.4.14 to 31.3.15

Other points of note are (rented accommodation discussed in next section).

- 'Not known' – if there is to be a proper understanding of the housing issue experienced by those approaching authorities for assistance, more attention should be paid to recording a reason
- Financial reasons: rent arrears are the main reason for the approach to the service (401 households, 7.4% of approaches), followed by the impact of the 'spare room subsidy' or 'bedroom tax' (122 households, 2.3% of approaches) and mortgage arrears (117 households, 2.2% of approaches).
- Harassment and violence: domestic violence is the main reason for the approach (437 households, 8.1% of approaches)
- Leaving an institution: this includes leaving prison, hospital or the armed forces. Data is unclear but it appears that prison the main reason for the approach

Of those approaching for advice, the majority were working age (25 to 59) (2,516 households, 72%) with relatively few older people (164 households 4.7%).

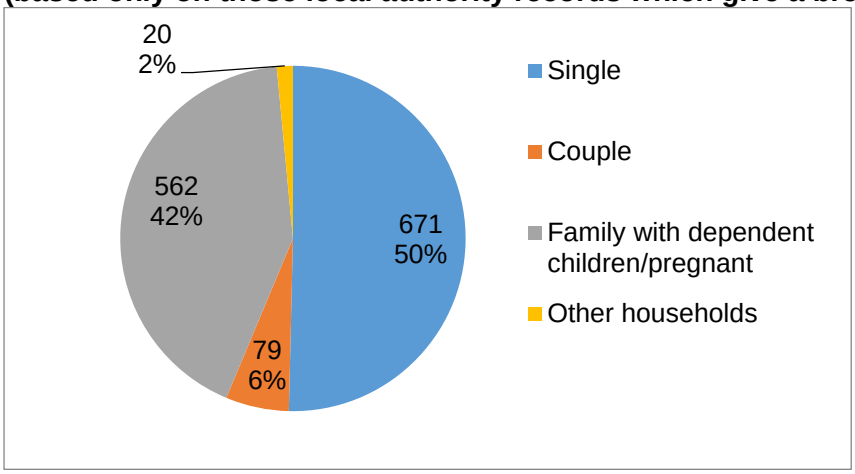
Figure 3: Age group of households approaching Housing Options services for advice/assistance (based only on those local authority records which give a breakdown by age)



Source: Derbyshire Local Authority approaches for homelessness and housing advice information 1.4.14 to 31.3.15

42% of those approaching for assistance were families with children (50%) and 50% were single people.

Figure 4: Household type - households approaching housing options services (based only on those local authority records which give a breakdown by household type)

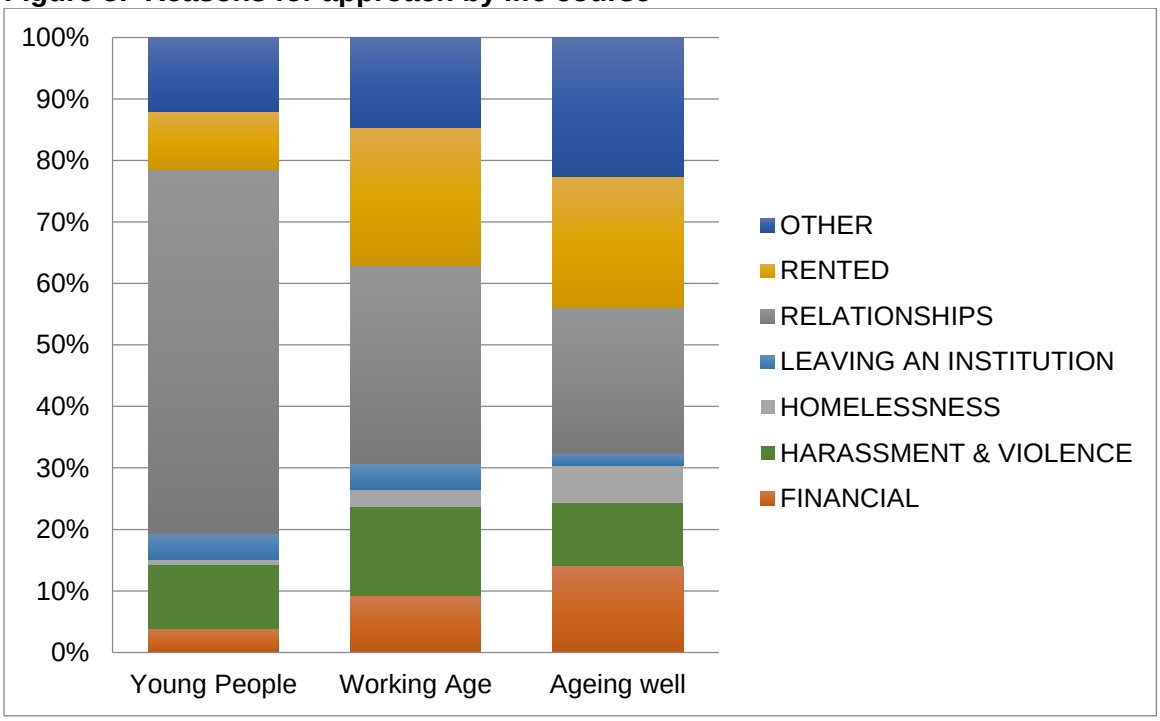


Source: Derbyshire Local Authority approaches for homelessness and housing advice information 1.4.14 to 31.3.15

The information available on reasons for approach by life course is of interest but must be considered carefully given the relatively low number of 'ageing well' households presenting overall:

- Younger households are much more likely to seek assistance as a consequence of relationship breakdown, than older households
- The older a household is, the more likely it appears that they will approach for financial reasons

Figure 5: Reasons for approach by life course



Source: Derbyshire Local Authority approaches for homelessness and housing advice information 1.4.14 to 31.3.15

Unfortunately, the information available on "approaches" does not tell us anything about the health and wellbeing of the households, and if this is a reason for the approach.

It is worth noting that there appears to be a wide fluctuation in the number of approaches year on year, with no clear pattern of increase or decrease. This might be worth further investigation. The housing options and advice teams did note the following about any "trends" over the past three years: -

- Type of presenting needs fairly static – mainly private rented tenants being given notice to leave; parents asking to leave; domestic abuse.
- More private rented tenants being given notice because the landlord is selling the property
- Increasing number of people asking for help with rent in advance
- Cases becoming more complex – people approaching have a multitude of issues, and with the reduction in services, it is proving more difficult to assist people
- More single applicants approaching due to difficulties accessing 1 bedroomed social housing, and accessing private rented flats due to the single room rent limits.

It is also worth noting that it is difficult to compare information between local authority areas: different data is recorded and full information is not given for every contact. For example, Chesterfield's recorded "approaches" of 459 are only face-to-face approaches, and do not reflect the advice given after email contact (115) and incoming telephone calls average at 6,608 per year.

The scale of actual homelessness

It is difficult to predict how many households who are at risk of homelessness, would become actually homeless without intervention and assistance.

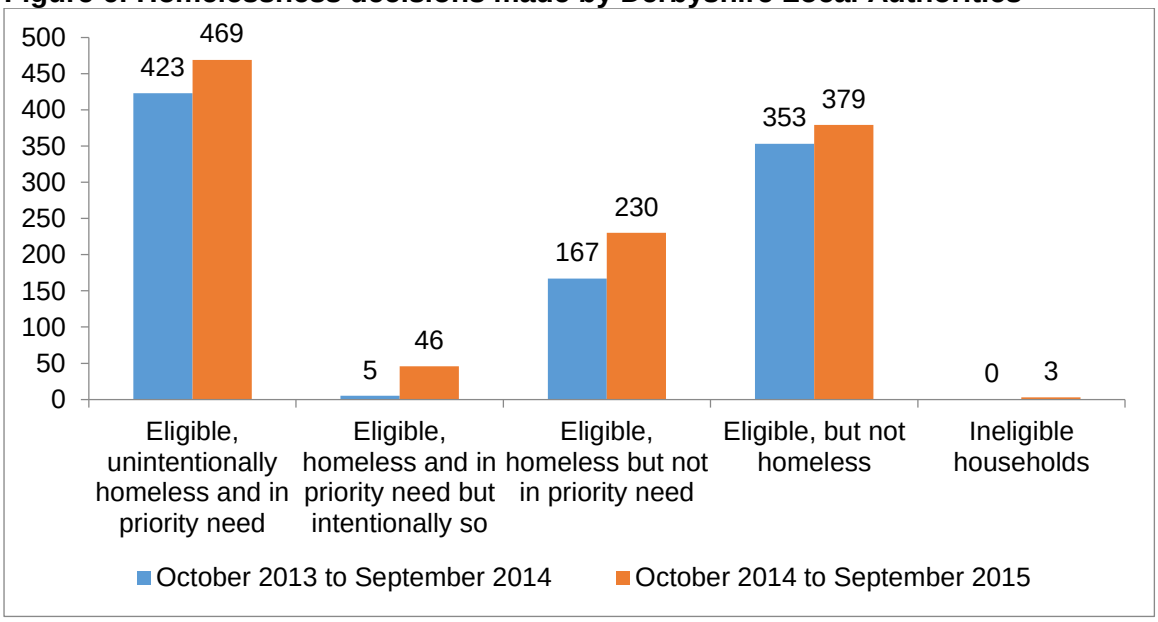
Statutory homeless household acceptances by the local authorities

The government requires information on homelessness to be reported, but detailed information is limited to those households for whom the local housing authority owes a statutory duty to provide accommodation.

Across all the eight local authorities, during the last year (October 2014 to September 2015) 1,127 official homelessness decisions were made, and of these, just 469 homeless households owed the 'main duty'. There has been a 19.4% increase in the number of homelessness decisions made across Derbyshire between September 2014 and September 2015.

There is a fairly notable disparity between the local authorities with regard to both the number of homelessness decisions made and also the number and percentage of statutorily homeless decisions. Ranging from 418 decisions by Amber Valley to just 35 decisions made by North East Derbyshire: from 43% of decisions by Erewash as statutorily homeless to just 27% in Amber Valley and High Peak. This could be for a number of reasons, relating not only to actual homelessness but also to the way in which homelessness is recorded.

Figure 6: Homelessness decisions made by Derbyshire Local Authorities

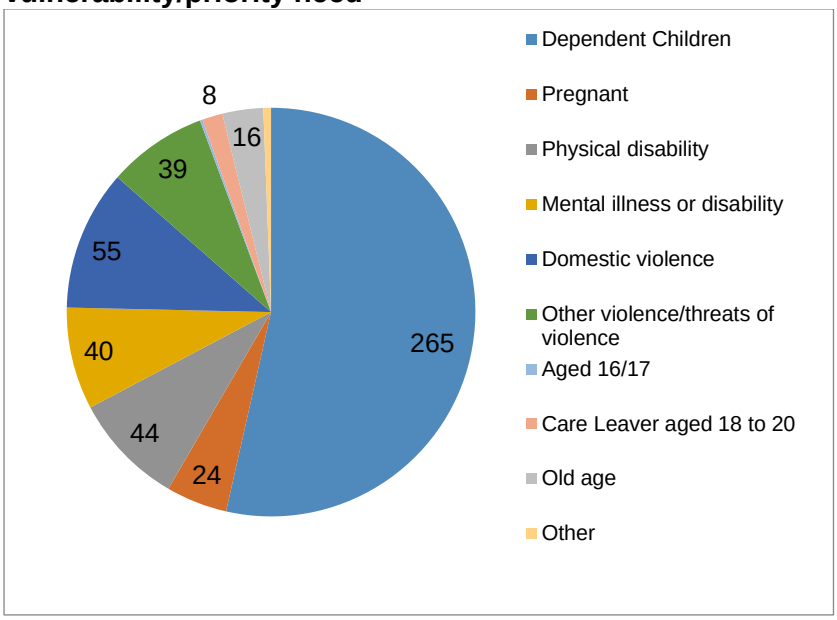


Source: P1E quarterly data returns October 2014 to September 2015

There have been particularly sharp increases (37.7%) in the number of “homeless but not in priority need”, who are likely to be single homeless people, to whom local authorities have no “duty” other than prevention where possible, and advice [note that this may change in future: the government is proposing to change legislation]. It is also notable, that Amber Valley had 3 cases of “not eligible” in comparison to none across Derbyshire in the previous year. These are people who are accepted as homeless, but are not eligible for assistance due, normally, to immigration status.

For all local authorities, the main “vulnerability” which gave the household a priority need was a household with children. It is also notable that in Amber Valley and South Derbyshire, people fleeing domestic violence and other violence were also a high percentage of acceptances (36% Amber Valley; 20% in South Derbyshire); in Chesterfield physical disability and mental illness or disability were 25% and in Bolsover, people who were vulnerable due to old age were 18% of all acceptances.

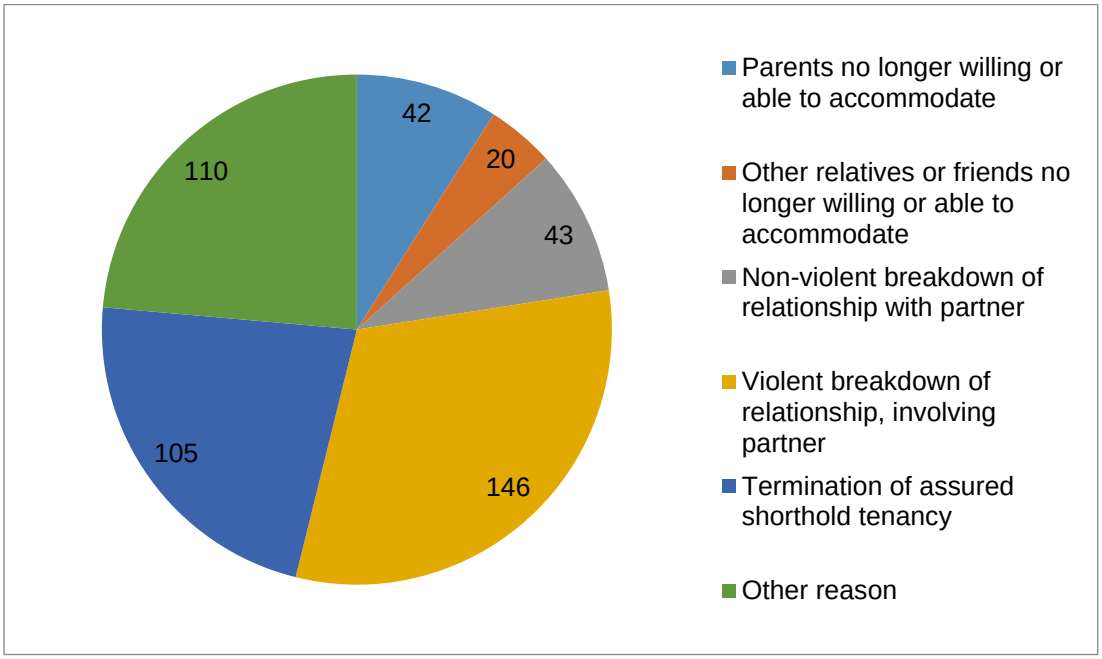
Figure 7: Acceptances (Eligible, unintentionally homeless and in priority need) by vulnerability/priority need



Source: P1E quarterly data returns October 2014 to September 2015

In Amber Valley, Chesterfield, Erewash and South Derbyshire, the main reason for homelessness was due to domestic violence, with particularly high levels in Amber Valley – 53% of all acceptances. We do not know whether this reflects higher levels of domestic violence reported to other agencies in these areas, and the local response from services to this but this may be an area worth further investigation. In Derbyshire Dales and High Peak the end of an Assured Shorthold Tenancy was the main reason for homelessness, and in Amber Valley – also high numbers for this reason.

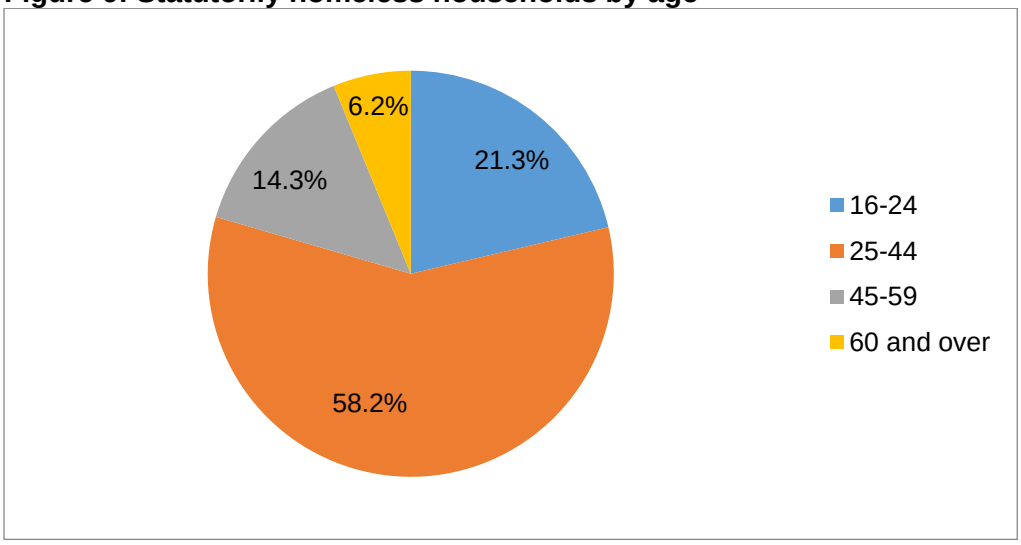
Figure 8: Acceptances (eligible, unintentionally homeless and in priority need) by reason for homelessness



Source: P1E quarterly data returns October 2014 to September 2015

The majority of those accepted as statutorily homeless are 'working age', although there will be children in these households, and potentially household members of older age.

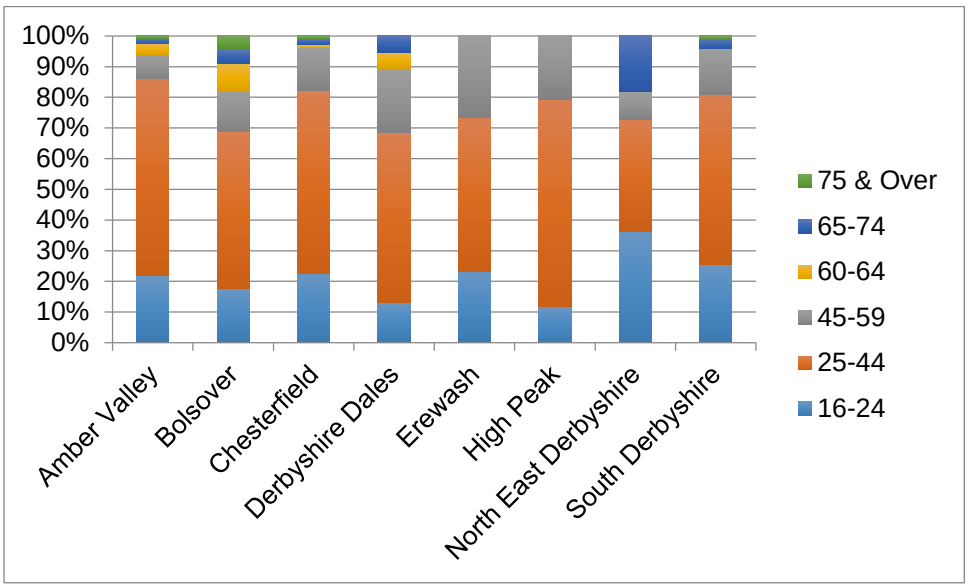
Figure 9: Statutorily homeless households by age



Source: P1E quarterly data returns October 2014 to September 2015

There is some variation in the age profile of accepted households between local authorities but this needs information from other years and comparison with the local population as a whole in order to draw any real conclusions.

Figure 10: age of applicant when accepted as statutorily homeless

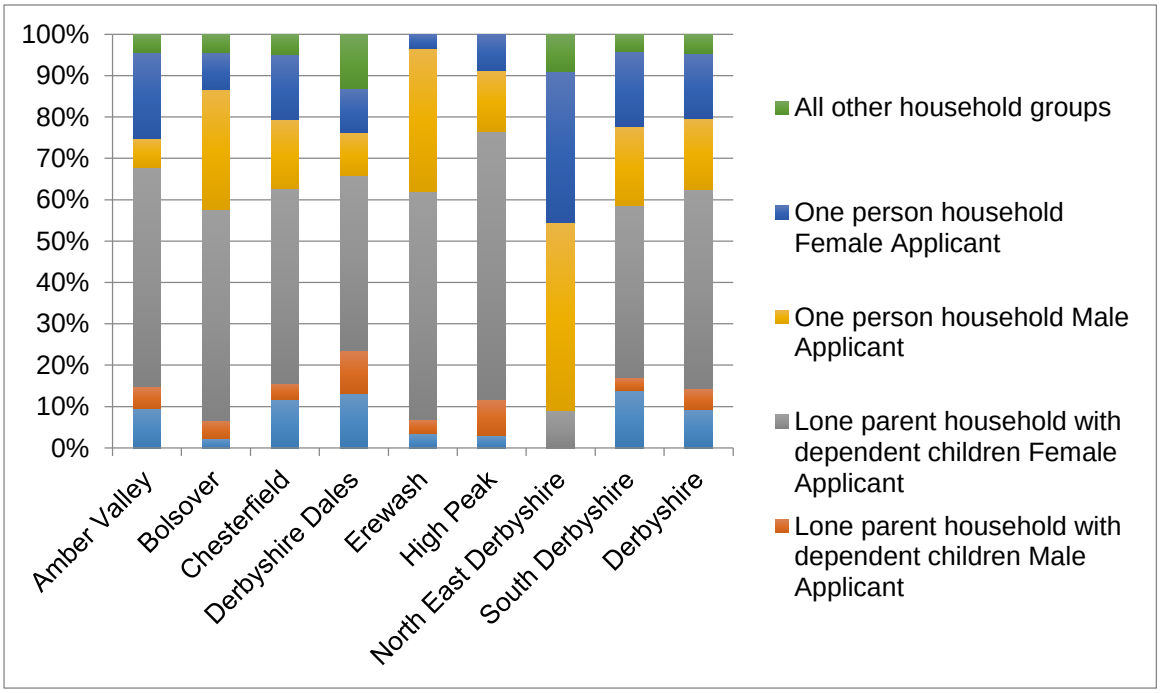


Source: P1E quarterly data returns October 2014 to September 2015

Households with children form the vast majority of statutorily homeless acceptances, which is unsurprising: dependent children meet the criteria of a priority need under homelessness legislation; it can be harder to evidence other reasons of vulnerability eg, mental health problems.

Similarly there is variation in household types across Derbyshire but conclusions can't be drawn from this alone. North East Derbyshire's profile diverges the most from the Derbyshire profile, with a greater proportion of one person households.

Figure 11: statutorily homeless household types



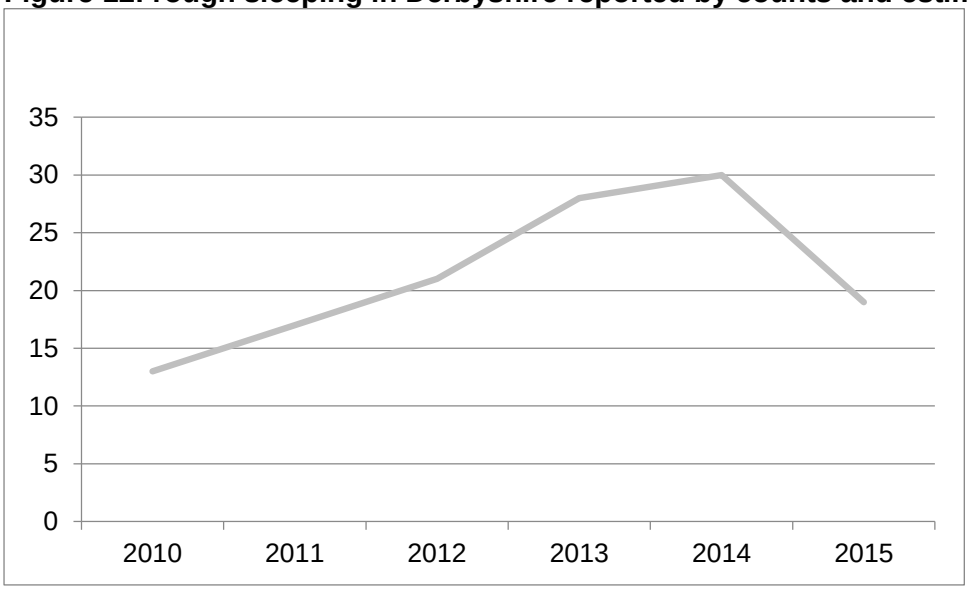
Source: P1E quarterly data returns October 2014 to September 2015

Rough sleeping

Local authorities are required to carry out an annual "rough sleepers count" or provide an estimate, working with agencies. This is not a sound basis on which to understand levels of rough sleeping. In addition rough sleepers are not always "visible".

Until 2015 the reported trend in rough sleeping in Derbyshire was in line with the national trend: increasing levels of rough sleeping. This changed in 2015 – nationally rough sleeping was 30% higher than in 2014, yet Derbyshire saw a decrease. This is worthy of further attention: people who rough sleep typically experience the worst health and wellbeing, and inequalities; No Second Night Out data reports an increase in rough sleeping during 2015/16

Figure 12: rough sleeping in Derbyshire reported by counts and estimates



Source: DCLG rough sleeping statistics

Other sources of information on rough sleeping indicate:

- Eight people approaching High Peak between April 2014 and March 2015 reported rough sleeping – no information was available from other services
- Five people supported by the homeless hospital discharge service, Healthy Futures between April 2015 and the end of January 2016
- 100 rough sleepers identified by the No Second Night Out service during 2014/15.
- During the period September 1st 2015 to February 29th 2016 (six months) the No Second Night Out service engaged with 93 rough sleepers – numbers appear to be rising.

No Second Night Out suggests that the majority of the rough sleepers were in Chesterfield, Amber Valley and Erewash. Project workers suggest that people from Bolsover and North East Derbyshire are more likely to rough sleep in Chesterfield town centre, hence the low numbers in these areas. It is also possible that people from Derbyshire were rough sleeping in Derby City, Nottingham or other areas, which will not be reflected in the figures here.

Table 4: Rough sleepers identified by No Second Night Out April 2014 - March 2015.

Local authority	Number of rough sleepers identified and assistance offered
Amber Valley	23
Bolsover	4
Chesterfield	41
Derbyshire Dales	4
Erewash	16
High Peak	7
North East Derbyshire	0

South Derbyshire	5
Total for Derbyshire	100

Source: Information from No Second Night Out project – Derbyshire statistics only

The breakdown of statistics by age, ethnic origin, and health issues includes rough sleepers identified in Derby City, which made up 75% of all cases so these have not been used here. However, we understand from project workers that the majority of rough sleepers in Derbyshire are male, white British; aged 40 and over and with long-standing drug and/or alcohol problems (particularly alcohol). This is common with the national profile, and the information reported by the Healthy Futures homeless hospital discharge service.

Table 5: Rough sleepers reported by Healthy Futures hospital discharge service

Number of people affected	Of which						
	Life Course Stage			Health Issues			
	Aged 16 to 24	Aged 25-59	Aged 60+	Mental Health	Drug Misuse/ Alcohol	Long Term condition (e.g. cancer)	Mental health/drug/ alcohol issues
5	1	3	1	2	1		1

Source: Healthy Futures Project
People who cannot be discharged from hospital due to homelessness (had been rough sleeping) 1.4.15 to 30.1.16

Insecure accommodation in the private rented sector

For the purpose of this assessment the role of the private rented sector has been considered specifically. The sector has doubled in size in the last ten years ([xvii]19% of homes in England are in this sector), has the highest prevalence of poor quality housing, costs considerably more than renting from the social rented sector, and typically offers tenancies that can be terminated with relatively little notice (tenancies are typically issued for six month periods, with 28 days notice to quit). Increasingly it is home to younger households, including families with children. This sector is also unregulated nationally. For these reasons, in the last decade the relationship between security of tenure, health and wellbeing has become of greater interest.

For some people the private rented sector will be a good housing option provided they have the income to afford their rent and any deposits and associated lettings fees and that their landlord feels that the rental income is the highest they can attract. These homes can offer the flexibility to move quickly and easily, for example if they need to move to access work; there can be a wider range of properties and locations; two thirds of homes are in good condition. These households however are not immune from landlords deciding to end their tenancy.

Lower income households are not in a position where they can exercise the same degree of choice or control over their home in the private rented sector. As owner occupation is increasingly unaffordable and access to social rented homes reduces, more lower income households in particular are accessing the private rented sector (the number of low income households in the sector has reportedly doubled in the last decade). The type and suitability, location and quality of home and landlord these households can access are limited (50% of landlords choose not to rent to tenants in receipt of the Housing Benefit), and they are at greater risk of their tenancy ending simply because their landlord wishes to secure a higher income or otherwise use the property. Research suggests that 93 per cent of initial tenancy agreements are for 12 months or less. [xviii]

The ‘worse case’ scenario for the end of a tenancy in the private rented sector is homelessness – the impact of which has already been discussed.

What are the main risks to health and wellbeing from insecurity in the private rented sector?

Research suggests that insecurity can have an impact on wellbeing, causing anxiety, stress, loss of confidence and worry about the future. [xixxx] People who are already vulnerable, for example because of other health or care needs, are reported to particularly struggle to sustain tenancies in the private rented sector, finding It harder to manage.

There are health impacts associated with regular moves. Children are particularly affected: it is reported that two or more moves in the first two years of life can be linked definitively with behavioural problems at the age of nine. For older children, home moves can mean school moves and this has been shown to negatively affect educational attainment.

The ability of adults to access and sustain employment can also be affected by regular moves.

There are implications for the wider community and neighbourhood if parts of this are relatively transient.

Alongside the fear of losing their home, lower income tenants may have had no choice but to live in an unsuitable home, or a home in poor condition and/or managed poorly. There are health risks from living in these circumstances, explored later.

The scale of the problem in Derbyshire

This assessment has drawn information from three sources to understand the number of households whose health and wellbeing may be at risk.

Housing register data suggests that almost a quarter of all households seeking to move into the social or affordable rented sector are currently living in the private rented sector (4,069 households, 23%).

- In High Peak – the area with the highest number of households on the Housing Register – private sector tenants represent almost one third of those on the register (1,189 households, 30%)
- 48% of those wanting to move are families with children – 50% of these have one child
- 31% are single people, 19% are childless couples
- The majority are ‘working age’ between the ages of 25 and 59 (77%) but 17% are over 60. Just 6% people are under the age of 25

The proportion of older people is a reminder that not all older people own their home, although they may have done so at some point in their life but their circumstances may have changed, for example as a consequence of relationship breakdown. This may be worth further investigation to inform future commissioning of housing, health and care services for this population.

Housing advice data suggests that 16% of enquiries in 2014/15 relate to the private rented sector (710 households). Preventions data highlights that 7% of these (49 households) were enabled to remain in their tenancies through negotiation or legal advocacy. (Homelessness was also prevented through resolving rent arrears and other assistance but it is not possible to extract figures specifically for the private rented sector).

Statutory homelessness data suggests that 23% of households in 2014/15 owed the main homelessness duty were homeless because their tenancy in the private rented sector had come to an end (105 households).

Many of the people who are “struggling” in the private rented sector may not come to the immediate attention of any public services: they may not think this will offer a solution if they are aware that access to social housing is unlikely. Outcomes in this scenario are that people will continue to struggle, or may consider moving back to parents, family or friends, with the possibilities of being overcrowded and having to share facilities.

It should be noted that households who are homeless because they have been asked to leave their PRS property, and who are owed a statutory duty by the local authority, may actually be rehoused again in the private rented sector, rather than be offered a social tenancy. Legislation and guidance allows local authorities to "discharge their homelessness duty" into the PRS, as long as a "suitable" property can be secured ("suitability" includes a minimum 12 month tenancy). Very few local housing authorities accommodate homeless households in the PRS partly due to the difficulties in securing minimum 12-month tenancies and it is quicker and easier to allocate a property in the social rented sector.

It should be noted, however, that we understand anecdotally that a number of people are choosing the PRS, even where they have, or have been offered a social tenancy. Reasons for this include: - a more desirable location; more choice over properties; superior fixtures and fittings – such as new kitchens and bathrooms/shower rooms; laminate flooring; redecoration; cookers and washing machines.

Housing unsuitable for the household's needs

Unsuitable housing can include:

- Housing which is unsuitable to meet the needs of physically disabled people
- Overcrowding
- Shared housing
- Location of housing

Unsuitable for disabled people

This information relates to people with a physical disability. It should also be noted that this might include people who are "frail", as well as those with a specific disability.

There are an increasing number of disabled people in Derbyshire who need homes and facilities to meet their needs. Homes are most likely to be unsuitable as a consequence of stairs, lack of level access; lack of suitable toilet/bathroom facilities.

The current home may become unsuitable suddenly, for example if a member of the household becomes disabled after an accident or illness, or their needs and requirements from their home change more gradually over time, for example decreasing mobility in older age; progressively degenerative conditions; or as a disabled child grows from babyhood. Some people who are disabled may become homeless. Physical disabilities, and the ways in which homes may be unsuitable, vary widely.

Disabled people who live in unsuitable homes may live restricted lives, for example only being able to live in one room; may be unable to access bathing, toilet or cooking facilities; may require care and support for example to bathe.

The home's suitability for a household including a disabled person, person with a long-term condition or with functional or cognitive difficulties is acknowledged as important to health and wellbeing, recognised only in housing legislation (the Housing Grants, Construction and Regeneration Act 1996) in terms of a statutory requirement on local housing authorities to provide a Disabled Facilities Grant. There is no single measure of unsuitability in this context but the English Housing Survey suggests that at most only 7% of homes in England meet all the desired attributes of a fully accessible home.([xxi])

What are the main risks to health and wellbeing from housing which is unsuitable for disabled people?

Children and families: an unsuitable home can severely impact on the capacity, and health and wellbeing, of the parents to look after the disabled children. There are increased levels of parental stress, and other children in the family are also affected negatively.[xxii]

Working age: an unsuitable home can contribute to loss of independence, ability to work, and social isolation.[xxiii]

Older age: an unsuitable home may restrict movement around, and out of, the home, contributing to stress, anxiety and isolation, and physical inactivity. [xxiv]

What is the scale and nature of unsuitable homes for disabled people in Derbyshire?

Derbyshire and Nottinghamshire Local Authorities commissioned Ecorys and the Chartered Institute of Housing to carry out the [xxv]Disabled People's Housing Needs Study 2012, which has provided significant data. More recent information from local authorities and service providers has updated this. Source material is from the Ecorys study unless otherwise stated. The full reports can be found at: http://www.erewash.gov.uk/housing-council-tax/housing/housing-needs-and-research.html.

To begin with, there is some indication of the level of unsuitability provided by responses to First Contact. This suggests that preventing falls in the home and enabling easy access to assistance in an emergency are priorities for people – although the characteristics of these contacts is not known.

Table 6: Responses to First Contact March 2015 – February 2016

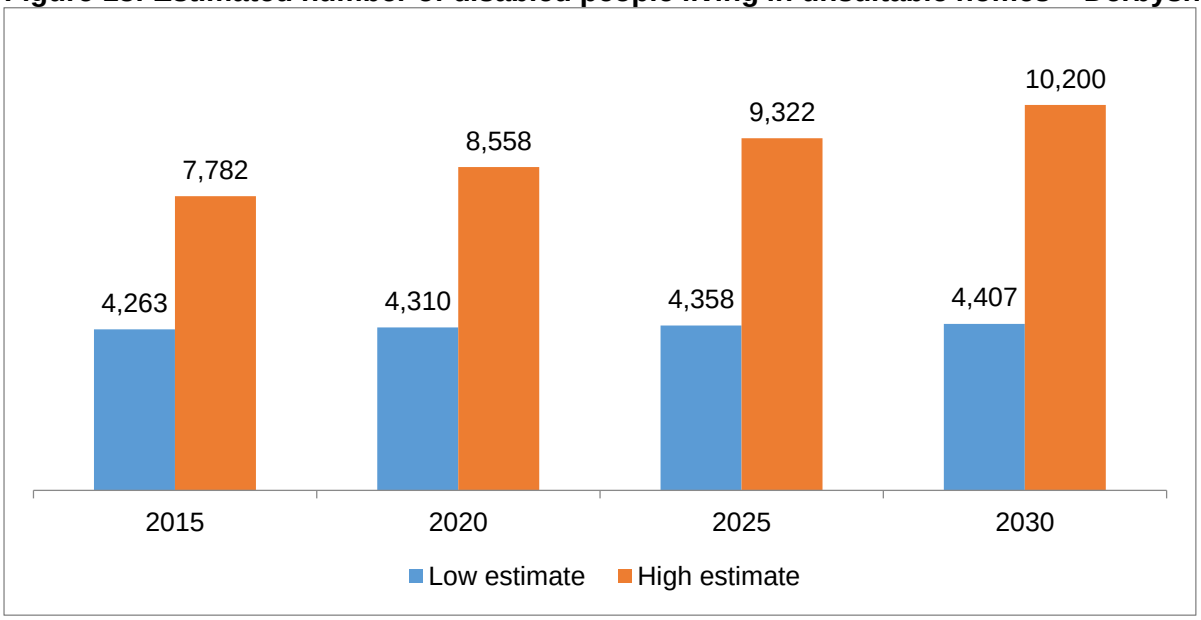
Query	Number responding yes
Would you like to discuss your existing and future housing needs with a housing options advisor?	447
Are you unsteady on your feet or have you fallen or slipped in the last 12 months? If yes, would you like a referral to the falls information service?	1,898
Do you have difficulty managing your daily living activities?	153
Would you like to be able to call for assistance at home if you get into difficulty by having a community alarm fitted?	1,725

Source: First Contact, Derbyshire County Council

Adults – disabled people aged 18 or older

In 2015, between 4,263 and 7,782 disabled people in Derbyshire were living in unsuitable accommodation, and this is predicted to rise by 2030 with estimates ranging from 4,407 to 10,200 (based on the assumption that 15.9% of disabled people are living in unsuitable accommodation, as suggested by the English Housing Survey). The range of figures is as a consequence of using two different measures.

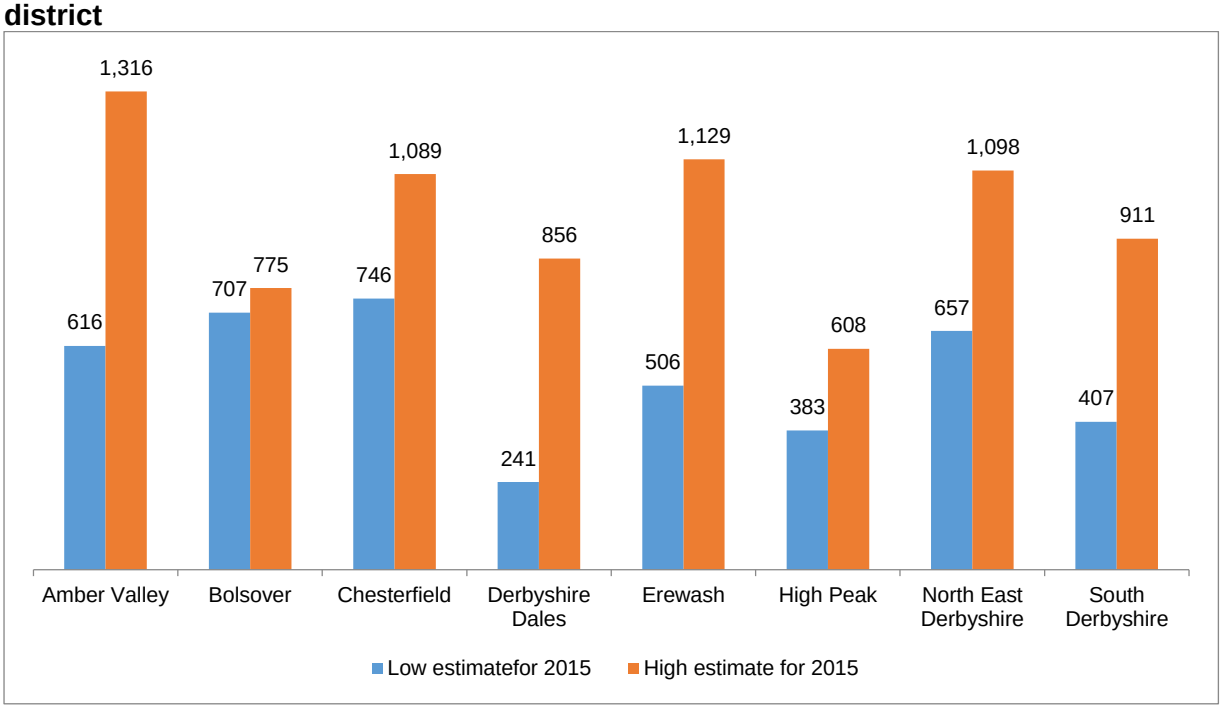
Figure 13: Estimated number of disabled people living in unsuitable homes – Derbyshire



Source: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Derbyshire statistics only

The estimates indicate particularly high levels of disabled people in unsuitable accommodation in Amber Valley, Erewash, North East Derbyshire, and Chesterfield.

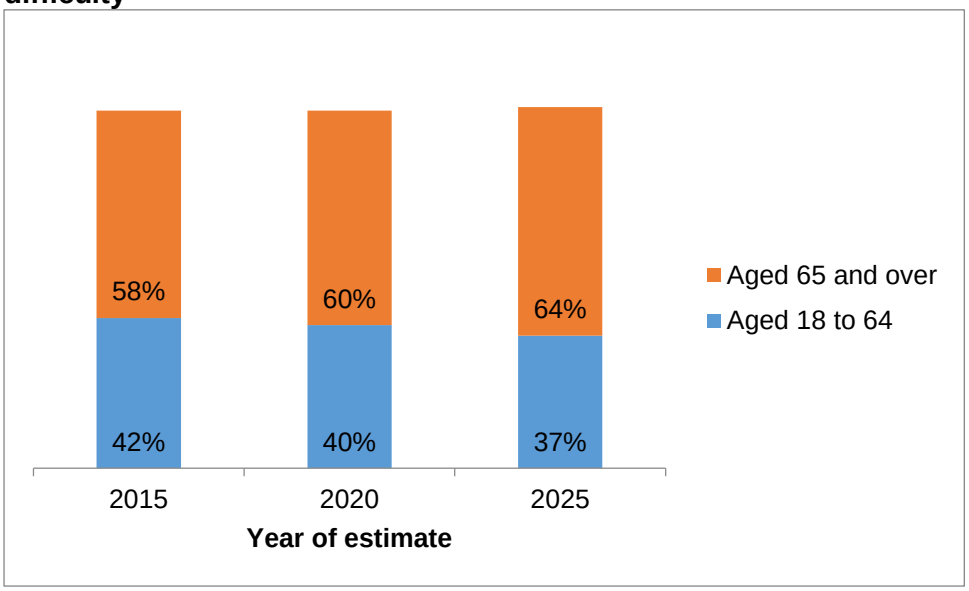
Figure 14: High and low estimates of disabled people in unsuitable accommodation – 2015 – by district



Source: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Annex one, Derbyshire statistics only.

On the higher estimates, it is assessed that 42% in Derbyshire are people of working age, with the remainder over aged 65, with some variation between local authorities.

Figure 15: Percentage of disabled people in unsuitable accommodation by age group. High estimate based on total under 65as unable to work and over 65s with at least one mobility difficulty



Source: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Annex one, Derbyshire statistics only.

Table 7: People with physical or mobility disabilities in unsuitable homes - percentage aged 18 – 64 (remainder are 65s and over)

Disabled People in unsuitable homes	Percentage aged 18-64		
Local authority	**2015**	**2020**	**2025**
Amber Valley	42%	39%	36%
Bolsover	43%	42%	38%
Chesterfield	41%	39%	36%
Derbyshire Dales	38%	35%	32%
Erewash	42%	40%	37%
High Peak	44%	41%	38%
North East Derbyshire	40%	37%	34%
South Derbyshire	47%	45%	41%
Derbyshire	**42%**	**40%**	**37%**

Source: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Annex one. Derbyshire statistics only.

It is notable that the percentage of "ageing well" disabled households in unsuitable accommodation increases over time, due to an increasing population of this age. There are less significant increases and in some cases, actual decreases in the population of younger people.

The findings of the Ecorys study are supported by more recent information from Derbyshire Home Improvement Agencies. This indicates that 29% of enquiries and services in relation to disability and mobility needs were from people under aged 60, with almost all other enquiries from people aged 60+, and almost half of all enquiries were from people aged over 75 years.

Table 8: Age range/life stage of Home Improvement Agency clients enquiring/applying for services to meet physical disability and mobility needs.

Age Range/Life Stage Percentage of total 350 cases				Age Range/Life Stage Number				
Young People Aged 18 to 25	Working Age 25-59	Older 60 -74	Older 75+	Young People Aged 18 to 25	Working Age 25-59	Older Age 60 - 74	Older Age 75+	Total
1.1%	28.0%	27.4%	43.4%	4	98	96	152	350

Source: Metropolitan Care & Repair Service data. Service in Amber Valley, Chesterfield, Erewash, North East Derbyshire and South Derbyshire 1 April 2014 to 31 March 2015
Enquiries and actions, regarding provision of services to meet physical disability and mobility needs, including adaptations, bathroom alterations, ramps etc.

Assessments for consideration of an adaptation to a home, reflects a similar picture, with 37% of assessments carried out for disabled people under the age of 65, and almost half of for people aged over 75 years.

Table 9: Assessments for consideration of a major or minor adaptation to the home of a disabled person 2015, by age

Assessments carried out in 2015 for consideration of a Major or Minor Adaptation in the Client's Home		
Age of disabled person	**Number**	**As a percentage of all assessments carried out**
19 and under	*20*	*1%*
20 to 29	*66*	*2%*
30 to 39	*108*	*4%*

Assessments carried out in 2015 for consideration of a Major or Minor Adaptation in the Client's Home		
Age of disabled person	**Number**	**As a percentage of all assessments carried out**
40 to 49	*236*	*9%*
50 to 59	*372*	*14%*
60 to 64	*180*	*7%*
Aged up to 64	***982***	***37%***
65 to 74	*478*	*18%*
75 to 84	*729*	*27%*
85+	*470*	*18%*
Aged 65 to 85+	***1677***	***63%***

Source: Derbyshire County Council Assessment records 1.1.2015 to 31.12.2015

A discussion about the difference between the number of enquiries and actual completed works in relation to home adaptations/Disabled Facilities Grants is found within the relevant section on interventions but in summary, many enquiries do not result in an adaptation, although this does not necessarily mean that this is not a need.

Limited data is available from Housing Registers about people who need to move to access housing suitable for a disabled person.

Table 10: Applicants on Housing Registers seeking a move to social housing, who have a medical needs/priority and physical disability

	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
Number of applicants	125	32	23	73	102	49	166	114

North Derbyshire were unable to supply any detailed information

Source: Housing Register information available from Derbyshire Local Authorities at February 2016

These are relatively low numbers, particularly in some areas, in relation to Ecorys data on households living in unsuitable housing (Figure 14). This would be worth further exploration (there will be a multitude of reasons, including that many people will be owner occupiers and a move to social rented housing will not meet their needs).

It is interesting that the Housing Register data indicates that, whilst there are slightly more older people (56%), there is still a large number of working age households (41%).

Table 11: Applicants on Housing Registers seeking a move to social housing, due to medical needs/priority and physical disability – by life stage

Age Range	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	South Derbyshire	Totals
Under 25								12
25 to 59	54	3	10	21	58	25	45	216
Aged 60 & over	68	29	13	52	40	22	64	288
Not stated								

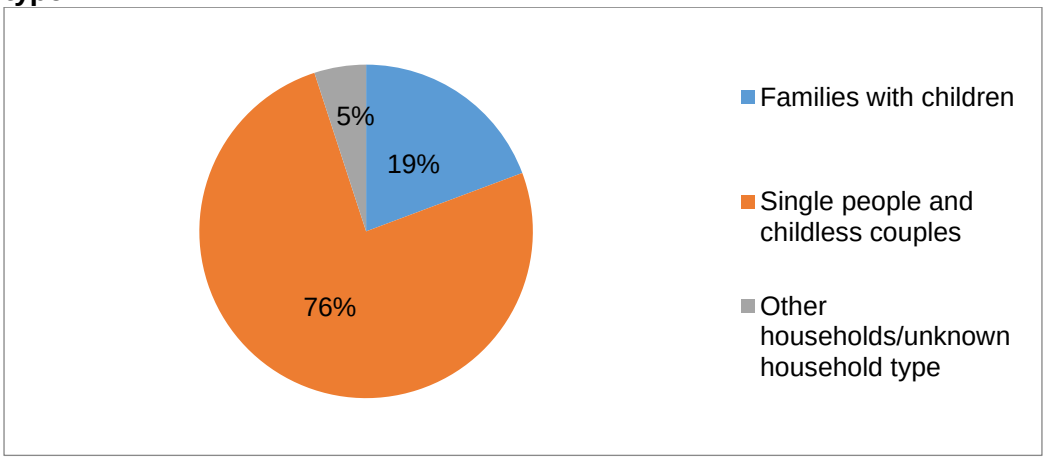
Totals	125	32	23	73	102	49	114	518

Detailed information not available from North East Derbyshire

Source: Housing Register information available from Derbyshire Local Authorities at February 2016

Information about household type suggests that 76% of those seeking a move are single people or couples.

Figure 16: Disabled people on housing registers seeking suitable accommodation by household type



Source: Housing Register information available from Derbyshire local authorities at February 2016: Applicants seeking a move to social housing, due to medical needs/priority and physical disability

Unsuitable homes can affect transfers of care from hospital. The proportion of delayed transfers of care (DTOC) as consequence of "awaiting community equipment and adaptations" is higher in Derbyshire than nationally (5.1% compared to 2.5%). Also those "awaiting a care package in their own home" may include people who are awaiting adaptations to their home, and require additional care at home in the home until these are made, for example, requiring care assistance to bathe until a level access shower is installed.

Table 12: Patients normally resident in Derbyshire, with no medical reason to remain in hospital, where discharge from hospital is prevented or delayed due to reasons which could indicate a home unsuitable to meet their disability needs.

		Numbers		Numbers of delays due to housing or awaiting community equipment & adaptations as percentage of all delayed days for all reasons	
	Total all delayed days (all reasons)	Awaiting Care Package in own home	Awaiting Community Equipment & adaptations	Awaiting Care Package in own home	Awaiting Community Equipment & adaptations
National (England)	1,625,020	206,053	41,389	12.68%	2.5%
Derbyshire	17,541	3,568	893	20.34%	5.1%

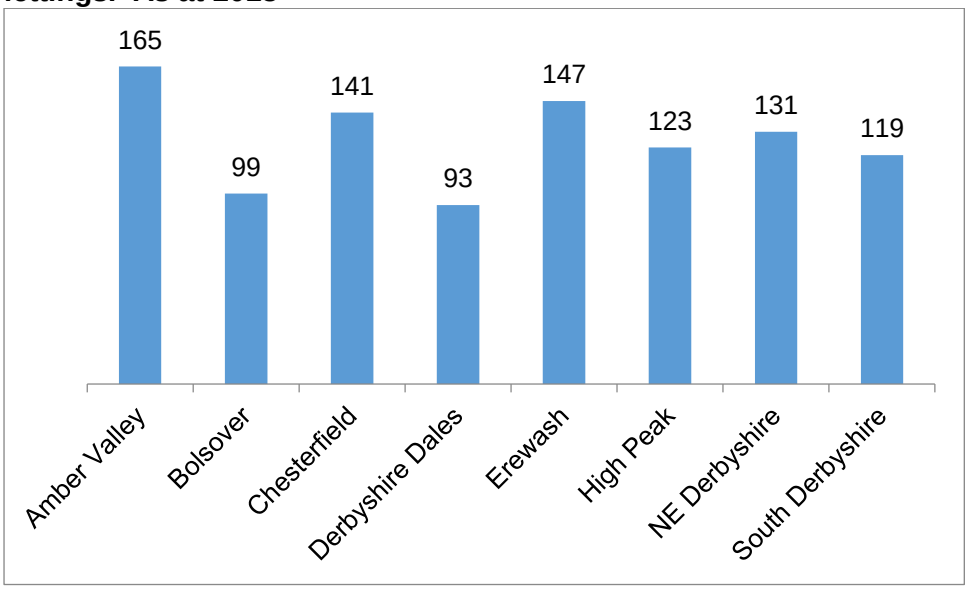
Source: NHS England. Delayed Transfer of Care Statistics for England 2014-15 Total delayed days Local Authority by month.

Information from the Healthy Futures Hospital Discharge Project at two hospitals in Derbyshire shows that four of the 23 cases they dealt with related to people who could not leave hospital due to their current accommodation being unsuitable to meet their disability or mobility needs.

Wheelchair users

Within the Ecorys estimates there is specific information about wheelchair users in unsuitable accommodation.

Figure 17: Number of wheelchair users in unsuitable accommodation, whose needs would not be met through existing provisions of Disabled Facilities Grants or existing social rented stock lettings. As at 2013

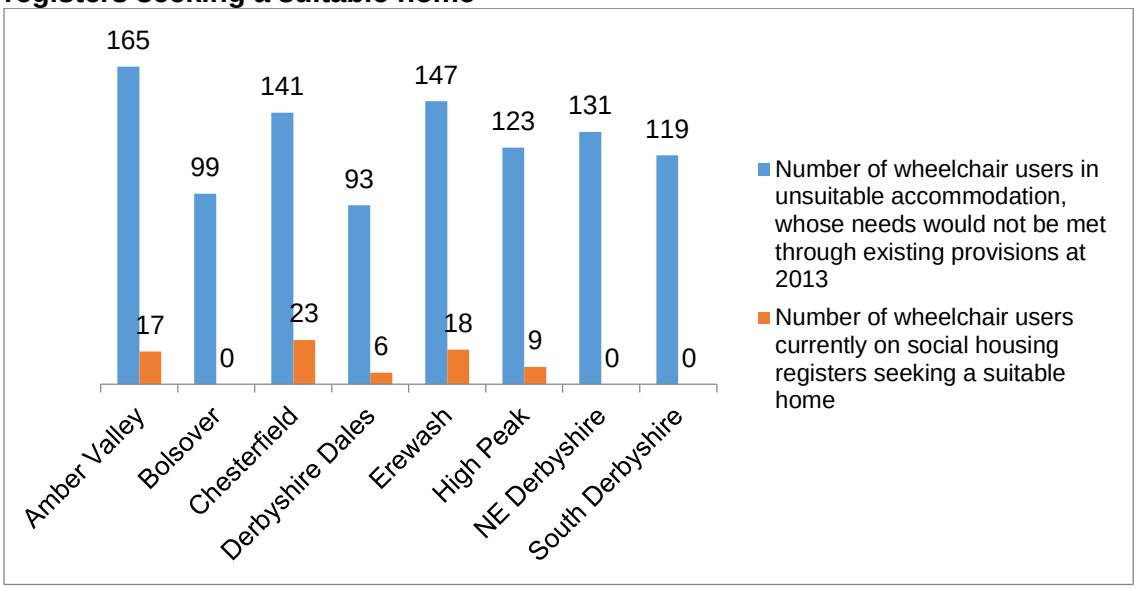


Source: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Annex one. Derbyshire statistics only. Based on Habinteg/London South Bank University study methodology

Housing Register data indicates that 73 wheelchair users (information only available from five local authorities) had applied for a social rented property, although it was not known whether this is because their current home is not suitable for this reason.

As before, the relatively low number of wheelchair users applying for a move to a social rented home – perhaps to improve suitability – is small compare to Ecorys data, and again this may be because these households are living in the owner occupied sector.

Figure 18: Number of wheelchair users in unsuitable accommodation, whose needs would not be met through existing provisions, at 2013 & number of wheelchair users currently on social housing registers seeking a suitable home



Sources: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Annex one. Derbyshire statistics only. Housing Register information available from Derbyshire Local Authorities at February 2016

Children with disabilities

The Ecorys study identified only those children who may need assistance to enable a suitable home environment, but not those who actually had a need.

Table 13: Number of children with physical disabilities (relevant to physical housing needs considerations)

	Children in Need Survey data	Special Educational Needs Children with physical disability data
Amber Valley	79	78
Bolsover	49	60
Chesterfield	79	91
Derbyshire Dales	57	59
Erewash	83	54
High Peak	90	66
North East Derbyshire	75	69
South Derbyshire	54	51
	566	528

Source: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Annex one. Derbyshire

As reported in Figure 16, Housing Register information indicates the number of families with children which contain a person with a physical disability (19%) but it is not known which household member is disabled, or if the move is to improve suitability.

Information from Derbyshire County Council Children's services showed that there were 105 applications in 2015 for a DFG for disabled children following an assessment, of which:

Table 14: Details of applications for a DFG for disabled children

Details of applications for a Disabled Facilities Grant for disabled children 2015		
Age	Under 12: Aged 12-19:	71 34
Gender	Male: Female:	64 41
Ethnicity	White: Other ethnicity:	94 11
Tenure of property	Private (could owner-occupied or private rented) Owner occupied Private rented Council tenancy Housing Association tenancy Not stated	38 10 7 29 19
Type of property	House: Bungalow	98 7
Size of property	4 bedroomed: 3 bedroomed: 2 bedroomed:	25 64 16
Number of people living in property	1 to 3 people: 4 to 5 people: 6+ :	5 55 45
Other disability	Learning disability:	24

Source: Derbyshire County Council DFG application information 1.1.15 to 31.1.15. (not including South Derbyshire)

Overcrowding

People who are overcrowded may be so for a number of reasons, for example: -

- A new household has formed and they cannot move to their own home eg, young couple or family with children living with their parents
- Since moving to their property, they have had children, or more children, or as the children have got older, they can no longer share a bedroom
- Single people sharing rooms because that is all that is available, or that they can afford – for example students or migrant workers
- Disabled people living with families may need additional rooms for equipment or carers: without this space the household may be forced to overcrowd in other rooms

What are the main risks to health and wellbeing from overcrowded homes?

Risks include tuberculosis[xxvi] (TB) and respiratory infection (children are particularly affected) and mental ill health[xxvii], particularly anxiety and depression. There is evidence that overcrowding significantly increases levels of stress within families and has a negative impact on children's education and development[xxviii]. It can lead to social problems such as low levels of tolerance, aggression and interpersonal conflicts, and limits social relationships.[xxix] Residents of overcrowded homes report higher levels of 'not good health', with households with children under 15 living in these conditions twice as likely to report this as those not[xxx].

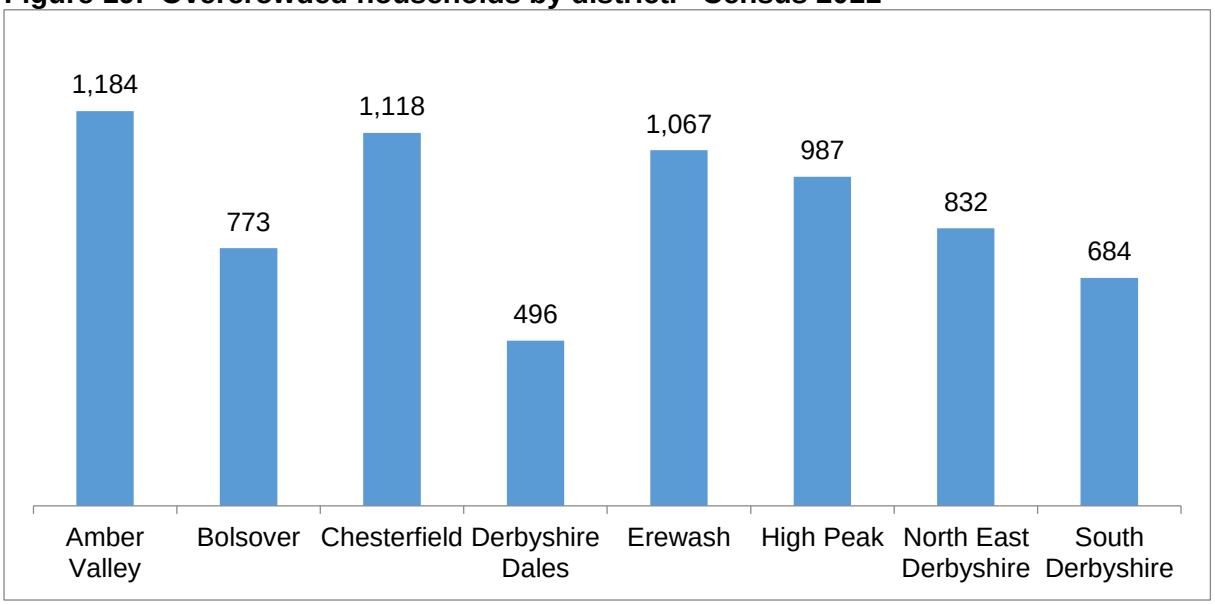
The rate of overcrowding in Derbyshire reported in the Census 2011 was 7,141 households (2.1% of all households), which is low in comparison to the national average of 8.74%. The highest rates are in High Peak (2.5%), and the lowest in Derbyshire Dales (1.6%).

Table 15: Overcrowded households in Derbyshire 2011

Local Authority Area	Overcrowded Households	Total Households	% Overcrowded
Amber Valley	1,184	52,596	2.3%
Bolsover	773	32,801	2.4%
Chesterfield	1,118	46,796	2.4%
Derbyshire Dales	496	30,744	1.6%
Erewash	1,067	48,692	2.2%
High Peak	987	38,946	2.5%
North East Derbyshire	832	43,070	1.9%
South Derbyshire	684	38,992	1.8%
Derbyshire	7,141	332,637	2.1%
England	870,540	22,063,368	3.9%
East Midlands	51,209	1,895,604	2.7%

Source: Census 2011: Occupancy rating (bedrooms) of -1 or less

Figure 19: Overcrowded households by district. Census 2011



Source: Census 2011: Occupancy rating (bedrooms) of -1 or less

[2]A comparison with 2001 Census data suggests that overcrowding has increased, particularly in South Derbyshire (55.6%).

Table 16: Overcrowded households. Comparison Census 2001 and Census 2011

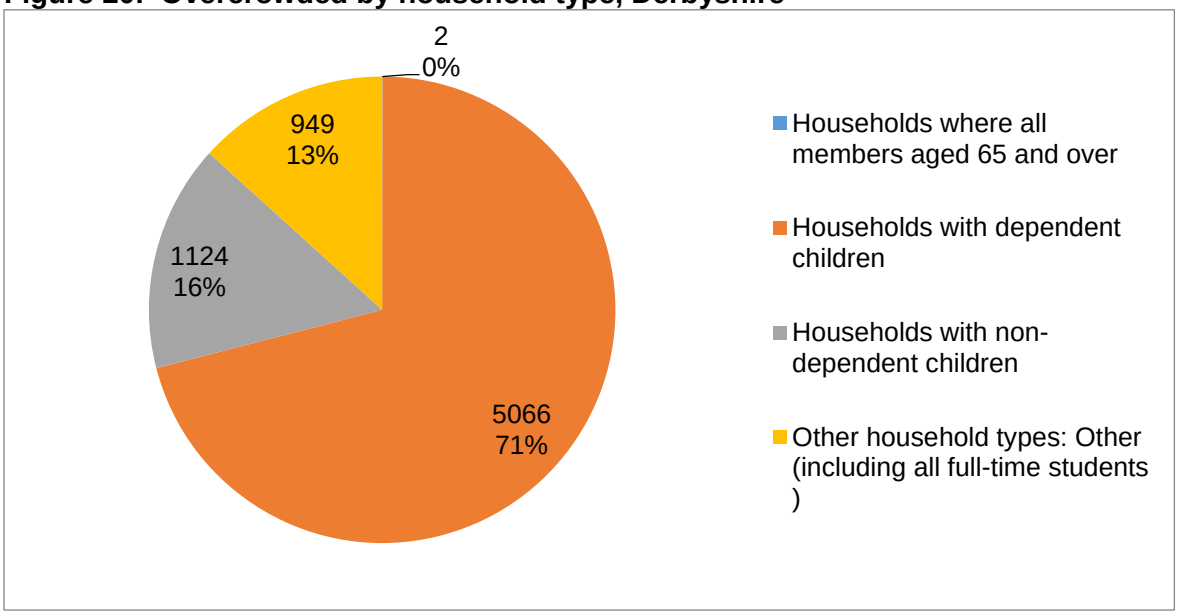
	Overcrowded households		
Local Authority Area	Census 2001	Census 2011	% increase
Amber Valley	1,260	1,697	34.7%
Bolsover	932	1,098	17.8%
Chesterfield	1,562	2,207	41.3%
Derbyshire Dales	945	1,007	6.6%
Erewash	1,471	1,794	22.0%
High Peak	1,587	1,857	17.0%
North East Derbyshire	1,098	1,304	18.8%
South Derbyshire	810	1,260	55.6%
Derbyshire	9,665	12,224	26.7%

Source: Census 2001 & 2011: Overcrowding (Rooms)

Households with dependent children make up the majority of all overcrowded households (71%), with families with non-dependent children as 16% of all overcrowded households. This is comparable with the national profile.

[2] To compare the changes in overcrowding between the two censuses, requires using the previous method of assessing overcrowding which was on the basis that all households should have one common room and there should be one additional room for each household member. Therefore a five person household living in a five room dwelling would be considered as overcrowded.

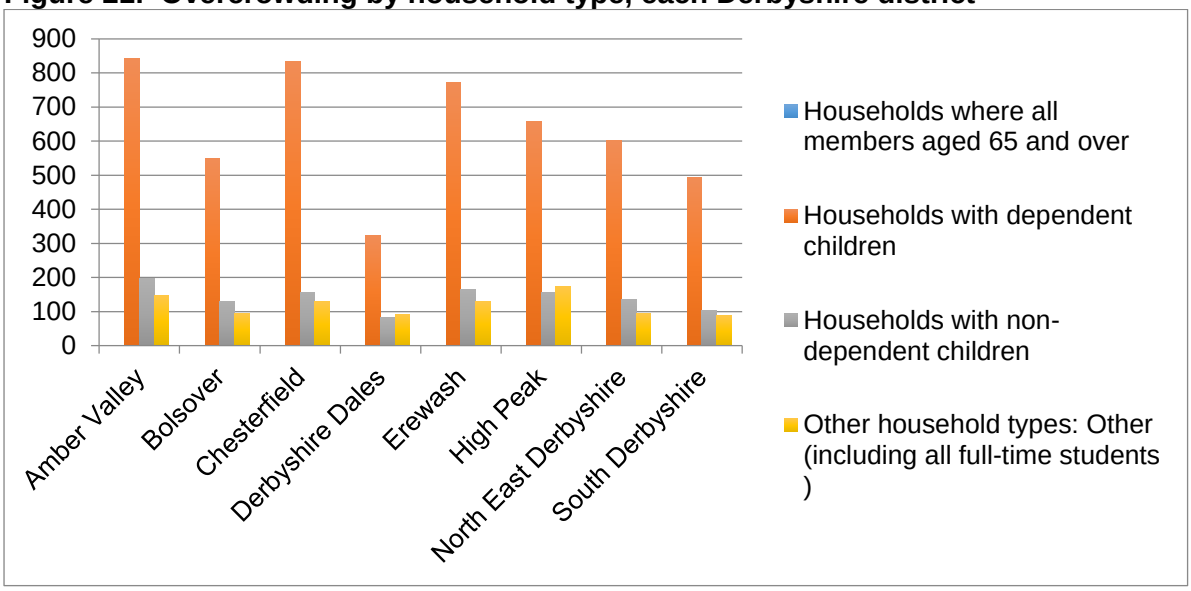
Figure 20: Overcrowded by household type, Derbyshire



Source: Census 2011: Occupancy rating (bedrooms) of -1 or less

The highest levels of overcrowding are found in Amber Valley, Chesterfield and Erewash and High Peak.

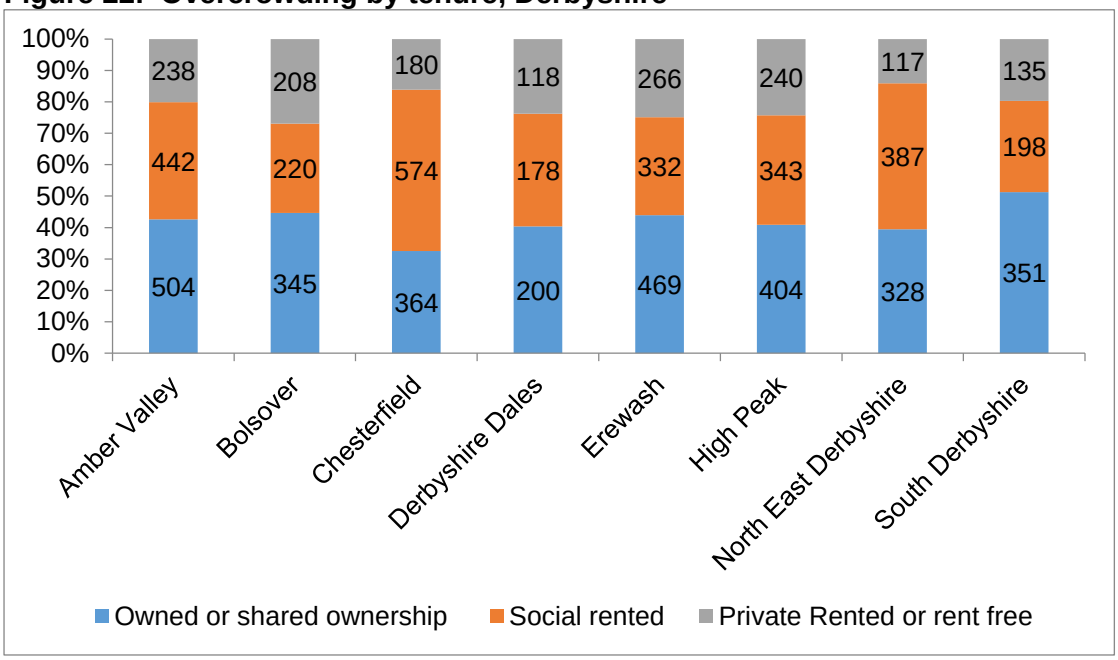
Figure 21: Overcrowding by household type, each Derbyshire district



Source: Census 2011: Occupancy rating (bedrooms) of -1 or less

The proportion of overcrowded homes in both the owner occupied and social rented sectors is higher in Derbyshire than for England (42% compared to 34%, and 37% compared to 32%, respectively).

Figure 22: Overcrowding by tenure, Derbyshire

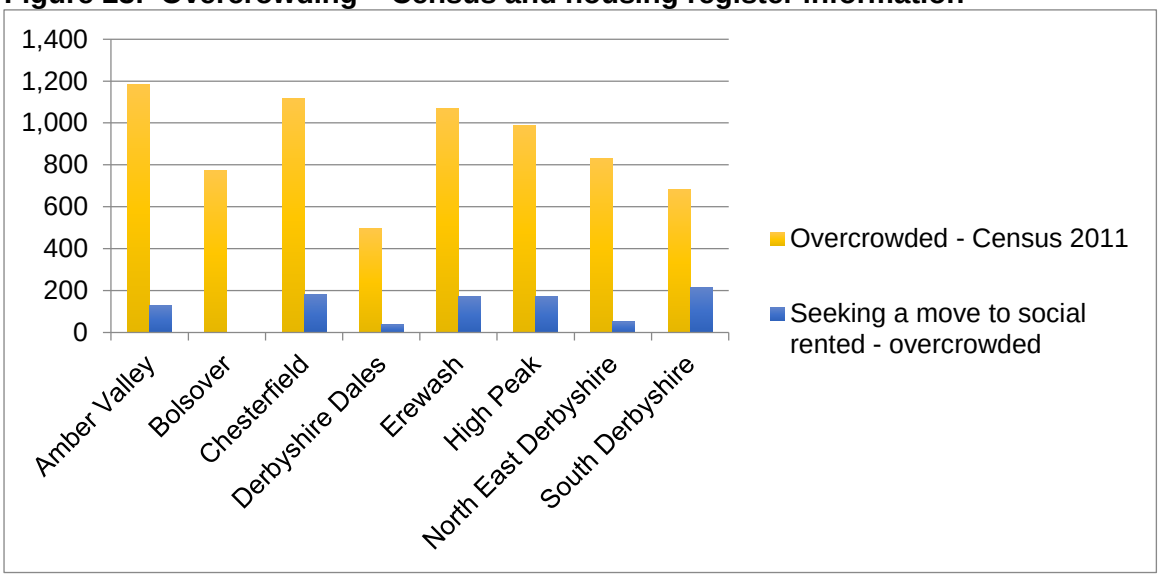


Source: Census 2011: Occupancy rating (bedrooms) of -1 or less

Local authority stock condition surveys do not all report overcrowding and have been completed at different times: this information has not been used.

Seven local authority housing registers record 967 households seeking a move to social housing due to overcrowding. This is significantly lower than the figure reported in the Census and reflects that a move into the social rented sector is not a solution for most overcrowded households, particularly as a large proportion are owner-occupiers.

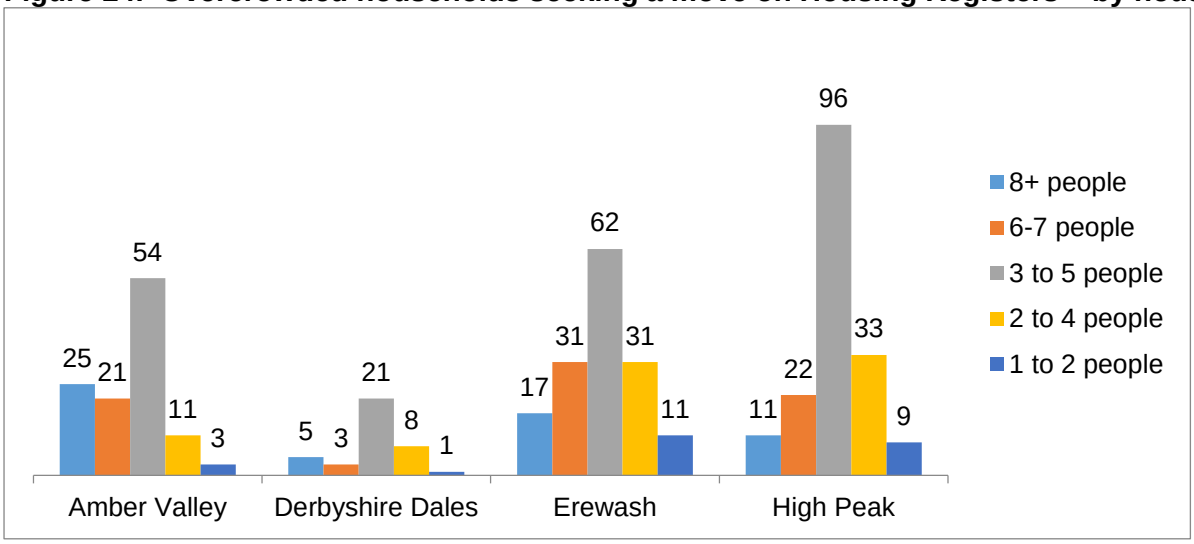
Figure 23: Overcrowding – Census and housing register information



Sources: Census 2011 and local authority housing registers (7, excl. Bolsover)

The majority of overcrowded households on housing registers are families with dependent children, and working age households, which compares with Census information. Housing register information about household size highlights that the solution to overcrowding is not simply larger homes: although there are 135 households containing six or more people, there are 107 households of just one to four members who need to move to alleviate overcrowding, suggesting they are newly formed/concealed households.

Figure 24: Overcrowded households seeking a move on Housing Registers – by household size



Source: Housing Register information available from 4 Derbyshire Local Authorities at February 2016

It is not possible to understand if the health and wellbeing of those overcrowded households on the housing register has been affected by their housing circumstances, but there is a higher likelihood that this is the case for households who have also reported a health condition. These numbers appears low and may merit further analysis.

Table 17: Overcrowded households seeking a move on Housing Registers with an identified health condition

	Amber Valley	Derbyshire Dales	Erewash	High Peak	South Derbyshire	Chesterfield	Total for the 6 local authorities
Mental ill health	5	3	6		22	0	38
Autism, ADHD, Asperger's					Information not available		7
Asthma							3
Other	5						14
Medical problem, but not given details			5				9

Bolsover Housing Register information available did not identify overcrowded households
North East Derbyshire Register information provided did not give further detail
Source: Housing Register information available from Derbyshire Local Authorities at February 2016

Housing register ethnicity data is not complete. Available information (for 245 households) suggests the majority are White British.

Table 18: Overcrowded households seeking a move on Housing Registers – by ethnic origin (where available)

Ethnic Origin	Amber Valley	Derbyshire Dales	Erewash	High Peak	Totals for 4 authorities
White - British	28	18	92	93	231
White - other	1	0	4	3	8
Asian or Asian British - Bangladeshi	0	0	1	0	1
Asian or Asian British - Other	0	2	0	0	2
Black or Black British - African	0	0	1	0	1
Mixed - White and Black Caribbean	0	0	0	1	1
Not Stated	0	0	0	1	1
	29	20	98	98	245

Source: Housing Register information available from Derbyshire Local Authorities at February 2016

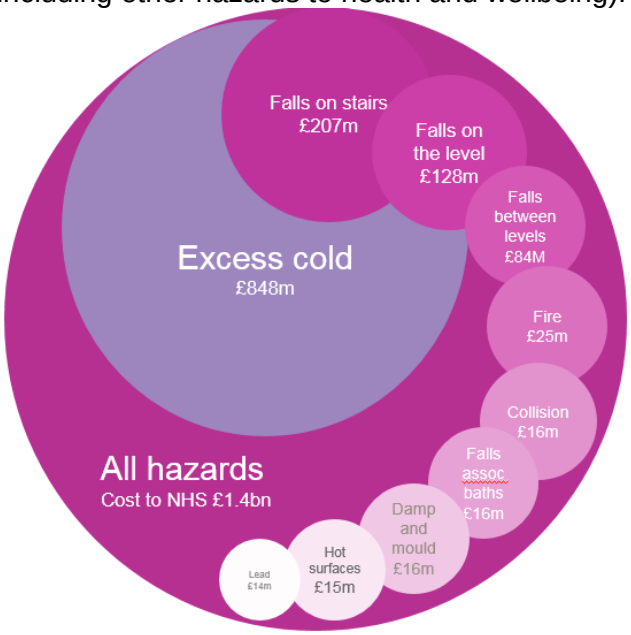
Unhealthy housing

The impact of poor condition housing on health and wellbeing is well documented and informed the Housing Health and Safety Rating System (HHSRS), introduced in the Housing Act 2004 as the most recent means by which local housing authorities 'identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings'. The underlying principle of the HHSRS is 'any residential premises should provide a safe and healthy environment for any potential occupier or visitor'. ([xxxi])

The HHSRS identifies 29 hazards to health, categorised under 'physiological requirements', 'psychological requirements', 'protection against infection', and 'protection against accidents'. Hazards are assessed and categorised, with a Category 1 hazard presenting the most extreme risk to health and wellbeing.

The 2013 English Housing Survey (EHS) reported that 1.6 million homes have a Category 1 hazard associated with a fall, whilst excess cold affects 1 million homes. Generally speaking the incidence of Category 1 hazards increases with the age of the home. The private rented sector had the highest proportion (17%) of Category 1 hazards compared with other tenures, partly because this sector had the highest proportion of homes built before 1919 and the highest proportion of converted flats, 23% of which had a Category 1 hazard. The EHS also reports that the private rented sector has doubled in size since 1996 to 19% of England's housing, whilst social rented housing and home ownership has decreased. ([xxxii])

The most recent and reliable estimate of the cost of sub-standard housing to the NHS, from the Building Research Establishment (BRE) and commissioned by Department of Communities and Local Government (DCLG), estimates first year treatment costs of between £1.4bn (Category 1 hazards only) and £2.5bn (including other hazards to health and wellbeing).



Source: BRE, The cost of poor housing to health, 2015

It is worth noting that there is no clear correlation between the degree of neighbourhood deprivation and poor housing conditions. ([xxxiii])

What are the main risks to health and wellbeing?

Almost half of all childhood injuries are associated with the physical condition of the home (every year, 1 million children under the age of 15 are taken to accident and emergency units after injuries occur in the home, many more are treated at home or by their GP[xxxiv]) and there is a greater risk of a domestic fire[xxxvxxxvixxxvii]. It is estimated that injury at home results in over 4,000 deaths in the UK annually[xxxviii].

Whilst the incidence of injuries in the home increases with age[xxxix], falls in the home can affect any member of a household, resulting in injuries which can be at worst debilitating or fatal, and are not simply the result

of declining mobility or age: only 35% of Category 1 falls hazards are associated with people over the age of 55.[xl] Typically the harm suffered from a fall is a physical impact type of injury. ([xli])

There is strong evidence of the impact of excess cold on health and wellbeing, and who is most likely to be at risk. Health effects of low temperatures include: an increased risk of respiratory and cardiovascular conditions; risk of hypothermia; impairment of the thermoregulatory system; reduced resistance to infection; healing of leg skin ulcers; increased risk of depression and anxiety. ([xliixliii]) The following people are vulnerable to the cold: people with cardiovascular conditions people with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma); people with mental health conditions; people with disabilities; older people (65 and older); households with young children (from new-born to school age); pregnant women; people on a low income. ([xliv])

Noise is a recognised hazard to health in the HHSRS: over 90,000 residential noise complaints were made in 2013/14 ([xlv]). Excessive noise interferes with people's daily activities, disturbs sleep, causes cardiovascular and psychophysiological effects, reduces performance and provokes annoyance responses and changes in social behaviour. ([xlvi]) Extreme psychological outcomes are reported to include suicide, and assault due to aggravation over noise. ([xlvii])

Poor housing impacts on wider outcomes, for instance, asthmatic children take twice as many days off school for illness as non-asthmatic children, and, controlling for relevant factors, adults are more likely to be workless after an asthma diagnosis.

What is the scale and nature of the relationship in Derbyshire?

Local housing authorities have a statutory duty to regularly assess housing conditions and to take these into account when considering the locality's housing needs. Typically this assessment was conducted through a stock condition survey, focussing on the private sector (the condition of homes in the social rented sector is in theory assessed by their owner and planned for). It is a costly exercise to complete a survey and, with most poor condition in the private sector and no funding to take action, it is common across England for local authorities to not complete these on a regular basis. Stock condition surveys in Derbyshire range from two years old to 12 years.

In response to local complaints about unhealthy housing, local authorities have a duty to assess the seriousness of any hazards to safety and health from housing and to ensure that action is taken to rectify them. The hazards are rated according to how serious they are and how likely it is that someone will be badly affected by them. A Category 1 hazard is a hazard that poses a serious threat to the health or safety of people living in or visiting a rented home. Examples of Category 1 hazards can include:

- exposed wiring or overloaded electrical sockets
- dangerous or broken boiler
- bedrooms that are very cold
- leaking roof
- mould on the walls or ceiling
- rats or other pest or vermin infestation
- broken steps at the top of the stairs
- lack of security due to badly-fitting external doors or problems with locks

The health of homes is also measured in terms of 'decency'. Decent homes should: be above a statutory minimum standard (i.e. be fit for habitation); provide a reasonable degree of thermal comfort; be in a reasonable state of repair; and provide reasonably modern facilities and services.

Derbyshire surveys, bearing in mind the time differences, suggest around 85,000 homes in the private sector do not meet this standard, and that this represents just under one third of homes in this sector (29%). This is higher than the recent figure for England: 21% of all private sector homes are non-decent.

Table 19: Number of non-decent homes in the private sector, and as a percentage of all homes in the private sector (historical records)

Local authority	Date report	Number of non-decent homes	Total Homes in Private sector	Non decent homes as a % of homes in the private sector
Amber Valley	2010	17,640	47,390	37.2%
Bolsover	2003	10,543	26,401	39.9%
Chesterfield - private sector	2007	8,309	38,004	21.9%
Derbyshire Dales	2009	12,410	32,358	38.5%
Erewash	2011	11,550	44,250	26.1%
High Peak	2009	7,061	35,730	19.8%
North-East Derbyshire	2008	11,106	32,004	34.7%
South Derbyshire	2014	6,141	37,701	16.3%
Derbyshire		84,760		28.8%

Source: Information from local authority stock condition surveys between 2003 and 2014

Surveys provide an indication of the proportion of households living in non-decent homes who were considered by a previous government as 'vulnerable' ie, a household in receipt of at least one of the principal means-tested or disability-related benefits (all ages).

Table 20: Percentage of vulnerable people living in decent homes in private sector – historical records

Local authority	Percentage	Date of information
Amber Valley	61.3%	2010
Bolsover	51.6%	2003
Chesterfield	75.0%	2007
Derbyshire Dales	58.5%	2009
Erewash	68.3%	2011
High Peak	78.5%	2009
North East Derbyshire	62.2%	2008
South Derbyshire	80.3%	2014
Government target	70%	This target ended in 2010

Source: Information from local authority stock condition surveys between 2003 and 2014

Pre-2010 the government provided capital funding to local areas to improve homes in the private sector. Information from South Derbyshire demonstrates how numbers of non-decent homes reduced significantly over the period from 2008 to 2014 (by 49.7%), in line with the national picture (32.8%): some of this will be a consequence of the capital investment, but not all (for example some improvement will be a consequence of changes in the housing market, private investment, new supply etc,).

Table 21: Number of non-decent homes comparison 2008 and 2014 South Derbyshire, including as a percentage of homes in the private sector.

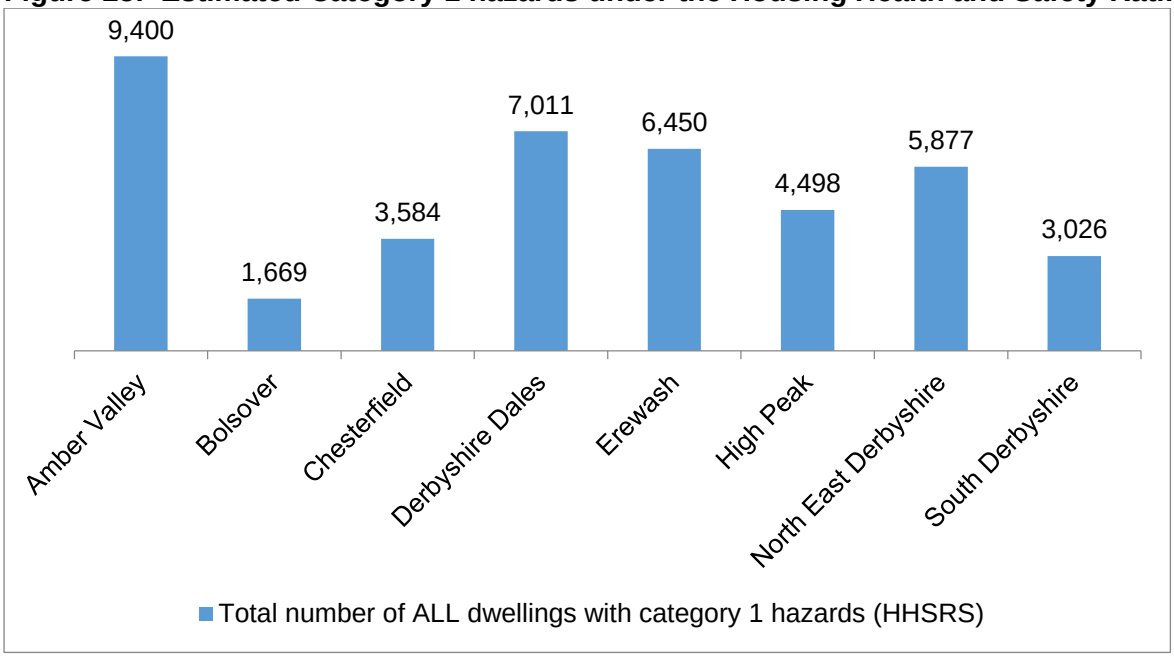
	Number of non decent homes				Non decent homes as a % of homes in the private sector				Reduction in non decent homes as a % of homes in the private sector
Local authority	Date of statistics	Number of non decent homes	Date of statistics	Number of non decent homes	Date of statistics	% non decent homes	Date of statistics	% non decent homes	% Reduction
England					2008	34.4 %	2012	23.1 %	32.8%
South Derbyshire	2008	11,300	2014	6,141	2008	32.4 %	2014	16.3 %	49.7%

Source: Information from South Derbyshire. February 2016.

It is not known whether this is the same picture across the other local authorities due to lack of up-to-date information.

Estimated Category 1 hazards are reported by local authorities to the government each year. These suggest significant issues in Amber Valley, Derbyshire Dales, Erewash and North East Derbyshire, but notably low levels in Bolsover.

Figure 25: Estimated Category 1 hazards under the Housing Health and Safety Rating System



Source: DCLG Local Authority Housing Statistics. Year ending March 2015

This demonstrates that virtually all of the Category 1 hazards are in the private sector (owner-occupied or private rented). It would not be expected that properties in the public sector (council housing or housing association) should have these hazards, which is demonstrated by the low figures (40 for the whole of Derbyshire).

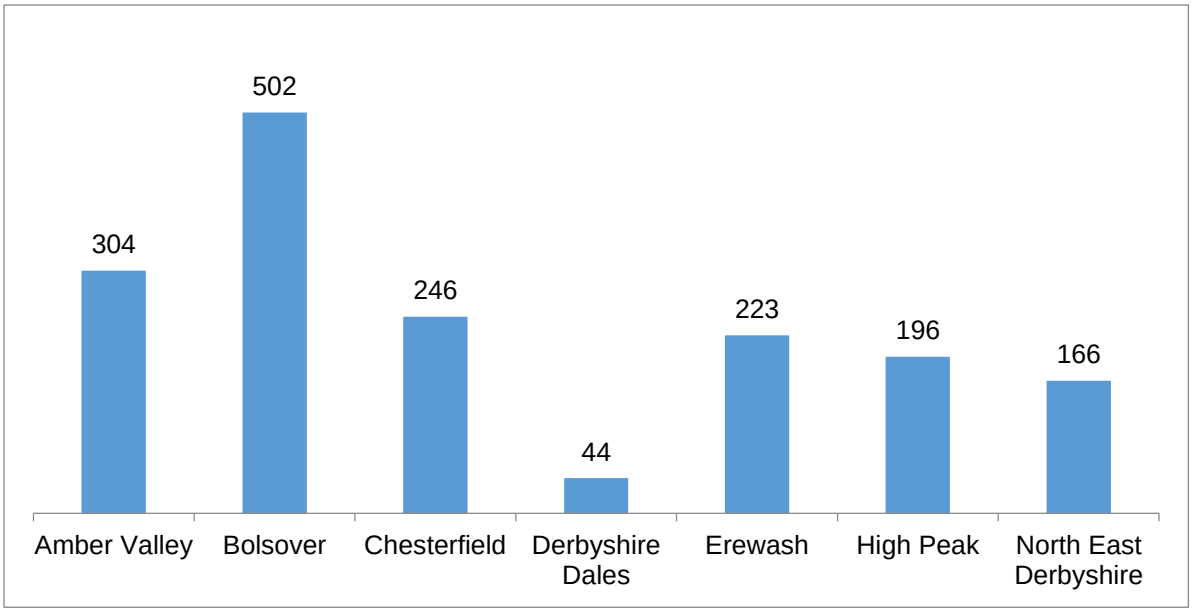
Table 22: Estimated Category 1 hazards under the Housing Health and Safety Rating System

	Total number of ALL dwellings with category 1 hazards (HHSRS)	Of which, owned by the private sector	Estimated cost (£ thousands) of removing all category 1 hazards from the private sector dwellings
Amber Valley	9,400	9,400	£5,600
Bolsover	1,669	1,664	£520
Chesterfield	3,584	3,584	£24,279
Derbyshire Dales	7,011	6,976	£9,229
Erewash	6,450	6,450	£36,700
High Peak	4,498	4,498	£2,374
North East Derbyshire	5,877	5,877	£50,123
South Derbyshire	3,026	3,026	£7,520
Derbyshire	41,515	41,475	£136,345

Source: DCLG Local Authority Housing Statistics. Year ending March 2015

An indication of the scale and nature of the issues of disrepair, unsafe and unhealthy housing currently has been drawn from the housing complaints and queries to local authority housing renewal/environmental services teams. This suggests that 1,681 homes are in disrepair and/or unhealthy and unsafe and there is some action being taken to remedy the situation (data quality is variable across the local authorities, and one property may have multiple issues).

Figure 26: Complaints and investigations re: disrepair, unhealthy, unsafe housing to local authorities 2014/15



Source: Local authority records of housing complaints and queries 1.4.14 to 31.3.15.

It is worth noting that although Bolsover appears to carry out the highest number of investigations and complaints whilst reporting the lowest estimate of Category 1 HHSRS hazards, further analysis suggests that 54% of complaints related to 'rubbish in gardens'.

Information on the type of disrepair reported to the local authorities is not of sufficient quality to draw conclusions from, nor is information provided by one of the home improvement agencies.

Unfortunately, none of the local authorities collates any information on the household living in poor housing conditions – this is a problem common across local authorities. Information from First Contact is also only available at this point on the number of responses relating to potentially unhealthy homes: the largest

number of responses relate to falls – but it isn't known whether this is an issue because of a hazard in the home, for example loose floor coverings, unprotected stairs, uneven surfaces, or because the home isn't suitable eg, would benefit from an adaptation to enable safer movement around the home.

Table 23: Responses to First Contact March 2015 – February 2016

Query	Number
Would you like information or support to help improve fire safety in your home?	668
Have you got any concerns about the security of your home?	299
Would you like advice about keeping your home warm?	312
Would you like some help or advice about arranging repairs to your home?	265
Are you unsteady on your feet or have you fallen or slipped in the last 12 months? If yes, would you like a referral to the falls information service?	1,898

Source: First Contact, Derbyshire County Council

Fire safety appears of considerable concern to First Contact customers.

Information from the Fire Service for Derbyshire shows that there were 18 cases in 2015 of fire due to disrepair in terms of faulty electrical wiring.

Table 24: Number of cases of fire due to faulty electrical wiring

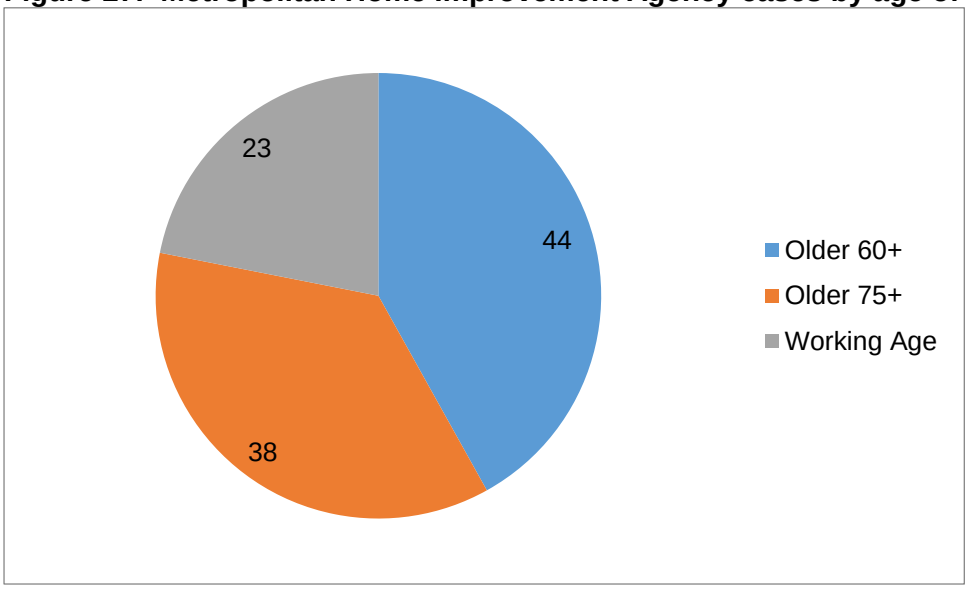
Local Authority	Number of cases of fire due to disrepair in terms of faulty electrical wiring
Amber Valley	3
Bolsover	3
Chesterfield	3
Derbyshire Dales	3
Erewash	5
High Peak	0
North East Derbyshire	2
South Derbyshire	0

Source: Derbyshire Fire Service. For January 2015 to December 2015

Three of the properties were flats in multiple occupation, and the remainder single occupancy houses. Two of the properties also had excessive and dangerous storage – indicating hoarding.

Information from one of the Home Improvement Agencies gives a little more information about the residents who are experiencing disrepair, however, this service is primarily targeted to older owner-occupiers: most clients were aged over 60.

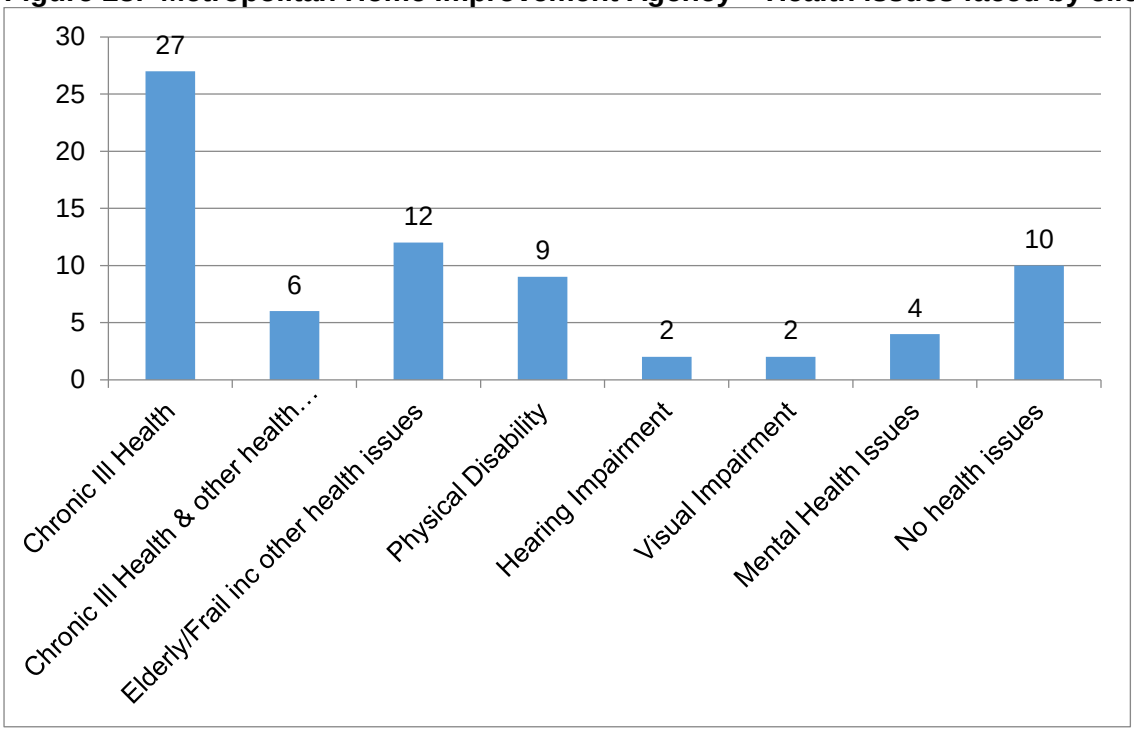
Figure 27: Metropolitan Home Improvement Agency cases by age of client



Source: Metropolitan Home Improvement Agency – covering all Derbyshire areas except Chesterfield. 1st April 2014 to 31st March 2015

There is some information about the health of clients approaching Metropolitan home improvement agency, but it is not known if ill health is a consequence of disrepair, or exacerbated by it.

Figure 28: Metropolitan Home Improvement Agency – Health issues faced by clients



Source: Metropolitan Home Improvement Agency – covering all Derbyshire areas except Chesterfield. 1st April 2014 to 31st March 2015

The other Home Improvement Agency could give figures on the number of disrepair issues (178 in 2014/15) and tenure (104 in private rented sector, 72 in owner occupied), but due to paper based records, could not give information on age, health issues of residents etc.

The significant difference between estimates of non-decent homes and those with a Category 1 hazard, and the number of complaints/enquiries made to local housing authorities is stark, and suggests there are

many households living with hazards which present a risk to their health and wellbeing who are not seeking assistance.

Table 25: Homes with Category 1 Hazards, and households approaching for assistance 2014 to 2015

Homes with Category 1 Hazards, and households approaching for assistance	
Private sector homes in Derbyshire estimated to have Category 1 Hazards at 1st April 2015	41,475
Households with disrepair issues approaching Local authority Housing Renewal teams 1.4.14 to 31.3.15	1,681
Households with disrepair issues approaching Home Improvement Agencies 1.4.14 to 31.3.15	209
Total approaches to agencies 1.4.14 to 31.3.15	1,890

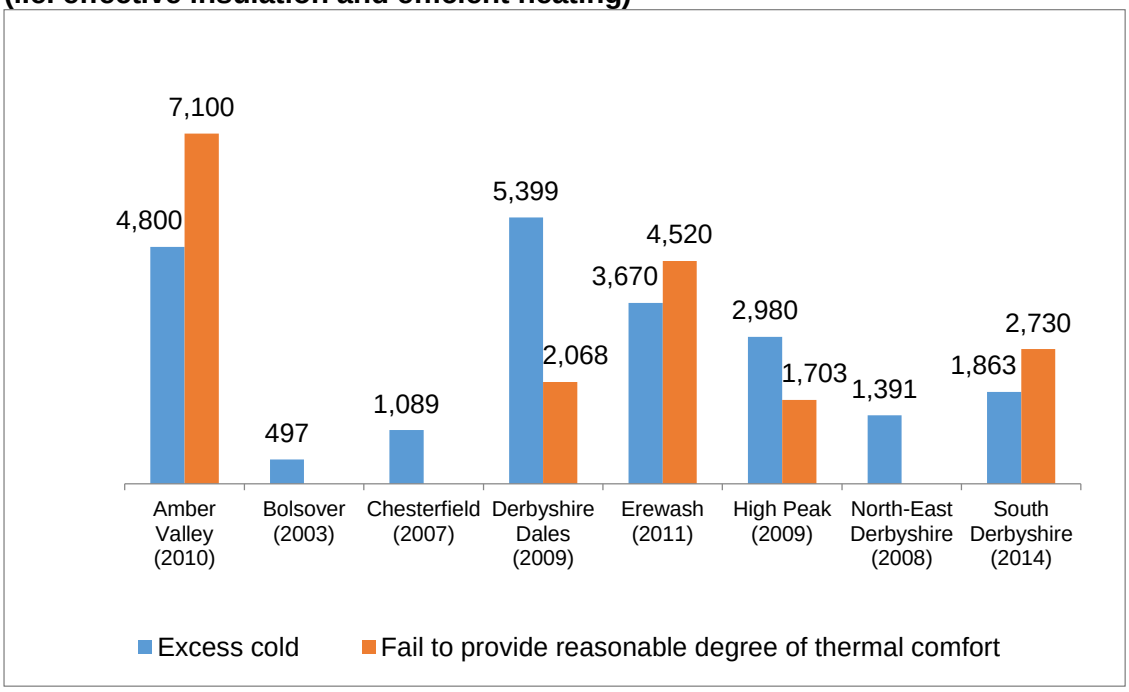
Sources:
DCLG Local Authority Housing Statistics. Year ending March 2015
Local authority records of housing complaints and queries 1.4.14 to 31.3.15.
Metropolitan Home Improvement Agency – covering all Derbyshire areas except Chesterfield. 1st April 2014 to 31st March 2015

Cold homes

Excess cold is the main hazard to health associated with unhealthy housing: further information about the scale and nature of this in Derbyshire is provided here.

Stock condition surveys, although most are many years out of date, give an indication of the number of homes, which were excessively cold or fail to provide a reasonable degree of thermal comfort (i.e. have both effective insulation and efficient heating). Amber Valley and Erewash both have high levels of both measures. Some local authorities were unable to supply some of the information.

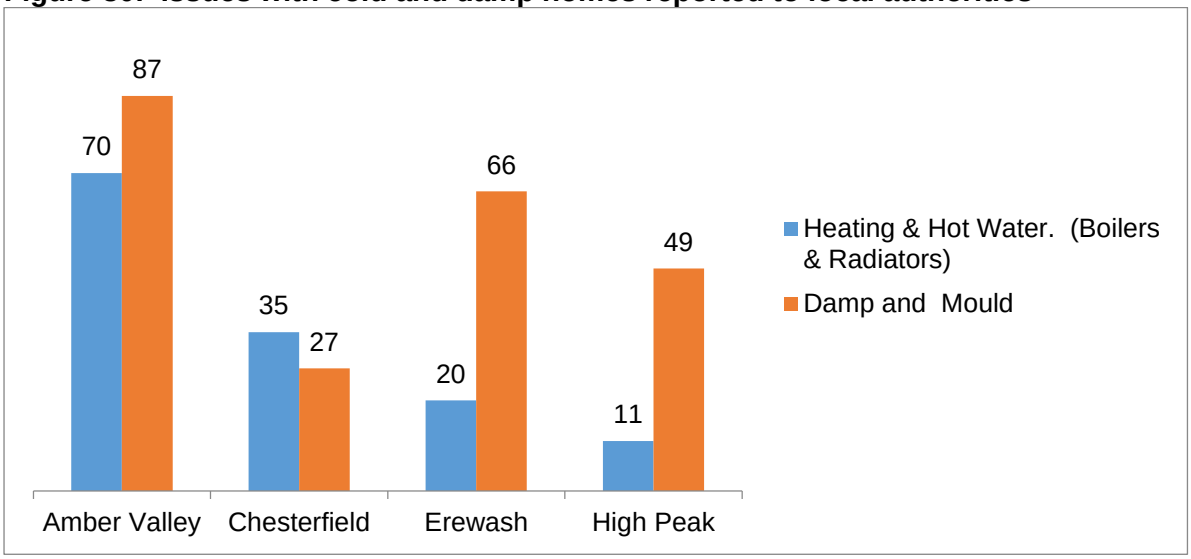
Figure 29: Estimates of excess cold and failure to provide reasonable degree of thermal comfort (i.e. effective insulation and efficient heating)



Source: Information from local authority stock condition surveys between 2003 and 2014

More recent complaints of cold and damp homes to Amber Valley and Erewash were higher than the other local authorities, reflecting the information from stock condition surveys (bearing in mind that not all local authorities could produce this information).

Figure 30: Issues with cold and damp homes reported to local authorities



Source: Local authority records of housing complaints and queries 1.4.14 to 31.3.15.

Table 26: Issues with cold and damp homes reported to local authorities

	Amber Valley	Chesterfield	Erewash	High Peak	Totals
Heating & Hot Water. (Boilers & Radiators)	70	35	20	11	136
Damp and Mould	87	27	66	49	229
Bolsover, Derbyshire Dales and North East Derbyshire do not hold information in a reportable format					

Source: Local authority records of housing complaints and queries 1.4.14 to 31.3.15.

Acknowledging the scale of the problem of many households in cold and damp homes, and in fuel poverty, the Derbyshire Healthy Home Project, has sought to target those in most need, through local GPs. During the period March 2015 to January 2016, through working with 7 GP surgeries; local authorities, Fire & Rescue Service, Adult Care and Welfare Rights in Derbyshire, they have identified 192 householders with health condition(s) made worse by living in a cold home. With the extension of the project to eighteen further GP surgeries, this will provide an ongoing source of useful data.

Data from the Derbyshire Healthy Home Project for 2014/15 reports that:

- The average age of those assisted is 72 (80% are aged 60-90)
- 55% of residents assisted are women
- 116 properties are privately owned (79%); 30 privately rented (21%)

Fuel Poverty

The term "fuel poverty" basically means that people cannot afford to heat their homes to an adequate level.

In 2010 the government used the "**10% definition":** a household was in fuel poverty if it needed to spend more than 10 per cent of its income on fuel to maintain an adequate level of warmth.

From 2012 a new **Low Income High Cost** (LIHC) definition was applied which considers a household to be in fuel poverty " if they have required fuel costs that are above average (the national median level) and, were they to spend that amount, they would be left with a residual income below the official poverty line" (i.e. they are more likely to spend an above average amount on heating their homes and be left below the poverty line as a result)

18.8% households in Derbyshire were reported to be fuel poor in 2012, using the [3]old definition of fuel poverty. This figure has been revised to 12.9% using the new [4]definition, where households are considered fuel poor if their required fuel costs are above average and spending on fuel would leave it below the poverty line.

Table 27: Levels of fuel poverty in all the district and boroughs in Derbyshire in 2010 and 2012

Fuel Poor Households	2010	2012	2012	2010	2012	2012
	10% definition		Low Income High Cost definition	10% definition		Low Income High Cost definition
Local Authority	Number of fuel poor households			% Fuel poor households		
Amber Valley	9,918	9,610	7,078	19.1	17.9	13.2
Bolsover	6,564	5,635	4,153	20.6	16.8	12.4
Chesterfield	9,191	8,028	6,217	20	16.8	13
Derbyshire Dales	7,483	9,314	4,917	24.4	29.6	15.6
Erewash	8,429	7,783	6,287	17.5	15.7	12.6
High Peak	7,027	8,248	5,281	17.8	20.7	13.3
NE Derbyshire	7,876	7,656	5,239	18.6	17.4	11.9
South Derbyshire	5,867	6,077	4,393	15.5	15.3	11
DERBYSHIRE	62,355	62,351	43,565	19.2	18.8	12.9

Source: Home Energy Conservation Act 1995 Progress Report 2015-17 on behalf of the
The Nottingham and Derbyshire Local Authority Energy Partnership (LAEP) & individual local authorities from https://www.gov.uk/government/collections/fuel-poverty-sub-regional-statistics

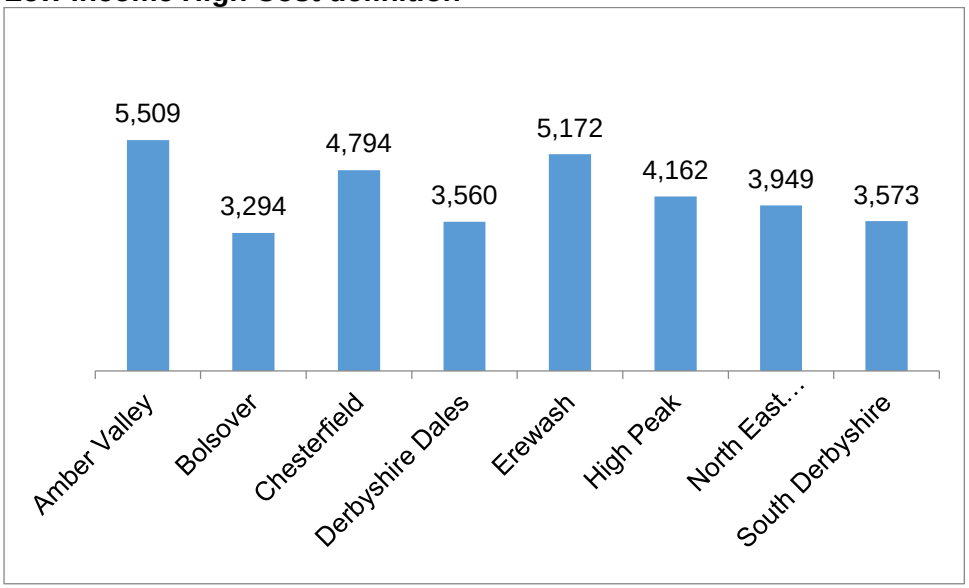
However, there has been a significant reduction in the number of fuel poor households between 2012 and 2013 using the new definition: from 43,565 households in 2012 to 34,013 households in 2013; from 12.9% of all households being in fuel poverty in 2012, to 10% of all households by 2013. The significant reduction in the number of fuel poor households since 2010 is likely to be due to the number of national and local projects and interventions.

Whilst percentages of fuel poverty as a proportion of total populations are similar across all local authorities, it is still helpful to show the number in each local authority to see the full scale.

[3] In 2010 the 10% definition was used whereby a household was in fuel poverty if it needed to spend more than 10 per cent of its income on fuel to maintain an adequate level of warmth.

[4] From 2012 a new Low Income High Cost (LIHC) definition was applied which considers a household to be in fuel poverty if they have required fuel costs that are above average (the national median level) and, were they to spend that amount, they would be left with a residual income below the official poverty line.

Figure 31: Levels of fuel poverty in all the district and boroughs in Derbyshire in 2013: Low Income High Cost definition



Source: National fuel poverty statistics, 2013
https://www.gov.uk/government/collections/fuel-poverty-sub-regional-statistics
First published 28 May 2015

In recent years the assistance available nationally to address fuel poverty has changed and, more recently, effectively ended. The rate of reduction of households in fuel poverty is unlikely to be sustained. There remain a high number of households who cannot afford to heat their homes adequately.

Falls

Falls as a consequence of unhealthy housing are identified by the BRE as the second main risk to health and cost to the NHS in England. Properties may include hazards due to disrepair or poor design, which can increase the risk of falls. Such hazards could be insecure banisters and handrails, uneven floors and crumbling outdoor steps.

Whilst we do not have any local information as to how many falls in Derbyshire are due to disrepair, there is a well evidenced link between housing conditions and falling[xlviii] and also analysis of how poor or unsuitable housing conditions increases the risk of falls.[xlix] Emergency hospital admissions for injuries due to falls are higher in Derbyshire than the averages for England.

Table 28: rates of emergency hospital admissions for injuries due to falls, per 100,000 population (2014/15 data)

Group	Derbyshire	England
65+ Person	2189	2125
65-79 Person	991	1012
80+ Person	5663	5351
	8843	8488

Source: Public Health Outcomes Framework Indicator 2.24

Derbyshire Adult Care reports that one third of those aged over 65 will fall annually, and falls are the largest cause of emergency hospital admissions. The impact of falls include:

- 10% of all people aged over 65 years who fracture their hips will die within 30 days and 30% will die within 1 year
- 50% of fragility fractures go onto fracture their hips.
- 50% never regain their current mobility
- Annual health and social costs of hip fractures is £2bn
- Falls account for 40% of ambulance call-outs to homes for people aged over 65, costing £115 per call out

The First Contact signposting service reported 1,898 people during March 2015 to February 2016, who said they were unsteady on their feet, or had fallen or slipped in the last 12 months, and wanted a referral to the falls information service.

Hoarding

Nationally, hoarding appears to be a growing problem, and has been raised as such by agencies in Derbyshire.

Hoarders will acquire or fail to throw out things that might be of little value to others, such as newspapers, flyers, bus tickets, clothes, broken equipment. It can include food. Homes and gardens and outbuildings may be crammed full of these possessions, creating little space for a person to function in a normal life, and causing health, fire and safety hazards to the household and also possibly to neighbours.

Derbyshire local authorities were notified of 36 cases of hoarding over the last year. It is not possible to further break down this data across life course stages.

Table 29: Hoarding reported to local authorities 2014 to 2015

Hoarding reported to local authorities	
Amber Valley	8
Bolsover	3
Chesterfield	6

Erewash	2
High Peak	13
North East Derbyshire	4
Totals	36

No information available from South Derbyshire.
Derbyshire Dales information does not record hoarding as a specific issue
Source: Local authority records of housing complaints and queries 1.4.14 to 31.3.15.

In recent years there have been efforts to understand hoarding and insanitary behaviour. It is sometimes, although not always, linked to Diogenes Syndrome (characterised by self-neglect, living in squalor, hoarding, apathy and social withdrawal), or to Obsessive-Compulsive Disorder (OCD), or sometimes to age and increasing inability to manage day-to-day activities. However there are cases involving children with the knock on effects this has to their development and socialisation. There are frequently questions around mental capacity and human rights and therefore a need for a multi-agency partnership approach to find the best way forward as hoarding tends to recur after interventions. The person would have an extremely difficult time parting ways with these possessions because they feel like they need to save them and feel anxiety or distress when they think about getting rid of these things.

Populations whose home environment and/or housing circumstances can particularly impact on their health and wellbeing

Offenders

Offender health is considerably worse than that of the general population: 90% of prisoners have substance misuse problems, mental health problems or both. 9% of the UK prisoner population suffer from severe and enduring mental illness and 10% of prisoners have a learning disability[I]. Poor quality housing, neighbourhoods and precarious housing circumstances are arguably more detrimental to offenders, yet it is common knowledge amongst those working in this field that it is exactly these circumstances that most offenders live in whilst in the community.

In Derbyshire accommodation is an issue for 16% of offenders supervised by the Community Rehabilitation Company (the CRC is responsible for low risk and short term offenders), with 25% of offenders also affected by health problems. For various reasons eg, quality of reporting and that not all offenders are supported by the CRC, this is likely to be an underestimate.

Table 30: Issues faced by offenders supervised by the CRC

Total No of cases	Accommodation Issues		Drug Misuse Issues		Alcohol Misuse Issues		General Health Issues	
Number	Number	%	Number	%	Number	%	Number	%
1452	229	16%	340	23%	360	25%	356	25%

Source: Snapshot data at 19.1.16 - Offender Needs - Derbyshire (not including Derby City) caseload on 19/01/2016. Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

Accommodation needs can relate to unhealthy, unsuitable and precarious housing and homelessness. For example a person may have a roof over their head but they may be living in a risky situation i.e. increased risk of re-offending, domestic violence or abuse if they were to remain in the household. Unfortunately the current national system doesn't record the actual unique circumstance of any individual.

It is also notable the percentage of offenders with issues of drug misuse (23%) and alcohol misuse (25%) for whom homelessness, insecure or unsuitable housing has the potential to exacerbate such issues. Unfortunately available data does not allow analysis of accommodation issues and health problems.

Those offenders who are of mixed race, male and of working age, face accommodation issues more than other groups.

Table 31: Issues faced by Offenders supervised under probation orders by age and life course

Life Course	Age Range	Total No of cases		Accommodation Issues		Drug Misuse		Alcohol Misuse		General Health Issues	
		No,	%	No.	%	No.	%	No.	%	No.	%
Children and young people up to the age of 25	18 - 20	97	7%	13	13%	19	20%				
	21 - 25	286	20%	41	14%	62	22%	64	22%	63	22%
Working age population	26 - 30	288	20%	53	18%	76	26%	92	32%	71	25%
	31 - 35	217	15%	30	14%	73	34%	58	27%	69	32%
	36 - 49	435	30%	74	17%	101	23%	105	24%	106	24%
Older People	50 - 64	118	8%					23	19%	29	25%
	65 +	11	1%								
		1452		229	16%	340	23%	360	25%	356	25%

Source: Snapshot data at 19.1.16 - Offender Needs - Derbyshire (not including Derby City) caseload on 19/01/2016. Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (Probation Services role)

Table 32: Issues faced by Offenders supervised under probation orders by Gender and Ethnicity

Gender	Total No of cases		Accommodation Issues		Drug Misuse		Alcohol Misuse		General Health Issues	
	No.	%	No.	%	No.					
Female	242	17%	23	10%	41	17%	46	19%	56	23%
Male	1208	83%	206	17%	299	25%	314	26%	300	25%
Not known	2	0%	0	0%	0	0%	0	0%	0	0%
	1452	54%	229	16%	340	23%	360	25%	356	25%
Ethnicity	**Total No of cases**		**Accommodation Issues**		**Drug Misuse**		**Alcohol Misuse**		**General Health Issues**	
	No,	%	No.	%	No.	%	No.	%	No.	%
Asian or Asian British	6	0%					0	0%	0	0%
Black or Black British	7	0%								
Chinese or Other Ethnic Group			0	0%	0	0%	0	0%	0	0%
Mixed	18	1%	7	39%	5	28%	7	39%		
White	1236	85%	201	16%	312	25%	320	26%	327	26%
Not Stated										
Not Recorded	177	12%	17	10%	19	11%	32	18%	24	14%
	1452	54%	229	16%	340	23%	360	25%	356	25%

Source: Snapshot data at 19.1.16 - Offender Needs - Derbyshire (not including Derby City) caseload on 19/01/2016. Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (Probation Services role)

A recent analysis of prisoner needs in HMP Nottingham (which holds prisoners connected to Derbyshire) for the period May to Oct 2015 showed accommodation was an issue for 41% of prisoners, with drug/alcohol and health problems affecting 40%.

Anecdotally the number of offenders with accommodation needs has increased.

People with learning disabilities

The Derbyshire Accommodation and Support Strategy for People with a Learning Disability 2015-2025 highlights the housing issues, summarised here.

There is potential increased demand for accommodation and support, within Derbyshire:

- Young people with severe and profound learning disabilities
- Older people with a learning disability
- Individuals with behavioural support needs (including autism)

People with a learning disability do not have the same choice of housing as other people. Research carried out by Mencap[li] identified that three out of four people with a learning disability were found to live with families, in registered care homes or in supported accommodation:

- 38% live with family and friends
- 22% live in registered care homes
- 16% live in supported accommodation.

The majority of adults with a learning disability known to Derbyshire County Council Adult Care live at home with family.

Nationally and locally it has been identified that carers are particularly concerned about the future and what will happen when they are no longer able to provide support. In Derbyshire 188 people with learning disabilities are known to live with parents/carers aged over 65, 115 of those carers are aged over 70.

In addition to an increase in older carers, the number of people with a learning disability aged over 65 is increasing. There is recognition that the prevalence of dementia in an ageing learning disability population is likely to increase.

The strategy recognises the needs of younger people with learning disabilities and their families to develop flexible, responsive accommodation and support options which utilise developments in assistive technology. Without suitable accommodation and support, therefore, there could be considerable impact on health and care services, both for the people with learning disabilities, and elderly parents or other carers. People could need to go into or remain in care settings unnecessarily.

Derbyshire Adult Care Teams identified people with learning disabilities needing accommodation in the next year. Many were living with parents, some of who were elderly and/or in poor health.

Table 33: People with learning disabilities needing accommodation in the next year, by area of current residence.

Local Authority	Number of People
Amber Valley	11
Bolsover, Chesterfield, High Peak, North East Derbyshire and Dales	20
Derbyshire Dales South	4
Erewash	14
South Derbyshire North	9
Total	58

Source: Adult Care Teams at 16th February 2016

50% of these people are aged 25 to 59 with 41% being young people aged 16 to 24.

Table 34: People with learning disabilities needing accommodation in the next year, by life stage

Life stage	Number of People	% of people
Aged 16 to 24	24	41%
Aged 25 to 59	29	50%
Aged 60+	4	7%
Not confirmed	1	
Total	58	

Source: Adult Care Teams at 16th February 2016

Whilst reasons for wanting to move were not always provided, the information gives some indication of the number of people living with relatives, (14 people) who are sometimes elderly and/or in poor health, and the number who are currently in Residential Care (6 people).

Whilst it is anticipated that in most cases, a carefully planned move to suitable accommodation can and will take a fairly long time to arrange, there were 3 people who were in, or near crisis, or homeless and for whom a rapid solution would need to be found.

Finding accommodation and living arrangements that are suitable is not always straightforward, with 5 people needing to move from their existing arrangements in independent or shared housing.

Table 35: People with learning disabilities needing accommodation in the next year, by Reason for move

Reason for move	Number of People
Want Shared Supported Living	6
Come out of Residential Care	6
Current independent accommodation unsuitable	1
Existing supported living unsuitable/match unsuitable	4
Planning for future	4
Homeless	1
In crisis, or near to	2
Living with elderly/ill relatives	4
Move out of family home	10
Move area for support/social networks	2
Require adapted property	1
Note: Reasons were not given for some people, and others had multiple reasons	

Source: Adult Care Teams at 16th February 2016

There is no evidence that people with learning disabilities are accepted by local authorities as homeless in any significant numbers. This may be because many are living with parents, who would not make them homeless by insisting that they leave the family home, but want a planned move to a suitable property.

A mixture of accommodation arrangements is needed, including accommodation with carers/support workers; shared living; and independent accommodation with visiting support. Although the information given did not always state clearly the type needed, the following gives an indication: -

Table 36: People with Learning Disabilities needing accommodation in the next year, by housing options being considered

Housing Option	Number of People considering option
Extra care	3
Independent Single Occupancy	3

Independent Single Occupancy with visiting support/care	5
Shared supported group living	20
Shared Supported Living	6
Residential Care	1
With carer	7
Not stated	16
Note: some considering more than one option	

Source: Adult Care Teams at 16th February 2016

22.4% of the people identified, have mobility issues and/or are wheelchair users who will need suitably adapted properties to meet their needs

Table 37: People with learning disabilities needing accommodation in the next year, by physical/mobility needs

Additional disability needs	Number of People
Mobility problems	4
Wheelchair user	9
Total	13

Source: Adult Care Teams at 16th February 2016

Anecdotally, supported accommodation providers have indicated that there are a number of people with learning disabilities who are housed in their hostels and shared houses, which have not been diagnosed as such, and therefore may not receive the support of appropriate services.

Five local authority housing registers report 374 people who say they have a learning disability, compared to the 58 people identified by the Adult Care Teams. They are also primarily working age.

Table 38: People on housing registers who say they have a learning disability

People on Housing Registers who say they have a Learning Disability	Number of People
Amber Valley	139
Derbyshire Dales	42
Erewash	79
High Peak	52
South Derbyshire	62
Total	*374
Note: Housing Registers of Bolsover, Chesterfield, and North East Derbyshire do not hold specific data with regard to people with Learning Disabilities	

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

Table 39: People who say they have a Learning Disability needing accommodation in the next year, by life stage

Life stage	South Derbyshire	Derbyshire Dale	Erewash	High peak	Amber Valley	Totals	%
Aged 16 to 24	13	8	10	12	38	81	22%
Aged 25 to 59	48	22	59	39	89	257	68%
Aged 60+	1	12	10	1	12	36	10%
Totals	62	42	79	52	139	374	

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

Whilst a number of people may misunderstand what is meant by "learning disabilities" when completing the form, it may also be that there are more people who are wanting to move, than those being assisted by Adult Care Teams, Those on the housing registers may also include the 58 identified by the Adult Care Teams, as they are encouraged to register to access social housing, and to be referred to other housing options.

The reasons for wanting to move are not so clear in the Housing Register group, but the existing accommodation is highlighted for about half of the applicants, indicating again as with the first group, that a significant number (37%) are living with family, and a number (22%) are in social housing, but one assumes that this is not entirely suitable as a move is wanted.

Table 40: People who say they have a Learning Disability by current accommodation

Current Accommodation	South Derbyshire	Derbyshire Dale	Erewash	High peak	Amber Valley	Totals
Living With Family or friends	4	13	11	10	31	69
Owner Occupier	0	5	1	0	3	9
Private Tenants	0	9	10	1	0	20
Social Housing Tenants	0	3	5	5	28	41
Rented - Private or Social	49	0	0	0	0	49
	Number where this information given (of total 374 applicants)					188

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

As with those identified by the Adult Care Teams, a proportion of people on the housing registers have both learning disabilities and physical disabilities.

Table 41: People who say they have a learning disability who also have a physical disability

	South Derbyshire	Derbyshire Dale	Erewash	High peak	Amber Valley	Totals
With Physical Disability	4	16	27	15	40	102
People who use wheelchairs inside and outside all the time						19

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

Adult Care staff advise that the location of accommodation for people with learning disabilities is a very important consideration, not only so that they are near to family, friends and other support and social activities, but also where they are not likely to be subject to people who may prey on their vulnerabilities.

Adult Care staff also confirm the importance not only of a suitable home in the right location, but also of the right support and care, to ensure that people with learning disabilities can live successfully.

The need for documents, from application forms to tenancy agreements which are easy to understand, is also crucial. Many people with learning disabilities will need more time than other people moving home, to

understand and prepare for a move, and all the changes this will entail. Some of these issues are covered further in the “Existing Interventions” section.

People with learning disabilities, are likely also to experience the same housing issues as others, including disrepair, cold and damp, etc, but unfortunately we do not have the records to be able to demonstrate this.

People with a drug or alcohol problem

In Derbyshire, during the period 1st April 2014 to 31st March 2015, there were: [lii]

- 15 people in urgent housing need (no fixed abode) at the start of Alcohol treatment (2% of those starting treatment)
- 52 people in urgent housing need (no fixed abode) at the start of Drug treatment (6% of those starting treatment)

There is no information available that gives a breakdown by area, age, or detailed information about the housing circumstances (for example whether they were "sofa surfing" or rough sleeping).

Information is not available on the housing circumstances of those who are exiting treatment programmes, but we are advised locally that "the numbers of people exiting treatment who have an urgent housing need would be extremely low, as service providers are unlikely to discharge someone from treatment if they were homeless as it would seriously jeopardise any treatment gains they had made".

There are 81 people on the five housing registers where we were able to extract data who stated that they had a drug and/or alcohol problem. This appears to be relatively low, from the experience of housing officers but many people may not declare this, or may not consider themselves to have a problem.

We do not have any information to know whether any, or how many, of these are trying to tackle their drug/alcohol problem, or how many have had, or have offending or anti-social behaviour, or what their health issues are. Some may be able to "function normally"; holding down a job, able to sustain a tenancy, but many may need support.

Table 42: People on housing registers (five local authorities) with a stated drug and/or alcohol problem

	Number of people on housing register with stated drug/alcohol problem	As a percentage of all of those on the housing register
Amber Valley	26	0.9%
Derbyshire Dales	13	0.8%
Erewash	15	0.5%
High Peak	24	0.6%
South Derbyshire	3	0.3%
Totals	81	0.6%

Source: Housing Register information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

However, the information may be useful in assessing the age, household type, and reason why people in drug and/or alcohol problems are seeking social housing. The main reason is that they are living with family, friends, or an ex-partner, and either being asked to leave or need/want to leave (17 people). The reasons why are not stated, but there could be difficult relationships, and/or overcrowded. (4 people need to move specifically because of overcrowding, 6 because they are sharing facilities with others) An equal number are in private rented or social housing, but want to move (17 people). For those who are trying to overcome a drug or alcohol problem, moving away from unhelpful influences may be a cause for wanting to move.

Table 43: People on housing registers (5 local authorities) with a stated drug and/or alcohol problem – by reason wanting to move to a social tenancy

Reason for wanting/needing a social tenancy	Totals
Homeless - no duty owed	7
Lacking basic facilities	
Living with family, friends or ex-partner	17
Medical needs	8
Medium social needs	5
Multiple needs	6
Move on from supported accommodation	4
Overcrowding	4
Owner occupiers	
Private rented tenants with desire to move	8
Sharing facilities	6
Social housing tenants with desire to move	9
Under occupying - Freeing up 1 bedroom	
Other/not stated	
All reasons	81

Source: Housing Register information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

The majority of those on the housing register are single people (67%), but 19% are families with children.

Table 44: People on housing registers (5 local authorities) with a stated drug and/or alcohol problem – by household type/size

Household Type/size	Totals
6+ people or 3+ children	4
Family with 2 children	6
Family, 1 child	5
Couple	6
Single Person	54
Info not available	6
All household types	81

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

The majority on housing registers are between the ages of 25 and 59 (93%), with only 1 person in the age range of 60 and over.

Approaches to local authorities for advice or assistance around homelessness or housing issues, do not give us any breakdown to identify people with drug and/or alcohol problems. Although seven people report being actually homeless, none of the local authorities accepted a statutory duty to any people stated as vulnerable due to a drug or alcohol problem.

Healthy Futures, assisting people where discharge from hospital was delayed due to housing issues, reports that 22% of the 23 clients seen during the period 1st April 2015 and 30th January 2016 had a main issue of drug or alcohol dependency or misuse (5 people).

Table 45: People with drug and/or alcohol problems assisted by Healthy Futures Hospital Discharge project 1st April 2015 to 30th January 2016

Healthy Futures Project People who cannot be discharged from hospital due to homelessness/lack of suitable accommodation 1st April 2015 to 30th January 2016
5 Clients assisted who are resident in Derbyshire and who have drug or alcohol problem
of which
2 Alcohol dependent, 2 drug misuse, 1 mental health/drug misuse/alcohol dependent
4 from CBC, 1 from SDDC
Average age 42
2 homeless due to relationship breakdown
2 homeless rough sleepers
1 homeless due to eviction from local authority accommodation

Source: Information from Healthy Futures Project for period 1st April 2015 to 30th January 2016

People with mental health problems

The 2016 Mental Health Taskforce report[liii] notes that:

"Stable housing is a factor contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.

One in five older people living in the community … are affected by depression.

People in marginalised groups are at greater risk, including Black, Asian and Minority Ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.

People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk. "

There are 984 people on five local authority housing registers who stated that they had a mental health problem. This is 8.9% of all those on those housing registers, but is particularly high in South Derbyshire (13.8%), and Amber Valley (11.5%)

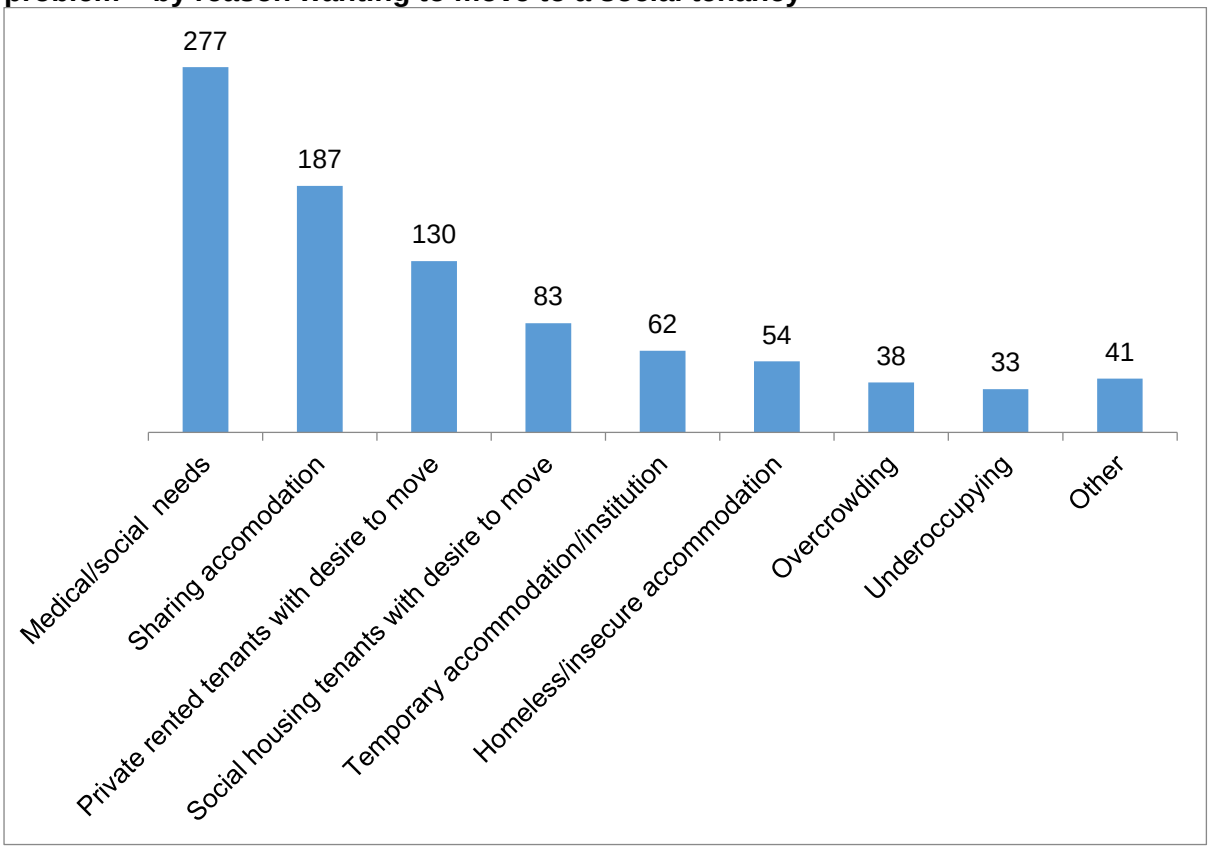
Table 46: People on housing registers (5 local authorities) with a stated mental health problem

Local authority	Number of people on housing register with stated mental health problem	As a percentage of all of those on the housing register
Amber Valley	335	11.5%
Derbyshire Dales	141	8.3%
Erewash	207	7.1%
High Peak	160	4.0%
South Derbyshire	141	13.8%
Totals	984	8.9%

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

The main reasons why people with mental health problems wanted or needed to move to a social tenancy, were medical or social needs; because they were sharing accommodation; or were in a private rented tenancy.

Figure 32: Table 47: People on housing registers (5 local authorities) with a stated mental health problem – by reason wanting to move to a social tenancy



Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016

Table 48: People on housing registers (5 local authorities) with a stated mental health problem – by reason wanting to move to a social tenancy

Reason for wanting/needing a social tenancy	Totals
Medium medical needs	189
Medium social needs	41
Multiple needs	38
Urgent medical priority	9
Medical/Social needs	277
Prevention of homelessness	21
Homeless - with duty to accommodate	16
Homeless - no duty	15
Sleeping at various addresses	2
Homeless/insecure accommodation	54
Living with family, friends or ex-partner	137
Sharing facilities	35
Lacking basic facilities	15
Sharing accommodation	187
Overcrowding	38
Private rented tenants with desire to move	130
Social housing tenants with desire to move	83

Move on	48
In Hostel/B & B	11
In hospital	
In prison	
Temporary accommodation/institution	62
Under-occupying	20
Under-occupying affected by welfare reform	13
Under-occupying	33
Other	6
Harassment/personal protection	
Major property factors - unfit	
Owner occupiers	30
Other	41
Information not available	79

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak and South Derbyshire as at February 2016.

The majority of households with someone with a mental health problem are single people (55%), but still with a significant percentage of families with children (26%)

Table 49: People on housing registers (4 local authorities) with a stated mental health problem – by household type

Household type	Amber Valley	Derbyshire Dales	Erewash	High Peak	Totals
Single Person	177	92	97	100	466
Couples	52	22	23	14	111
Families with children	92	26	57	43	218
Other Adult households			5		10
Not known	12		25		38
Totals	335	141	207	160	843

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak as at February 2016.

The majority of people with mental health problems on housing registers are in the age range 26 to 45 (42%), with around 13% in the younger (under 25s) age group, and older (60 and over) age group

Table 50: People on housing registers (5 local authorities) with a stated mental health problem – by age range

Age range	Amber Valley	Derbyshire Dales	Erewash	High Peak	South Derbyshire	
Under 25	52	13	29	28	17	139
26 to 45	134	47	104	68	60	413
46 to 55	80	36	38	37	30	221
55 and 59	28	11	14	13	19	85
60 and over	41	34	22	14	15	126
	335	141	207	160	141	984

Source: Choice Based Lettings "Housing Register" information from Amber Valley, Derbyshire Dales, Erewash, High Peak as at February 2016.

Whilst we know that 984 people with stated mental health problems are on housing registers, only 34 people were accepted as statutorily homeless and vulnerable due to mental illness or disability.

Table 51: People accepted as statutorily homeless and vulnerable due to mental health problems

Local authority	Applicant, or a member of their household is vulnerable as a result of mental illness or disability
Amber Valley	2
Bolsover	1
Chesterfield	14
Derbyshire Dales	0
Erewash	3
High Peak	3
North East Derbyshire	3
South Derbyshire	8
Total	34

Source: P1E quarterly data returns on homelessness October 2014 to September 2015

Gypsies and Travellers

Information in this section is taken from The Derbyshire and East Staffordshire Gypsy and Traveller Accommodation Assessment 2014[liv], published in 2015 ("the GTAA"). The GTAA assesses the number of new pitches, permanent and transit, which are needed. Reference should be made to this document for definitions and further explanation.

Gypsies and Travellers are defined as "Persons of nomadic habit of life" even though they may have ceased to travel temporarily or permanently. The living circumstances of Gypsies and Travellers include:

- Living in "bricks and mortar" homes permanently
- Living in bricks and mortar homes, but also travelling in caravans for part of the year
- Living in caravans on a site owned by them or their family
- Renting a space for their caravan on an authorised site
- Travelling continually

Those travelling may be stopping on "transit" sites or other authorised or tolerated stopping places. Others may have no alternative but to park their caravans on private or public land without permission, and thus be moved on.

The GTAA highlights the poor physical and mental health of Gypsies and Travellers in comparison to the general population.

According to Cemlyn et al[lv], although statistical data is not currently collected within the National Health Service about the needs of Gypsies and Travellers, studies have found that the health status of Gypsies and Travellers is much poorer than the general population. Parry et al (2004) found that, even after controlling for socio-economic status and comparing them to other marginalised groups, Gypsies and Travellers have worse health than others: 38% of a sample of 260 Gypsies and Travellers had a long-term illness, compared with 26% of age and sex-matched comparators.

Significantly more Gypsies and Travellers reported having arthritis, asthma, or chest pain/discomfort than in the comparison group (22%, 22% and 34%, compared with 10%, 5% and 22% respectively).

Mental health constitutes a key health issue. Gypsies and Travellers have been found to be nearly three times more likely to be anxious than others, and just over twice as likely to be depressed, with women twice as likely as men to experience mental health problems[lvi].

A range of factors may contribute to this, including the stresses caused by accommodation problems, unemployment, racism and discrimination by services and the wider public, and bereavement.

Numerous GTAAs have reported Gypsies and Travellers in housing experiencing hostility from neighbours, and it is likely that the constant exposure to racism and discrimination has a negative impact on mental health. The Derbyshire and East Staffordshire GTAA highlighted that of respondents to their surveys, over two thirds of families living in bricks and mortar accommodation stated that they had suffered discrimination when trying to access services or had been a victim of racism or bullying

For women, long-term mental health difficulties can result from feeling trapped on a site where no one would want to live. Moving into housing is associated with depression and anxiety, and may be reflective of loss of community and experiences of racism and discrimination[lvii].

Greenfields[lviii] found that, where New Travellers moved into housing to escape violence or because of family law cases, which impacted, on their ability to live on a site, respondents reported depression and anxiety in a similar manner to Gypsies and other Travellers. In response to the consultation, Shelter noted that research is needed into mental health issues among housed Travellers, while a specialist Traveller team referred to 'Travellers psychological aversion to housing and how housing can impact on Travellers' mental and physical health'.

Parry et al[lix] found that the health impacts of residence in housing were profound, with travelling acting as a protective factor in terms of both physical and mental health. Gypsies and Travellers living in housing who travelled rarely had the worst health status of all Gypsy and Traveller groups and reported the highest levels of anxiety. Conversely, isolation from relatives and community structures has a profoundly negative impact on well being, social functioning and mental health.

The number of Gypsy and Traveller households in Derbyshire can be difficult to assess, due to travelling patterns, and the fact that most housing providers do not have a category of Gypsy or Traveller on equality and diversity monitoring forms. . The GTAA highlights that any information on local populations should be only used to assess trends.

The information, which is available, is for the study area of Derbyshire (including Derby City) and East Staffordshire, except where indicated. It is based on the number of caravan "pitches" indicating the number of households resident temporarily or permanently.

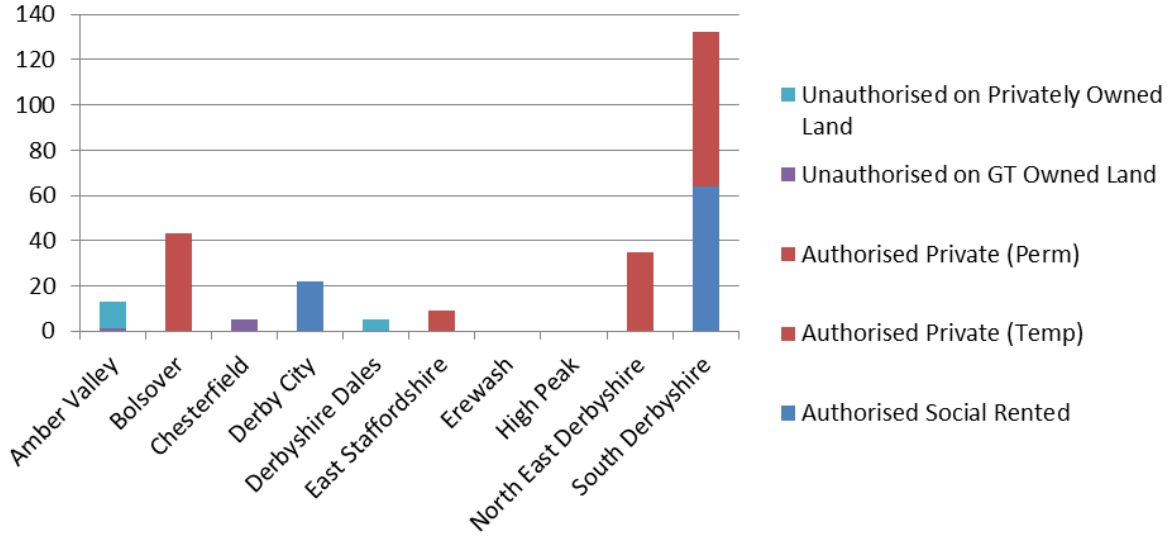
While there are deficiencies in the Traveller Caravan Count, it remains the only national source of secondary data on caravan levels and is useful for determining trends in the number of Gypsies and Travellers living on sites. This has been used in conjunction with data collected locally by Derbyshire County Council and East Staffordshire Borough Council in order to look at Gypsy and Traveller population trends and estimates in the study area.

However, Derbyshire's count is one of the lowest in the East Midlands region, and is low compared to some neighbouring counties such as South Yorkshire and Leicestershire. When population is taken into account the density of caravans within the study area varies widely with Bolsover, North East Derbyshire and South Derbyshire containing relatively high densities of Gypsy and Traveller caravans.

Data collected as part of the GTAA indicates a total provision of 168 permanent, temporary, transit, and unauthorised pitches across the study area. There are substantially more permanent private pitches (109) than local authority pitches (26), although some private pitches are occupied by single families and not commercially available for rent. The study area also contains 9 unauthorised development pitches and 21 transit pitches.

Between January 2008 and September 2013 there were 98 instances of unauthorised encampments within Derbyshire (including Derby City) a total of 1,557 days (although no records are available for the period October 2011 to June 2012). The number of caravan days per quarter varies widely. A large proportion of unauthorised encampments were due to the movements of a small number of families.

Figure 33: Caravans by District 2014



Source: From Derbyshire and East Staffordshire Gypsy and Traveller Accommodation Assessment 2014. Source CLG 2014

The survey recorded 581 Gypsies and Travellers living on authorised and unauthorised sites and encampments.

The average size of families living on the survey sites is 3.5 Gypsy or Travellers compared to a 2011 UK average of 2.4.

The survey was completed by respondents representing a fairly wide range of age groups. Over a third (39%) of respondents were aged between 31-40 years, compared to over a fifth aged 21-30 (27%). Smaller proportions of respondents were aged 41-50 years (10%), 51-60 (13%), 61-70 (8%), or aged 71 years or over (3%).

However, the households represented by the survey contained high proportions of younger people with over half (53%) of all members of respondent households being aged 20 or under.

Around two thirds (65%) of respondents completing the survey were female compared with one-third (35%) males. Although the survey was undertaken throughout all times during the day (usually between 9am and 7pm), the gender difference may reflect the likelihood that females (especially those with young children) are more likely to reside on site during the day.

The gender composition of survey households is 43% male and 57% female.

Most Gypsies and Travellers living on sites in the study area described themselves as Romany Gypsies (71%) compared with Irish Travellers (28%) (One respondent described himself or herself as 'other').

'Bricks and mortar' accommodation

There are also Gypsies and Travellers living in bricks and mortar homes. The survey was based on 22 households; information was not given on the household characteristics such as age, gender.

Compared with respondent households living on sites, families residing in bricks and mortar accommodation were more likely to reside in publically owned housing. Importantly, whilst some families said that they were used to living in housing, over two fifths said that they did so because they had no alternative. Also, around a third of families stated they are not satisfied with living in bricks and mortar accommodation.

Housing providers do not tend to include Gypsy and Traveller categories in ethnic monitoring forms, so it is difficult to estimate population numbers.

Gypsies and Travellers living in bricks and mortar accommodation may experience all of the housing issues outlined in this Housing and Health Joint Needs Assessment, including overcrowding; the insecurity of the private rented sector; and unhealthy homes.

Unsuitability

Those living on sites may experience overcrowding; insecurity in not knowing how long they will be able to stay there; and their home may be unsuitable for any disability or mobility issues.

Precarious housing and homelessness

Those travelling, particularly those unable to park on authorised sites, may experience the issues of homelessness, although few will approach local authorities for assistance, unless they want to move into bricks and mortar accommodation.

Annex B Health and social care performance context

It is necessary to put the analysis of housing and health data into the context of relevant performance measures presented in the:

- Public Health Outcomes Framework
- The Adult Social Care Outcomes Framework
- The NHS Outcomes Framework

There are a number of measures that cut across more than one framework.

Public Health Outcomes Framework and NHS Outcomes

There is evidence of a relationship between the following public health measures, the home environment and/or housing circumstances. Most measures can be compared with the England average but not all (these do not have a red, amber or green rating).

Indicators with a yellow highlight are shared with indicators in the Adult Social Care Outcomes Framework, whilst those with a pale purple highlight are shared with the NHS Outcomes Framework.

Domain and indicator		Performance
Overarching	0.1 Healthy life expectancy	
1. Improving the wider determinants of health	1.01 Children in poverty	
	1.02 School readiness	
	1.03 School absence	
	1.04 First time entrants to youth justice system	
	1.05 16-18 year NEET	
	1.06 Adults with a learning disability/in contact with secondary mental health services in settled accomm (Also NHS 2.5ii)	
	1.09 Sickness absence rate	
	1.11 Domestic abuse	
	1.13 Reoffending levels	
	1.14 % population affected by noise	
	1.15 Statutory homelessness - acceptances	
	1.15 Statutory homelessness - in TA	
	1.17 Fuel poverty	
	1.18 Social isolation: social care users	
	1.19 Older people's perception of community safety	
2 Health improvement	2.01 Low birth weight of term babies	
	2.06 Excess weight in 4-5 and 10-11 year olds	
	2.07 Hospital admissions injuries in children	
	2.08 Emotional well-being of looked after children	
	2.14 Smoking prevalence – adults (over 18s)	
	2.15 Successful completion of drug treatment - opiate	
	2.15 Successful completion of drug treatment - non-opiate	
	2.18 Alcohol-related admissions to hospital	
	2.23 Self-reported wellbeing	
	2.24 Falls and injuries in the over 65s	
	2.24 Falls and injuries in the over 65s - aged 80+	
3 Health protection	3.03 Population vaccination coverage - children	
	3.05 Treatment completion for Tuberculosis (TB)	
4 Healthcare public health and preventing premature mortality	4.01 Infant mortality	
	4.03 Mortality from preventable causes	
	4.04 Mortality from cardiovascular diseases considered	

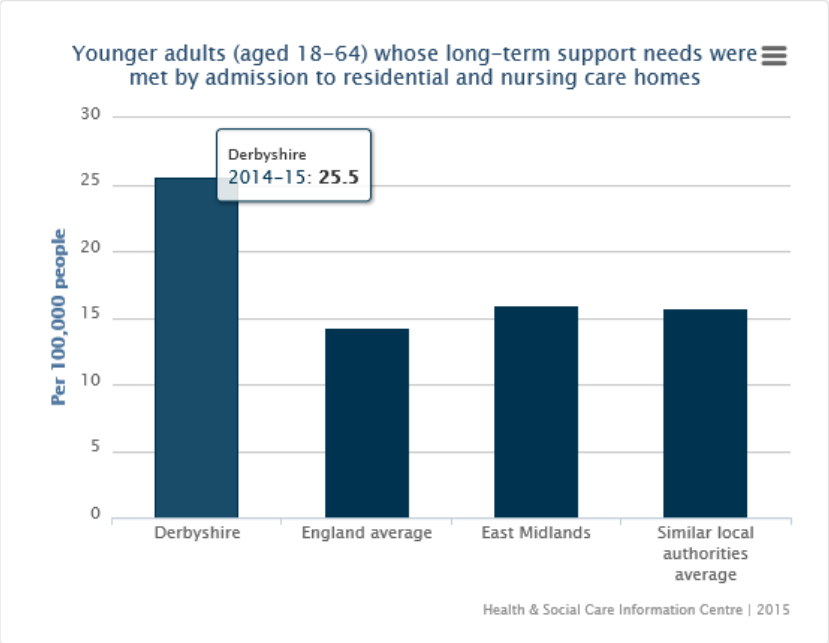
Domain and indicator		Performance
	preventable	
	4.07 Mortality from respiratory diseases	
	4.08 Mortality rate communicable diseases	
	4.10 Suicide rate	
	4.11 Emergency readmissions within 30 days of discharge from hospital	
	4.13 Health-related quality of life for older people	
	4.14 Hip fractures in over 65s	
	4.15 Excess winter deaths	
	4.16 Dementia diagnosis	

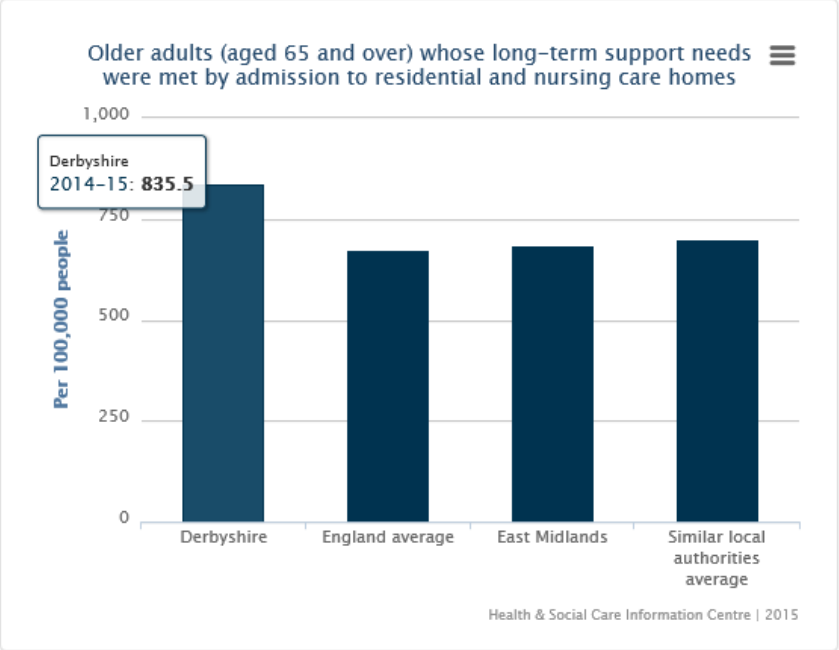
Adult Social Care Outcomes Framework (ASCOF)

In addition to the outcomes of settled accommodation for adults with a learning disability and adults in contact with a secondary mental health services (1.06 in the PHOF), there are four other measures of interest from a housing perspective in the ASCOF. These relate to delaying and reducing the need for care and support.

The number of adults aged 18 to 64, and adults aged 65 and over, who had their long-term support needs met by admission to residential and nursing care homes, compared to the population in this age group, is considerably higher than for comparable local authorities, the East Midlands and England. A lower score is better. Research suggests that, where possible, people prefer to stay in their own home. It is acknowledged however that for some client groups, admission to residential or nursing care can represent an improvement in their situation. This measure is the rate per 100,000 population.

These measures are relevant because they could indicate that there are no alternative housing solutions for people who do not need residential and nursing care but are unable to live in their current home and/or they are not able to access services in their home to support their life there and/or their home environment has contibuted to worsening health and wellbeing.



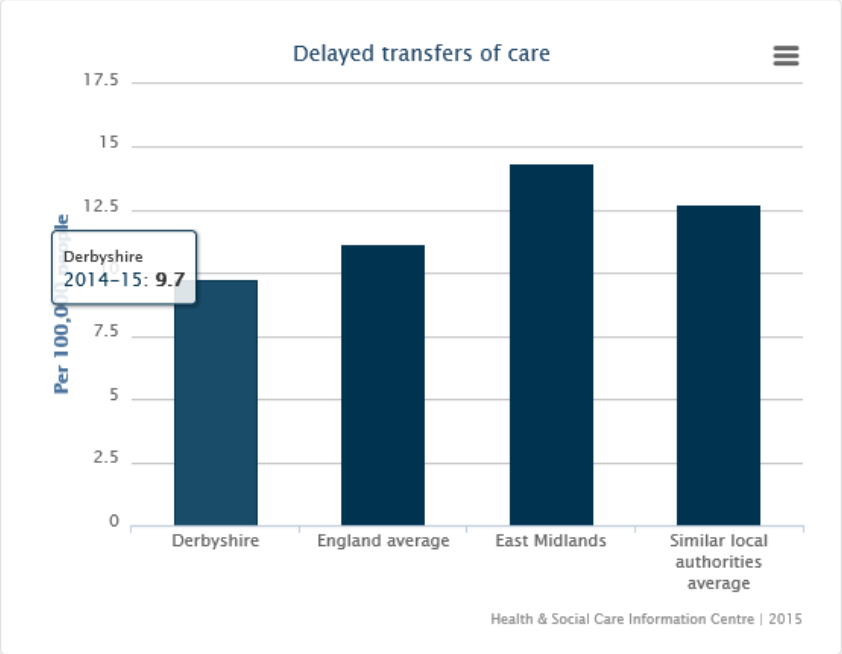


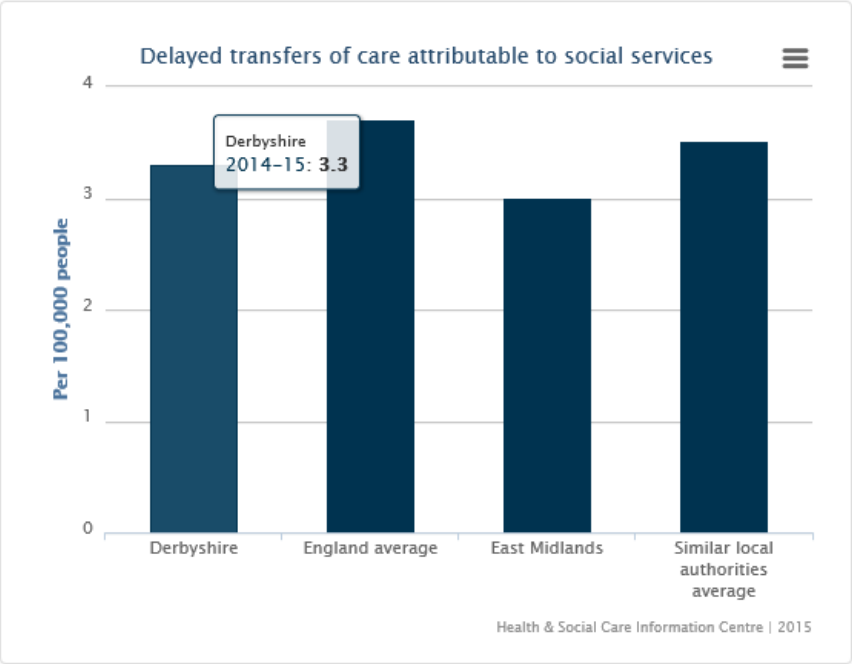
The average number of patients who have been ready to leave a hospital bed but been delayed by the NHS or social services is lower in Derbyshire than for comparable local authorities, the East Midlands and England. The average number of patients who have been ready to leave a hospital bed, but have been delayed because of waiting for social care services is broadly similar to those for England, East Midlands and similar local authorities. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but hasn't been moved. In each case a lower score is better.

These measures are relevant because they could indicate that the patient is unable to leave hospital because:

- They have no home to return to ie, they are homeless
- Their home is not suitable for their needs
- Their home does not provide a healthy environment in which to recover
- The unsuitability of the home requires the patient to receive social care

Delays may be incurred until an alternative solution is found.




Delayed transfers of care attributable to social services
Per 100,000 people
4
3
2
1
0
Derbyshire
2014-15: 3.3
Derbyshire
England average
East Midlands
Similar local authorities average
Health & Social Care Information Centre | 2015

Annex C Desktop review of local housing strategies – the local framework for homes

This aspect of the assessment sought to understand the framework provided by district councils, in their role as local housing authorities, to improve health through the home and/or housing related activities. This framework is just part of the picture in practice: the County Council and other local partners also have an influence and this was explored through stakeholder engagement.

1. The statutory framework

Local housing authorities (lower tier, single tier and unitary councils) are required by legislation to provide a strategic framework for a number of housing-related activities.

Strategy/policy	Required by	Purpose	In place?
Allocation scheme	Housing Act 1996, amended by Localism Act 2011	To allocate social rented housing to those most in need of assistance as defined by the scheme	Yes
Discharge homelessness duty into the private rented sector	The Homelessness (Suitability of Accommodation) (England) Order 2012	Only required if the local housing authority intends to discharge the main homelessness duty through the use of the private rented sector	Only High Peak known to have policy
Home Energy Conservation Act report, and progress reports from 2013 at 2 yearly intervals to 2027	Home Energy Conservation Act 1995 – secretary of state guidance	Sets out energy conservation measures that the authority considers practicable, cost-effective and likely to result in significant improvement in the energy efficiency of residential accommodation in its area.	Yes See also fuel poverty strategies
Homelessness strategy, informed by a homelessness review, at least every five years from 2002	Homelessness Act 2002	To prevent homelessness, and provide accommodation and/or support for people who are or may become homeless.	Yes
Housing assistance policy	The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002	Describes the assistance available for the purpose of improving living conditions in the area	Only four strategies, see below
Local plan	Planning and Compulsory Purchase Act 2004 (as amended)	Sets out local planning policies and identifies how land is used, determining what will be built where, including housing	Yes: not in scope of desktop review
Tenancy strategy	Localism Act 2011	To help shape the policies of social landlords in the council's area, especially on the extent to which they make use of fixed term tenancies.	In all areas except Bolsover

2. Local practice

Local housing authorities are able to provide a framework for other activities.

Strategy/policy	Purpose	In place?
Housing strategy	To set out the local housing authority's vision for housing in its area: objectives and targets and policies on how the authority intends to manage and deliver its strategic housing role; provides an overarching framework against which the authority considers and formulates other policies on more specific housing issues. The Local Government and Housing Act 1989 and Local Government Act 2003 made provisions to require a housing strategy to be formulated. The Deregulation Act 2015 removed the requirement to prepare these.	All areas with exception of High Peak
Private sector housing strategy	Direction for activity to improve housing conditions in the private sector and/or management within the private rented sector. May include intentions to reduce empty homes, demolition, renew or regeneration neighbourhoods.	Amber Valley, Derbyshire Dales, Erewash, South Derbyshire,
Fuel poverty/affordable warmth	To provide direction to reduce fuel poverty and meet carbon reduction targets. May incorporate the HECA report (earlier section)	Not in South Derbyshire
Older persons housing strategy	To provide direction to activity to meet the housing and related needs of older people	Amber Valley only
Growth strategy/housing market investment strategy	Framework for additional housing supply/regeneration to support local economic ambitions	Bolsover, High Peak, North East Derbyshire

3. Approach to the review

The desk-based review sought to answer the following questions of each strategy, policy or plan reviewed, for 'start and develop well', 'live and work well', and 'age well' (the life course approach).

Scale and nature of the challenges (the problem)

- What does the strategy plan say about the scale and nature of the relationship between the home environment, housing circumstances, health and wellbeing for each of the life courses?
- Does it demonstrate a robust understanding of all the issues ie, unhealthy homes; unsuitable homes; precarious housing and homelessness; neighbourhood environment?
- What does it say is in place/it will do to respond to identified issues?

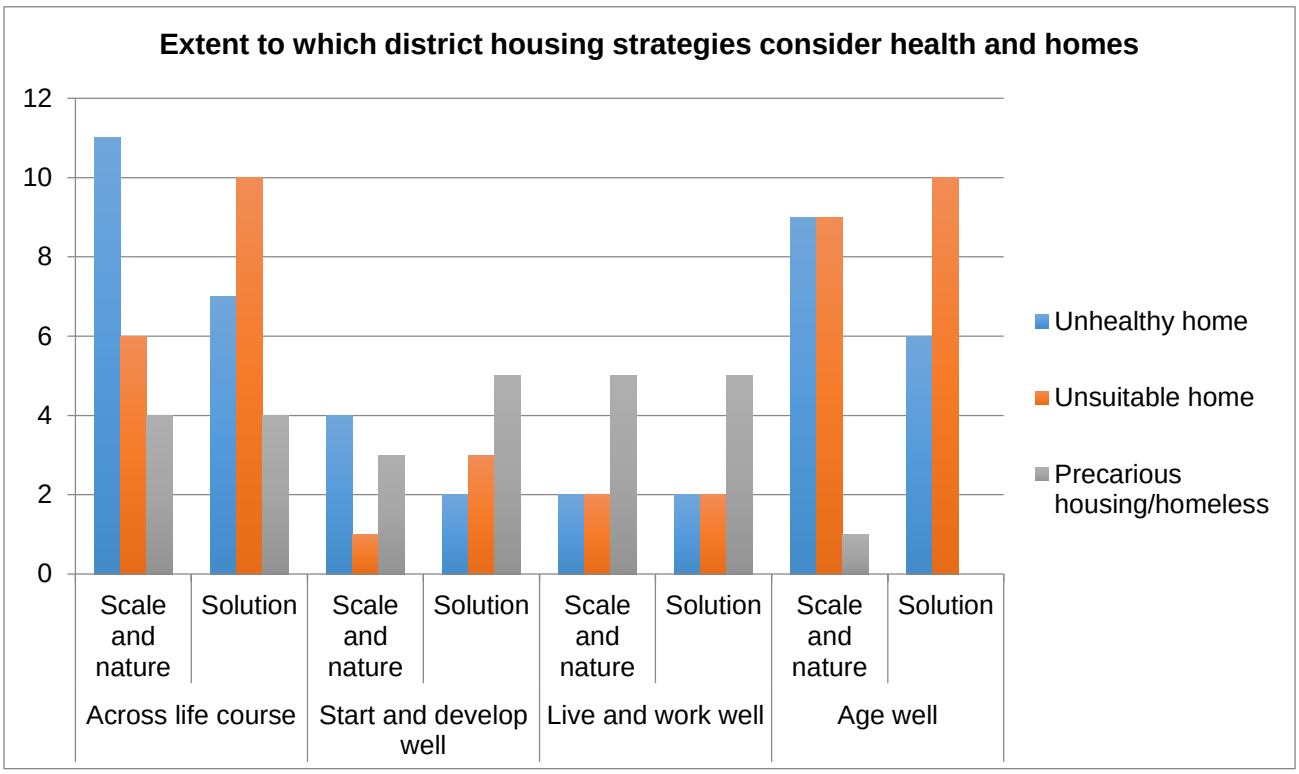
Interventions and ways of working (the solution)

- Does it clearly communicate action to address the identified issues, and how likely are these to have an impact eg, are interventions based on evidence of what works?
- Will they be delivered in partnership with others/as part of an integrated approach?

At this stage 44 district housing strategies have been reviewed, of which 30 are required by legislation. A small number of plans are cross-authority.

4. Review findings

The chart below depicts the extent to which housing strategies have answered the review questions across the life course.



4.1 Scale and nature

The main focus of attention is on the relationship between unhealthy housing conditions, health and wellbeing for all households, with a particular focus on older households (much less attention has been paid to the relationship for other parts of the population). The aspect of 'unhealthy housing' described most is cold and energy inefficient homes, and related to this fuel poverty and excess winter deaths.

Problems of unsuitable housing, for example the home does not enable mobility or independence, and the associated impact on health and wellbeing is considered primarily in relation to older people. A small number of plans recognise that people who have a long-term condition and/or disabled people may be adversely affected: the implication is that these individuals/households may be any age. Overcrowding is also referenced as a problem.

The relationship between precarious housing and homelessness, health and wellbeing, is explored in a very limited way, primarily in relation to adults with additional needs related to substance misuse or mental ill health. There is just one reference to homelessness in later life.

With a very few exceptions, strategies do not reflect any depth of understanding of specific health impacts of the home environment or housing circumstances on health and wellbeing, on specific populations. This limits confidence in proposals to use resources.

4.2 Solutions

The emphasis of solutions is on addressing unsuitability through: the allocation of social housing; interventions to improve the suitability of the existing home eg, home adaptations; alternative forms of accommodation to enable moves from unsuitable housing. Most attention is paid to the older population; the main solution specifically identified for other parts of the population eg, families with children, is the allocation of social housing.

Although unhealthy homes are recognised for their potential impact across the life course, solutions are mainly focused on the older population.

Solutions to homelessness are focused on 'starting and developing well' and 'living and working well', and these are targeted at meeting government targets, for example not using bed and breakfast accommodation to accommodate 16/17 year olds or families with dependent children for more than six weeks.

4.3 Overall

An understanding of the scale and nature of the relationship between homes, housing circumstances, health and wellbeing, as experienced by different populations is not evident in strategies. Where reference is made to health and wellbeing, housing strategies tend to do this in general terms, and mainly in reference to the intended outcome of a solution. The impact of the home or housing circumstances is, in the main, not evidence as a driver for strategic priorities or actions.

Annex D Stakeholder perspectives on homes and health

This section draws together perspectives from stakeholders in Derbyshire, gathered prior to and during the housing and health needs joint assessment. These are presented under the headings provided by the 'improving health through the home' national memorandum of understanding on housing and health that largely reflects local stakeholders' views on what should be in place in Derbyshire in 2020 (an exercise completed at the March workshop).

Stakeholders shared their views through the following opportunities (some contributed more than once):

- A housing and health needs workshop held 15 December 2014 (number of participants unknown)
- The housing and health needs assessment oversight group (10 participants)
- District strategic housing officers group meeting held 18 February 2016 (11 participants)
- Interviews completed during the assessment process (14 participants)
- Stakeholder workshop held March 2016 (16 participants)

The following stakeholders were felt to be under-represented in the assessment process, and should be engaged in subsequent activity:

- Health care commissioners and providers
- Other, non-local government, commissioners and providers who contribute to improved health through homes and housing eg, housing providers, advice providers
- Representatives of Derbyshire communities

STAKEHOLDER PERSPECTIVES

1. Systems leadership

1.1 There is a shared vision and commitment to action from leaders in the local system is evident

The stakeholder perspective is that, for Derbyshire, there is no shared vision, or joint commitment to action on homes for health from system leaders. This is despite the development of county-wide plans to integrate health care and social care eg, the Better Care Fund plan, and despite clear statutory guidance supporting the Care Act 2014 that housing is a health-related and preventive service and must be integrated.

The only Derbyshire-wide plan that was felt to have considered 'home and health' in any sense (affordable warmth) was the recently revised anti-poverty strategy. A shared vision and strategy across a wider geography is generally felt to be essential by some, desirable by others, but achieving this in practice will need a fundamental change to the current approach to commissioning for better health and wellbeing. Such a strategy is necessary to enable a shift to sustainable services.

At a local level it is felt that there is little capacity to develop, review and revise housing-related strategies eg, so that they contribute more to improved health and wellbeing. Also, even where these are in place, there is little time to deliver as the focus of local energy is increasingly on providing a reactive service to the public. The only route to overcoming this is felt to be through a combination of strong leadership across organisations, capable of challenging and changing the current position, and additional expert strategic/commissioning capacity to develop and provide direction.

On the topic of leadership, stakeholders suggested this was needed to widely communicate the reality of decreasing resources for public services and that this will necessitate a change in the decisions the public may make about their own circumstances, particularly those who are able to meet their own needs, before crisis. For example, remaining in their own home may not be the best route to independence for some people as they age, and may increase the likelihood of an injury or ill-health as a consequence and demand for health care and social care. At the moment there is no incentive to consider alternatives.

Stakeholders suggest that the 'integration paradox' is very much in existence in Derbyshire: everyone talks about the need to integrate, to work differently and together, but in practice the effect of reducing resources

has been for organisations and individuals to protect their own budgets and services. The effect of this is to increasingly focus on reacting to crises instead of making the shift to a more preventive model.

Without a Derbyshire-wide or other cross-authority vision and commitment to action it has not been necessary before now to consider whether existing groups, partnerships and associated meetings are fit for purpose in the Derbyshire context. The multitude of groups and associated meetings between organisations with an interest in homes and health in Derbyshire was first identified in December 2014, and further explored in the 2015/16 assessment. In summary, there are different perspectives on the purpose of existing groups, whether these are 'fit for purpose' and therefore should continue in a climate of tightening resources:

- A number of groups exist to serve individual district areas – these are felt to best enable local responses to local needs that may not be common in other districts
- In the absence of resources for training, development and associated travel costs, cross-authority groups provide the only opportunity to share information and learn
- There is a disconnect between governance for health and wellbeing at the upper-tier level of Derbyshire, and the housing-led groups who are in a position to enable a greater contribution from homes and housing (including those that operate across Derbyshire).
- There is evidence that existing cross-authority housing-led groups have been effective in attracting resources to Derbyshire to address issues that present a risk to health and wellbeing, notably the work of the Derbyshire Homelessness Officers Group and the Local Authorities Energy Partnership. This is despite the disconnect with health and wellbeing governance
- The disconnect is felt to contribute to missed opportunities to attract resources into the area, lack of co-ordination and duplication of activities ie, inefficient use of resources
- Better outcomes through integrated services and interventions will not be achieved if commissioning is not integrated

Annex A lists the current groups identified in the assessment process.

2. Intelligent commissioning

2.1 Organisations in the area understand their populations, their housing and health needs

The December 2014 exercise with stakeholders identified a number of potential sources of intelligence to inform commissioning homes and housing for better health and wellbeing, and the challenges associated with these. The 2015/16 assessment was only able to explore a small number of these sources, for reasons discussed in the 'scale and nature' Annex, but these include:

- Local capacity to either provide raw data and/or complete any analysis was severely limited by the need to focus on the 'day job'
- Lack of capacity to respond to every customer often means that these approaches are not always recorded and/or only recorded in relation to some types of work – pressures on services goes unnoticed, as do opportunities for preventive and early intervention
- There are varying degrees of understanding within services and also amongst some commissioners of the purpose of collecting and analysing data

These problems were widely acknowledged by stakeholders but no concrete solutions were suggested beyond:

- Making better use of the data already collected
- Improving data sharing in order to identify households at risk, enable more effective monitoring and evaluation of interventions
- Seeking alternatives to more costly approaches eg, housing stock condition surveys

Stakeholders felt that there is no common understanding of the impact of national policies and local decision making on homes, housing circumstances, health and wellbeing, specifically the impacts of

reducing housing related support provision and welfare reform. Related to the latter, it was felt that the introduction of Universal Credit would reveal failures in the current 'support' on offer to people in Derbyshire who will need to manage a reduction in their income.

2.2 Evidence of the impact of the home/housing on health and wellbeing is widely understood, accessible to and accepted by local partners

Most stakeholders agree that they do not know the impact of housing interventions on health and wellbeing, again related to local capacity and access to useful data. It was acknowledged that this is a barrier to:

- Engaging colleagues in health care and social care in discussions about the potential for better outcomes through integration
- Gaining support for public investment in improvements to homes in the private sector where this will deliver savings to the public purse
- Gaining support from elected members for investment in the local housing workforce as a preventive and proactive measure
- Understanding what actions the local authorities can already take, and what needs to be changed which is outside their immediate control or influence, for example revisions to enforcement powers to enable empty homes to be brought back into use. These changes could form the basis of devolution 'asks'
- Understanding the economic impact of improving health through the home: this will be particularly important thinking ahead to future funding through local retention of business rates.

There have been some moves to address gaps:

- Use of evidence generated elsewhere in the country eg, through academic research
- Use of case studies and real examples 'to win hearts and minds' [this is a common approach in the housing sector]
- Participation in national work eg, the Derbyshire Healthy Homes Project and the 'Healthy and Warm' project in Amber Valley were involved in recent pilots in a DECC scheme and the Healthy Home Project has contributed to the development of a DECC Health and Affordable Warmth Evaluation Toolkit.

Although stakeholders recognise the importance of co-production and that there are some existing means to engage with customers, this input isn't evidently central to understanding either what is needed or what works. It was suggested that Healthwatch could play a role in addressing this gap.

3. Effective integrated solutions

3.1 Effective, efficient, innovative and integrated health, care and support, and housing interventions/ approaches are adopted

Questions were raised by stakeholders in 2014 about how to better integrate commissioning, make best use of resources, and to enable access to services for those most in need but who perhaps do not do this currently eg, young people. Stakeholder suggestions at this time and in 2015/16 were to:

- Adopt a person-centred and holistic outcomes-based approach
    - The home environment and/or housing circumstances must be assessed at the same time as health care and social care needs
- Develop clearer and quicker pathways to better outcomes:
    - There should be no additional 'hoops' to jump through
    - Advocacy is needed by some
- Improve experience and outcomes from the first point of contact, wherever this may be
    - Make better use of the opportunities to identify risks to health and wellbeing from the home or housing circumstances eg, through every member of the 'home visiting' workforce ('making every contact count')

- Introduce a single point of access - a hub (there are different views about the best geography for the hub) supported by a multi-disciplinary teams
    - The South Normanton hub was cited as a good example [although not clear from service information how housing related needs are met]
    - The recently introduced Vulnerable Adults Risk Management Meetings (VARMM) were cited as having potential beyond safeguarding
- Inform and enable those that can take action to improve their health and wellbeing through the home
    - Housing options for owner occupiers need to be available across local authorities eg, only Chesterfield offers a home improvement loan scheme
    - Only Derbyshire Dales was cited as providing a comprehensive housing options service for older people (other services have existed but ended as a consequence of budget cuts)
- Increase availability of and access to a wider range of housing options, going beyond social housing and the provision of Disabled Facilities Grants
    - In support of this, new homes must be accessible
- Enable individuals and communities to support one another, for example: volunteering for a service such as Silver Links (this supports older people to make decisions about the home and care needs in the future); sharing a home in return for support that enables the home owner to remain independent for example Shared Lives.

The effectiveness of Call Derbyshire and First Contact in enabling people to quickly access solutions to better health through the home was questioned by some stakeholders.

Stakeholders cited a number of specific populations and/or health and care needs that would benefit from an integrated approach sooner rather than later:

- People whose home is either unsuitable now, or will be at some point in the short-to-medium term as a consequence of long term conditions and/or older age, and that will increasingly pose a risk to health and wellbeing eg, from falls
- Households experiencing homelessness: accessing housing, health care and social care was felt problematic for this population and would benefit from an integrated approach.
- The impact of homes and housing circumstances on the health and wellbeing of children and young people could be significant and if not considered early enough is likely to affect life chances, including increasing the likelihood of an adulthood with multiple and complex needs
- People with mental health problems, including people who hoard – it was felt that there isn't a wide-enough recognition of the relationship between home, housing circumstances, health and wellbeing for this population. From a housing perspective there has been some good work to try to respond to hoarding but without input from health care and social care this can only achieve so much. Also, health care and social care input may be more effective in influencing customer behaviour when they are resistant to housing interventions to remove risks.

3.2 The housing, health and care workforce is confident and equipped to deliver integrated solutions

Lack of capacity in all workforces, and lack of willingness amongst the social care and health care workforce to engage with the topic of 'home', is felt to be the main barriers to the housing workforce being able to contribute more through integrated working. Opportunities for workforce development are also limited by available resources (see section on systems leadership).

Annex A to stakeholder feedback: existing housing groups that contribute to health and wellbeing

Overall

- Derbyshire Health & Housing Group
- Derbyshire Housing Strategy Officers Group
- Derbyshire Housing & Planning Group
- Housing Market Area groups (sub-regional)
- Built Environment Group
- District Council Housing Group
- Chesterfield Health & Housing Group
- Derbyshire Planning and Health Group

Healthy homes

- Derbyshire Chief Environment Health Officers Group
- Local Authority Energy Partnership (LAEP)

Suitable homes

- Learning Disability Partnership
- Major Adaptations Group
- Move on Protocol – Derby & Wider, plus mini MOPs
- Care Act Implementation
- Carers and prevention support sub-group
- 21st Century joined–up care

Stable homes (precarious housing and homelessness)

- Derbyshire Homelessness Officers Group
- Accommodation & Support Commissioning Group
- Homeless link - East Midlands
- Traveller Issues Working Group
- Financial Inclusion Group
- Area based – local homelessness forums

Health groups

- GP Practice Care Co-Ordinator Groups (Network)
- Clinical Commissioning Group – Integrated Care

Annex E Local approaches to improving health through the home

Information compiled and collated by Tessa Paul for Derbyshire County Council Public Health, with support from Gill Leng from GLHS

Table of Contents

Note: There are additional tables and charts, collated as part of this project, in a separate document

Scope

It was not within the scope of the Housing and Health Needs Assessment to map and audit all existing housing-related interventions that improve health and wellbeing, or to identify all the opportunities for other (non-housing) services to identify a risk to health and wellbeing from the home and take appropriate action. To complete such an exercise requires leadership and 'buy-in' from those involved in commissioning and delivering services; it could be resource intensive for frontline services to respond[5].

Given this, and the timetable for the assessment, the emphasis has been on collating information on:

a) Existing housing services that are ***delivered primarily to meet statutory housing duties*** but could provide further opportunities to improve health and wellbeing. In an environment of tightening local budgets, the interventions delivered by these services must continue to exist in some shape or form. It will be of interest to understand if these services can be more effective in responding to housing needs as a means to improve health and wellbeing. These services are described at the beginning of each section.

b) Identifying other housing services that are ***delivered to prevent, delay or reduce the need for crisis services***, including statutory housing services, and are able to demonstrate actual or likely positive impact on health and wellbeing. These services are typically at greatest risk from decisions intended to reduce local expenditure: the savings they 'accrue' may be non-cashable, or be accrued by another organisation. However, these interventions offer the greatest potential to contribute to a number of improved outcomes

[5] An audit may be a subsequent action, perhaps targeted to address a specific health issue related to housing, or a population.

and generate savings to the public purse, if they are effectively commissioned eg, through joint, integrated and outcomes based commissioning. In the following section these services are presented under the heading ‘preventive services’.

There are of course a number of housing services that deliver interventions that fit into both categories.

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Informing housing choice, preventing and responding to homelessness

Housing options and advice services

These services contribute to improved health and wellbeing through addressing, in order of scale and nature of enquiries (largest first):

- Precarious housing and homelessness
- Unsuitable housing
- Unhealthy housing

All local housing authorities provide housing options/housing advice services, primarily as a means to prevent and respond to homelessness – there are a number of statutory duties in this area - but also to inform decisions to improve housing circumstances eg, a move to more suitable housing.

Accessible to households across the life course, the response to requests for assistance will vary depending on the duties 'owed' to the household. Referrals are made from many sources including: self-referrals; probation; social care; voluntary agencies such as Citizens Advice Bureau; other local authority departments; the police.

Requests for assistance primarily relate to:

- Insecurity of the private rented sector
- Risk of homelessness
- Homelessness
- Rough sleeping

Seeking to prevent homelessness forms the main part of their duties, which they will do through a range of support and advice including:

- Liaising with mortgage companies and landlords where repossession/eviction is threatened
- Mediating with parents, families and friends to encourage them to allow someone to stay, at least until an alternative home can be found
- Providing or referring to debt counselling; money management services; housing benefit sections and benefits agency to maximise income and resolve debt problems and arrears
- Liaising with support services such as social care or probation, including case conferences, to work jointly to understand and provide appropriate advice and accommodation
- Advising on/assisting access to the Choice Based Lettings housing register, including awarding priority for those at risk of homelessness
- Referring to housing providers including supported accommodation providers, housing associations or council landlords, private rented sector landlords
- Providing or referring to "Bond Bank" or "deposit" schemes to provide or guarantee deposits to secure a tenancy

Service representatives will also attend a number of multi-disciplinary meetings in Derbyshire and sometimes adjoining authority areas as a means to identify, prevent and respond to housing needs, for example MAPPA (Multi-Agency Public Protection Arrangements), which tackles the housing and related needs of prolific offenders, and Teenage Parent Implementation groups.

Derbyshire housing authorities recorded over 5,300 approaches to their housing options and advice services, a likely and significant underestimate as not all approaches eg, telephone enquiries, are recorded. For example, Chesterfield Borough Council only recorded 459 approaches, but took over 6,000 calls with regard to homelessness and housing queries; Derbyshire Dales gave face to face housing advice to 940 people, but not all were opened as cases on the system.

Table 52: Number of approaches to local authorities for housing and homelessness advice 1.4.14 to 31.3.15.

Local authority	Recorded number of "approaches" for housing /homelessness advice
Amber Valley	779
Bolsover	228
Chesterfield	459
Derbyshire Dales	186
Erewash	2191
High Peak	544
North East Derbyshire	544
South Derbyshire	467
Totals	5398

Source: Derbyshire Local Authority Housing Enquiry forms 1.4.14 to 31.3.15.

Should homeless prevention not be successful, the legislative framework for homelessness assistance requires a number of tests to be passed before the main duty is owed. These are tests of eligibility, homelessness, intentionality and vulnerability (also referred to as 'priority need'). In practice 'at risk of' and homeless households who are less evidently vulnerable eg, they cannot prove their health condition, may not be found to be owed the main homelessness duty to accommodate. This is primarily a problem of the legislation (although national homelessness bodies do suggest there is also room for improvement in practice): the government is expected to propose a change in the legislation which will require local housing authorities to provide more assistance to households who in the past have not been identified as vulnerable.

Homeless households likely to be owed a duty are accommodated in temporary accommodation, and if they are found to be owed a duty, will remain in this accommodation until settled housing is found. Only snapshot information is available on the use of temporary accommodation. At the end of September 2015 there were 58 households in this accommodation, lower than figures for the same time in previous years.

Table 53: Households in temporary accommodation, by local authority 2013 to 2015

	At end September 2013	At end September 2014	At end September 2015
Amber Valley	18	25	12
Bolsover	0	0	-
Chesterfield	18	26	11
Derbyshire Dales	10	7	11
Erewash	12	9	11
High Peak	7	7	-
North East Derbyshire	5	6	6
South Derbyshire	10	7	7
Derbyshire	80	87	58

Source: Detailed local authority level homelessness figures. DCLG

In practice, in Derbyshire, settled housing has to date meant a home is found in the social rented sector. Legislation allows local authorities to "discharge their duties" to homeless households by finding them a suitable property in the private rented sector, with a minimum tenancy term of 12 months. The low level of households owed a duty means this is possible at the moment.

Stakeholders identified the following challenges to the continuation of current services.

Demand

- Increasing numbers of people approaching the local authorities for advice and assistance
- Increasing numbers of more "complex" cases which take more resources and time to resolve
- More households placed in bed and breakfast and temporary accommodation (TA): has cost and performance target implications and affects households

Supply

- Reductions in
    - Staff to deliver the housing options and advice services: services are at breaking point
    - Housing-related support services to help people to maintain their tenancies and avoid homelessness. This is particularly because there was a considerable negative impact on homelessness in Derby City following reductions in services 2 years ago, will be experienced in Derbyshire. Also, that Derbyshire people are unable to access any Derby City Services
    - Level of input and co-operation DCC Adult Care, and timeliness (more reactive)
    - Willingness of landlords to accommodate more vulnerable clients without housing-related support
    - Homeless prevention funding for interventions [allocated from government but not ring-fenced]: this is directed by some local authorities to pay for staff
- Discretionary Housing Payments to reduce impact of welfare cuts, including Bedroom Tax, is unsustainable.
- Inconsistent approach to homeless prevention interventions across Derbyshire eg, some local authorities use second homes funding whilst others do not

Other preventive services

Pathways of Chesterfield

Health, housing support and advice to people who are homeless or at risk of homelessness

Purpose: to offer a range of support and advice to people that are homeless or at risk of becoming homeless to improve outcomes including health and wellbeing	
Why the service was set up/commissioned?	Evidence consistently shows the health of homeless and vulnerably housed individuals to be poorer than that of the rest of the population. Out of 2,590 people in 19 different areas Homeless Link Identified 73% of homeless people experience physical health problems and 80% have some form of mental health issues. Out of these 15% claim they are not receiving help for physical needs and 17.5% mental health needs. 7% of those asked were denied access to dentist or GP. There is a need for health input into homeless services in order to support people back into mainstream services. When Pathways homelessness hostel was first opened they were aware of the health needs of their clients and that many of them were chaotic users of health and social care provision and used emergency services in preference to the GP services. As a consequence, with the support of the Director of Public Health, they were able to provide much needed specialist healthcare on site.
What does the service do, and for whom?	The service is available to all of Pathways' clients who are over the age of 18 years old - individuals & families. It aims to identify any health issues individuals may be experiencing and support them to address these. It also enables a more holistic service to be delivered to the clients to enable their health issues to be addressed within the context of the wider impacts of homelessness. The service includes: • A holistic health assessment carried out by one of their two nurses (RMN'S) in conjunction with the housing staff. • Information on accessing GP services; addressing mental health; physical

	health; sexual health; smoking; alcohol intake; family history; basic health checks – blood pressure; weight; medications and compliance with this. • Dentist, Podiatrist, Opticians and therapeutic massage services. • Emergency clothing & bedding, food provision and rough sleepers breakfast. • Benefits advice; money coaching from the CAB • Weekly social group/drop in facilitated by the nurses at the Quakers meeting room is proving a great success. Plan now is to extend this to two sessions per week. • Housing support.
How is the service is delivered?	Appointment system although flexible to individuals needs and group settings at Pathways and away from Pathways.
Where is the service delivered?	The service aims to be a place where support staff trained with specialist knowledge and our on-site trained nurse can deliver an effective service of constructive and beneficial interventions at the right time and at the client's pace. The main service is based in a building on Saltergate, Chesterfield that has offices, kitchen and dining room. The social group takes place in the Quakers meeting room on Ashgate Road, Chesterfield
When is the service delivered, and for what period of time?	Monday to Friday according to service need. No time limit on input from our health service whilst ever an individual is engaging with our service.
How is the service tailored for individual needs?	Every person is seen as an individual and therefore dealt with in accordance with their needs within staffing and time constraints. The service aims to have a nurse accessible each day they are open.
Evidence of success?	Individuals are able to access appropriate healthcare with support thus aiming to reduce inappropriate A&E visits. The service supports the local housing department with evidence when looking at Priority need decisions. No formal evaluation of the service has been carried out.
What has been learnt from the project? How could this learning be used by other services?	Homelessness and poor housing brings with it many health and social care issues and therefore requires a multi-pronged approach from a holistic team. Homelessness and housing issues are rarely just that.
Partnership working and funding?	Owing to the complex nature of homelessness it is imperative that we work with many organisations including GPs, social care, alcohol services, probation, drug services, Community Mental Health Teams, local hospitals, schools, local authority housing departments, Prisons and colleges to achieve a positive outcome for our clients.
Number of people assisted by the project	305 people presented at Pathways during 2015 and all will have been offered access to a health assessment or health intervention if needed.

Source: Sandra Johnson, Pathways Trustee; Sarah Sammans, Specialist Nurse. Pathways of Chesterfield. February 2016.

Healthy Futures: homeless hospital discharge project

Purpose: to facilitate a timely transfer of care from hospital for homeless people, and support them in the community to improve their health and wellbeing and avoid inappropriate use of urgent care	
Why the service was set up/commissioned?	Based on evidence of effectiveness, the Department of Health Homeless Hospital Discharge Fund was established, which provided a local voluntary, community and social enterprise (VCSE) opportunity to deliver a service that would address delayed transfers of care through the use of housing specialists in a clinical environment to assist hospital staff.

<table>
<tr><td>What does the service do, and for whom?</td><td>It targets homeless people in hospital and high impact users of urgent care at all life stages, although they tend to be single people.

• The full service: to secure accommodation, broker an appropriate support package, provide liaison and advocacy, support the service user during the move from hospital to the community and intensive support in the community to help them live independently and use health services appropriately. This is a 12-week service.
• Brief intervention: to provide housing advice, advocacy, signposting, and staff support and advice to secure the accommodation plus support necessary for speedy discharge

As Healthy Futures also provides community support, it works to prevent emergency re-admissions and to develop personal assets and resilience.</td></tr>
<tr><td>How is the service is delivered?</td><td>1-1 wraparound support delivered in the community plus brief advice/advocacy interventions on the ward to patients who have a housing issue but do not need the full package of support.</td></tr>
<tr><td>Where is the service delivered?</td><td>In the individual’s own home and in hospital/care environments. Across Derbyshire</td></tr>
<tr><td>When is the service delivered, and for what period of time?</td><td>Daily to weekly contact over an average 12 week period</td></tr>
<tr><td>How is the service tailored for individual needs?</td><td>Support is person-centered and is guided by the individual’s own goals and aspirations. There is a health focus, but this is delivered holistically.</td></tr>
<tr><td>Evidence of success?</td><td><table>
<tr><td>Key performance indicator</td><td>*To date</td><td>Target</td></tr>
<tr><td>Reduction in hospital admissions</td><td>84%</td><td>75%</td></tr>
<tr><td>Reduction in Emergency Department attendance</td><td>92%</td><td>75%</td></tr>
<tr><td>Reduction in 999 use</td><td>88%</td><td>75%</td></tr>
<tr><td>Engagement with Primary Care – appointments attended</td><td>95%</td><td>75%</td></tr>
<tr><td>Self-discharge as a proportion of discharges on project</td><td>20%</td><td>25%</td></tr>
<tr><td>Average Length of Stay admissions on project</td><td>2.2 days</td><td>6 days</td></tr>
<tr><td>Average Length of Stay on project</td><td>72 days</td><td>84 days</td></tr>
<tr><td>Throughput</td><td>200%</td><td>200% per quarter
300% per annum</td></tr>
</table>
*October 2013 to 30.1.16.

Social return on investment modelling shows that for every pound invested by Southern Derbyshire CCG, Erewash CCG and the northern districts they achieve a return of £11.85 across the health/social economy.</td></tr>
<tr><td>What has been learnt from the project? How could this learning be used by other services?</td><td>Establish what data you need to gather to prove your value;
Make sure you can gather it within legal frameworks (Data Protection Act etc)
Have a steering group made up of key partners to ensure your project continues to meet their needs</td></tr>
<tr><td>Partnership working and funding?</td><td>Staff work as a broker and navigator, they source the most sustainable packages of support and care they can. To do this they have to work closely with key agencies and providers across Derbyshire:
Adult Social Care; VCSE sector – including housing related support providers; GPs; drug and alcohol treatment agencies; Community Psychiatry; Housing providers</td></tr>
</table>

Source: Kate Gillespie. Strategic Development Lead. Derventio Housing Trust. February 2016

No Second Night Out: support and accommodation for rough sleepers

Purpose: To provide support and emergency accommodation for rough sleepers, and support them for sustainable independence	
Why the service was set up/commissioned?	No Second Night Out Derby City and Derbyshire (NSNO DD) was set up in March 2013 as part of a nationwide response to the Coalition Government's Strategy to end rough sleeping (DCLG, 2011). The NSNO DD outreach team – based within Riverside ECHG - assesses the needs of new rough sleepers and links them to emergency accommodation. This service provides a range of support to homeless individuals across Derby City and Derbyshire.
What does the service do, and for whom?	The service provides support to people new to the street and rough sleepers and those with mental health, drug/alcohol problems and ex offenders. In Derbyshire, these tend to be slightly older males. It provides safe and secure accommodation in which customers can begin recovery and prepares customers for for sustainable independence through support,preventing future rough sleeping and homelessness. The service addresses the causes of homelessness and provides effective homelessness prevention services, to improve service access for drug and alcohol treatment and for mental health treatment amongst homeless clients. The work with partners to co-ordinate measures to address hospital discharge delays due to lack of support.
How is the service is delivered?	From referrals and calls from the public who have identified people rough sleeping, project workers will go out to them, on the streets to engage them in the service and provide emergency accommodation. They then continue to work with the client; they offer support and referrals to other agencies to help them to independent living, and addressing the health and housing issues.
Where is the service delivered?	Amber Valley; Bolsover; Chesterfield; Erewash; Derbyshire Dales; High Peak; South Derbyshire; North East Derbyshire On the streets, in the clients accommodation or at the Riverside supported accommodation in Amber Valley.
When is the service delivered, and for what period of time?	When a rough sleeper has been identified, and ongoing until they are in settled accommodation.
How is the service tailored for individual needs?	From the moment the service engages with a new client the service has been planning for their exit from the service, the eventual move on from the service is the ultimate goal of the support plan, the success of which is ensured by the achievement of the housing related support needs all clearly set out and evidenced in their person centered support plan.
Evidence of success?	In May 2014, Riverside ECHG commissioned the Sustainable Housing & Urban Studies Unit (SHUSU) at the University of Salford to carry out a rapid evaluation of NSNO DD. The evaluation was undertaken by reviewing the following data sources: - Existing secondary data relating to NSNODD; Interviews with seven key stakeholders; Interviews with four NSNO DD representatives; and Interviews with 14 service users.
What has been learnt from the	Working in partnership with other service providers is perceived as critical for the ongoing success of the project. Initially the project was met with resistance from

project? How could this learning be used by other services?	some service providers but this has largely been overcome as a result of the outreach team's commitment to supporting other service providers. A key successful partnership identified by respondents is that which has been established between NSNO DD and private housing providers. In operation, NSNO DD establishes contact with service users in wide variety of ways, including follow up of online referrals, rough sleeper counts, frequently attending hostels and encouraging word-of-mouth referrals among individuals who have previously been supported. This was valued by the service users and has maximised opportunities to support a large number of individuals who have experienced homelessness. A continued need to raise awareness of the service was highlighted by one respondent who stated that had he been aware of NSNO DD, self-referral would have occurred much sooner.
Partnership working and funding?	Funding for the extension of the work in Derbyshire was accessed through Derbyshire Homelessness Officers group who continues to work very closely with the project. Other referral agencies include police; community safety teams; and the project works closely with supported accommodation providers; hostels and private landlords.
Number of people assisted by the project	During the period September 1st 2015 to February 29th 2016 the service engaged with 93 beneficiaries in Derbyshire

Source: Reg Smith Area Manager Riverside Care and Support. February 2016.

Supporting people to remain living in their own homes or to recover from crisis

Housing related support services

The Care Act 2014 requires local authorities to commission preventive and integrated services, which must include housing services, to prevent, delay and reduce the need for social care, and health care. Housing related support services are an example of this type of provision.

Housing-related support services are designed to offer support, which would enable vulnerable people to live independently; prevent them from becoming homeless; prevent crime and reduce re-offending; prevent ill health and the need for social care and health care. Support is typically described in terms of:

- Floating support – support provided to the individual/household regardless of their tenure
- Supported housing – support provided within specialist accommodation eg, a refuge, recovery housing for people with drug problems etc,

It can include:

- Help with claiming benefits and filling in forms
- Help with developing skills to manage a tenancy
- Advising and helping people to get other services they need
- Help to find or keep their home
- Support to participate in training or education
- Support to re-establish contact with friends/family
- Support to better manage physical and/or mental health and to stay safe

It is not personal care tasks eg, help with feeding, dressing, bathing etc,

The services provide support to all life stages of all ages, although supported accommodation (other than refuges) are typically for single people. People who benefit from housing-related support services include:

- Single homeless people
- Homeless families
- People with drug and alcohol problems
- Older people
- Young People, including Teenage Parents and Care Leavers
- People with Mental Health Problems
- People with Learning Disabilities
- Offenders, including persistent and prolific offenders
- People at risk of Domestic abuse

Referrals to housing related support services come from housing options and advice services; police; probation; adult care; social landlords and some private sector landlords.

Housing related support is provided by many different organisations, which may be private, voluntary sector or a local authority. Prior to 2013, Derbyshire County Council funded many of these from specific funds under the Supporting People programme. DCC staff commissioned and contract monitored services. However, due to cuts in DCC funding, and the removal of ring-fencing the funding has been reduced. In some cases – such as for hostels, supported accommodation and floating support for single homeless people, DCC funding has stopped altogether. Many of the supported accommodation services have remained, through funding via Housing Benefit, but many of the floating support schemes have now stopped.

There is now no co-ordinated way of monitoring all of the housing related support services across Derbyshire, as many are no longer funded centrally by Derbyshire County Council. From historical records, we understand that there are still at least 25,000 people assisted in housing related support services in

Derbyshire each year, some commissioned by DCC, others reliant on Housing Benefit intensive housing management payments (this may be affected by changed to Housing Benefit in 2017) and other funding.

There are currently 21,905 places in services funded by Adult Care and managed by Derbyshire Accommodation and Support Team (DAST). The majority of these places (92%) are in the Community or Social Alarm Services, floating support and Handyman services for whom the main client group is older people with support needs, and the Home Improvement Agencies.

Table 54: Services funded by Adult Care and managed by Derbyshire Accommodation and Support Team (DAST). As at April 2016

Service Type	Main Client group	Number of *units	Total units for main client group
Home Improvement Agency	Adults	2,000	
			2,000
Community or Social Alarm Service	Older people with support needs	6,793	
Floating support	Older people with support needs	5,601	
Handyvan	Older people with support needs	5,880	
Accommodation based service - leaseholder	Older people with support needs	20	
Extra care	Older people with support needs	373	
			18,667
Accommodation based service	People with Mental Health Problems	16	
Accommodation based & Floating support service	People with Mental Health Problems	294	
Floating support	People with Mental Health Problems	180	
			490
Community or Social Alarm Service	People at risk from domestic abuse	140	
			140
Accommodation based service	People with Learning Disabilities	157	
Floating support	People with Learning Disabilities	132	
			289
Accommodation based & Floating support service	Young People	294	
			294
Accommodation based service	Offenders / people at risk of offending	15	
			15
Accommodation based service	People with a Physical or Sensory Disability	10	
			10

Total units			21,905

Note: Number of "units" can mean number of rooms or places in supported accommodation, or the number of places available at any one time for floating support
Source: Derbyshire Accommodation and Support Team. Derbyshire County Council Adult Care. April 2016

A national evaluation of housing related support in 2009 provided the basis for a local estimate of the cost benefits for every £1 spent by on housing related support services against the potential cost to partners both to Adult Care and external to partners such as health.

Table 55: Cost Benefits of housing related support services

Client group	Cost Benefit per £1
Mental Health	£17.64
Older People Accommodation Based	£9.25
Young People Services	£8.94
Older People Floating Support & Alarms	£7.55
Domestic Abuse	£5.61
Physical/Sensory Disabilities	£2.55
Adult Services (including single homeless, people with drug and alcohol problems, offenders)	£1.45
Learning Disability	£1.21
High Risk Offenders	£0.80

Source: The Benefits of Housing Related Support Services. Derbyshire County Council Accommodation and Support Adult Care. June 2013. Figures for 2012/13

The challenges faced by these services and their clients include: -

- Cuts to/withdrawal of Supporting People funding leave supported accommodation reliant on increased Housing Benefit payments. The level of these payments is under threat from a government "cap" on Housing Benefit: a decision will be taken in 16/17.
- The withdrawal of DCC funding for supported accommodation and floating support services to single homeless people has not, in most cases, been replaced by funding from district councils.
- Many services have reduced provision either in the number of people assisted and/or the level or time of support given. There are few services with 24/7 support and management except for older people services.
- The closure of many floating support services is making it difficult to secure accommodation for vulnerable people in the social or private sector
- Social landlords are reducing or removing their own formal or informal support services
- The impact of the preventative nature of the services is not always immediately seen, but the closure or reduction of services outside of Derbyshire has anecdotally resulted in a significant increase in people in crisis, in rent arrears, becoming homeless; accessing health and care services and hospitals.
- The uncertainty around the continuation of services means that qualified and dedicated staff are leaving, and the experience is lost if funding becomes available in the future.

Assistive Technology & Telecare

Purpose: To provide a range of sensors and equipment to help manage risks within the home enabling people to live safely and independently for longer. Includes Just Checking and Falls Recovery systems.	
Why the service was set	Assistive Technology effectively supports health, independence and wellbeing, allowing the client to remain safely and confidently in their own home and

up/commissioned?	reducing the need for intervention by health and social care resources – delivering efficiencies and improving outcomes.
What does the service do, and for whom?	Assistive Technology includes a range of alarm pendants, falls detectors, door alarms, enuresis sensors, gas and temperature detectors etc. The devices support vulnerable people to manage their lives, enabling them to continue living in their own homes and communities, reducing the dependence on residential care and enabling timely hospital discharges and reducing admissions. Assistive Technology is provided by the Derbyshire Accommodation and Support Team (DAST) and assessed and delivered by personalisation and prevention Assessment Teams, Hospital Discharge Teams and Specialist Homecare DSO's.
How is the service is delivered?	An assessment of needs is made by personalization and prevention Assessment Teams, Hospital Discharge Teams and Specialist Homecare DSO's. Alternatively, individuals or carers can request assistance through Call Derbyshire, which can trigger a fieldwork assessment. The Assessment is added to the Support Plan and once authorised the equipment is ordered and installed through the countywide Handy Van Service who also repair and maintain the equipment.
Where is the service delivered?	The intervention occurs in the clients' home environment allowing vulnerable people to continue living independently in their own home environment reducing admissions to hospitals and more structured care facilities. Intervention also occurs in hospitals by the hospitals Discharge Teams.
When is the service delivered, and for what period of time?	The equipment allows for faster and safer hospital discharge and reablement thus releasing expensive hospital or care home beds. Reduces the need for care and support services and eases the burden on carers. The equipment is currently free to Derbyshire residents if they meet eligibility criteria. A monitoring charge is made by the call centers of between £2.50 and £5.00 a week depending on location within the county.
How is the service tailored for individual needs?	Assistive Technology is part of a mainstream assessment and prevention strategy and is integral to the reablement process. The intervention is based on the client's individual needs as assessed by the personalisation and prevention teams involved and as part of an overall long or short term Care Plan.
Evidence of success?	Derbyshire case Study: www.tunstall.co.uk/Uploads/Documents/Derbyshire%20Falls%20Case%20Study%20-%20Integrated%20Falls%20Service.pdf As part of a wider Derbyshire Housing Related support programme, Assistive Technology contributes to a ROI of £7:1 During April 2014 to March 2015 (inclusive) as a result of using detectors, the Falls Delivery Service triaged *5160 clients and safely lifted *4286 clients without the need for an expensive ambulance or hospital admission. Out of the sample of 70 cases where Just Checking has been used as part of the assessment process and the outcome has been recorded, 31% of cases reduced costs by £160,356 and the following outcomes were identified • Supported effective and timely hospital discharges • Obtained a more accurate assessment regarding potential areas of risk • Provided care packages that were more personalised and least intrusive • Provided reassurance for carers/relatives • Enabled clients to remain in their own home for as long as possible, reducing unnecessary residential and nursing home admissions
What has been learnt from the	Challenges include simplifying the order process to encourage take up by Fieldworkers and extend the use of assistive technology and continued support

project? How could this learning be used by other services?	and training for fieldwork staff. Provision of information to the public to promote the technology and encourage independent enquiries and use through Call Derbyshire. There is an opportunity for housing organisations to increase their provision of assistive technologies to support their clients and help the health care services achieve greater efficiencies.
Partnership working and funding?	District and Borough Councils, Care Providers and Technology providers

Source: Ram Paul, Derbyshire County Council

Age UK Derby and Derbyshire Housing Options Service: advice service for older people

Purpose: to enable people aged 50 years + to live independently in their own home or if necessary, to help them find a more suitable one.	
Why the service was set up/commissioned?	The population of the Derbyshire Dales District is made up of an unusually large percentage of older persons. The District is also quite rural which leads to a significant amount of social isolation and a relative lack of public services. The Housing Options service supports this client group.
What does the service do, and for whom?	The service is delivered to people aged 50+. They may often be in very poor health, both physical and emotional. They might have problems with memory, finance, alcohol, social isolation, familial abuse, anti-social behaviour, failing eyesight, literacy or numeracy, recent bereavement or personal care needs. The service works with the client to achieve the best outcomes possible and how they do that depends very much on their needs.
How is the service is delivered?	The service advises clients and their families by phone, e-mail or they can come to their office. Visiting the client in their home – usually on a one-to-one basis – is the most effective way to engage and to spot issues they might have missed using one of the other delivery methods.
Where is the service delivered?	The intervention can occur at the client's home (or care home if they are unable to return home) or at the service's base at the District Council's Town Hall.
When is the service delivered, and for what period of time?	Intervention may occur just once by giving advice over the phone but usually involves one or two home visits and for particularly vulnerable clients, they might end up supporting the client intermittently for a number of years.
How is the service tailored for individual needs?	Different clients engage in different ways. Some clients are happy to share their problems straight away but for others, much time has to be spent building up trust and a rapport with the client before they can even get down to their problem. This is especially difficult for those clients suffering with memory problems.
Evidence of success?	Feedback from clients and other stakeholders suggests the impact is a very positive one. Outputs include maximising the income of many clients (money which is then used within the local community), helped people return home from hospital in a timely way (preventing delayed transfer of care), prevented clients from presenting to the Council as homeless, assisted people in taking a more active role in their community and a whole lot more besides. The service is evaluated by Derbyshire Dales District Council every year.
What has been learnt from the project? How could this learning be used by other services?	"We have learnt that often, just a little bit of help (a form to be filled in for example) can have a drastically positive effect on the life of a client. We have also learnt that the most obvious problem a client has is often just the tip of the iceberg and can be the sum of an awful lot of smaller problems which were never nipped in the bud."
Partnership working and funding?	They work closely with the Council's Housing, Benefits and Revenues departments, local housing associations, adult care, charities and local organisations (Churches/luncheon clubs for example).

Source: Clive Gray, Housing Options Manager. Age UK/Derbyshire Dales. February 2016

Access to social and 'affordable rent' housing

Housing options, allocations and lettings services

There are around 51,000 social and affordable homes to rent in Derbyshire [unless stated otherwise, 'social rent' is used to describe all these homes in this section].

A move into social rented housing can be for many reasons but is primarily related to a need for financial assistance to meet housing costs: rents in social housing are below those in the private rented market. Households may find themselves in housing need as a consequence of homelessness (risk or actual), because their current home environment poses a risk to their health eg, it is cold, damp, in disrepair or is otherwise hazardous, or because their current home is unsuitable eg, they are overcrowded, their home is not adapted or accessible for their needs, etc. The data available to this assessment was not sufficient to understand what the balance between these housing issues is in practice: this may be worth further investigation.

Although three local housing authorities in Derbyshire do not own and manage their own social rented housing (Amber Valley, Derbyshire Dales and Erewash), all local housing authorities are required to operate an allocations scheme for social rented housing, and related to this, a Tenancy Strategy. The scheme determines who will prioritised for social rented housing, and the Tenancy Strategy indicates the local housing authority's preferences for the length of tenancy that housing providers should offer to which household and in which circumstances.

The allocations scheme is delivered in practice through a housing register and in Derbyshire, through Choice Based Lettings (CBL) schemes. Households apply to be on the housing register, and once accepted are able to 'bid' for homes that meet their needs. Anyone over 16, British citizens who have the right to stay in the UK for an unlimited time, or an immigrant whose terms of stay say there is recourse to public funds, can apply to be on the register. However, it is not usual to be granted a tenancy until the applicant is 18 years old. Also, there may be local exclusions in place to the register and on bidding, for example as a consequence of not having a housing need as defined by local policy, debt or previous behaviour.

Social landlords may also operate their own housing register and CBL or equivalent schemes, they do not have to comply fully with the local allocations scheme and they must only have 'due regard to' the Tenancy Strategy. This is at the direction of the Localism Act 2011. In practice, access to social rented housing can be complicated and requires assistance to navigate – a role the housing options and advice services provide.

Four local authorities (Amber Valley, Derbyshire Dales, Erewash and High Peak) operate a combined scheme, with separate schemes for all the other local authorities.

The CBL schemes all operate in a similar way:

- People register on the schemes, online, or in some areas, on paper based forms, giving details including their current housing situation and household, any "vulnerabilities" such as ill health which are affected by where they live, and which may affect the type of property they are seeking
- They are then awarded points and/or put in separate "bands" which reflect re-housing priority, in line with the allocations scheme. Those in most urgent need, are normally awarded the highest points or bands
- Social landlords advertise their properties on the website, and sometimes in printed form, when they become available to let
- People on the register then apply or "bid" to show their interest in the property
- The social landlord allocates a property, normally to the household with the most points or at the top of the band

For vulnerable people, family; friends, and support workers may help them to register and bid. Assistance can also be given by the local authority or others operating the scheme – for example by sending details of suitable properties, and allowing bids by telephone.

For people with multiple and complex needs and who may require a multi-disciplinary decision on the suitability of a property – then a suitable property may be identified and allocated outside of the CBL scheme.

The schemes can all allow a "direct let" to be made outside of the scheme for a specific property – particularly homes suitable for a disabled person. This is a means to ensuring the best use of a limited resource to meet specific needs.

A snapshot of Derbyshire's housing registers in February 2016 indicates that just over 17,000 households are registered for a move into, or within, social housing.

Table 56: Households on housing registers

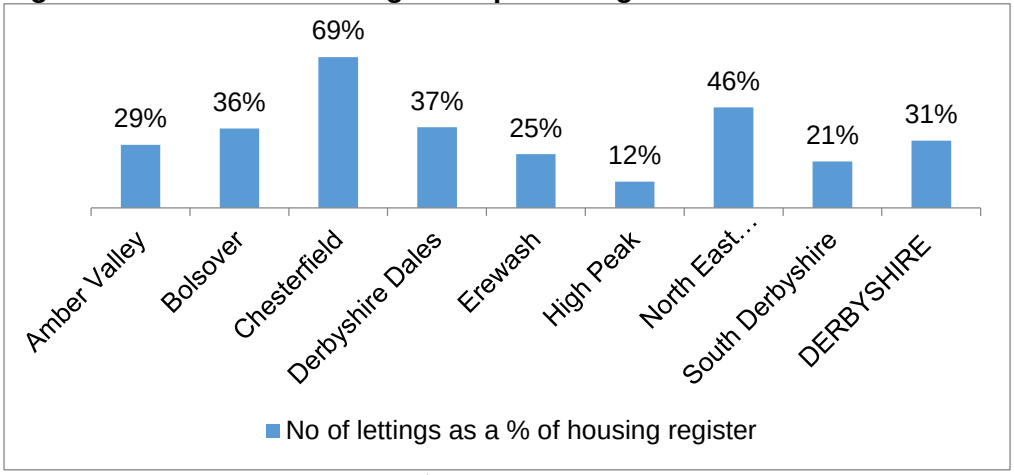
	Number
Amber Valley	2,925
Bolsover	1,676
Chesterfield	1,510
Derbyshire Dales	1,699
Erewash	2,924
High Peak	3,986
North East Derbyshire	1,519
South Derbyshire	1,023
Derbyshire	**17,262**

Source: Local housing register snapshot Feb 2016

There is a demand and supply mismatch - in 2014/15 just 5,187 lettings into social housing were made – but this varies greatly between local authorities: there is a complex relationship with the overall number, type and turnover within social housing available in each area, the wider housing market, the employment market and so on.

A comparison of the annual lettings alongside the housing register snapshot provides a rough indication of the likelihood that a household on the housing register will access social rented housing – and likelihood this is a solution to improving health and wellbeing if this is the reason for the move. It is more likely households in Chesterfield and North East Derbyshire will gain access to social housing, and least likely in High Peak and South Derbyshire. Of course, this tells us nothing about what type of housing is available and which types of household are having their needs met (for example Amber Valley, have a significant amount of supported housing, primarily for older people): further analysis would be needed to understand if access to social housing is improving health and wellbeing as effectively as possible, across the life course.

Figure 34: Number of lettings as a percentage of the number of households on the housing register



Sources: Housing Register at 1st April 2014: Local Authority Housing Statistics 2014/15; Lettings 1.4.14 to 31.3.15: DCLG - social-housing-lettings-in-england-april-2014-to-march-2015

In relation to the 5,187 lettings it is known that:

- 77% (3,989) moves were in to 'general needs' housing (not supported housing) and 23% (1,198) moves were made into supported housing
- 54% (2,187) moves into general needs housing were into homes owned by a local authority but just 24% (280) moves into supported housing were into homes owned by the local authority
- 95% of homes were let at a 'social rent' and 5% at an 'affordable rent' (more expensive, at up to 80% of market rent). All 'affordable rent' homes were owned by Registered Providers.

Households with additional needs, for example related to their health or care, may be less likely to have their needs met through a move into social rented housing. For example, a 2012 study of disabled housing needs identified a shortage of suitably adapted homes, with a wide variation between local authorities, as demonstrated by the percentage of disabled people on the housing register who are able to secure such a tenancy.

Figure 35: Social Rented Property Lettings to people with physical disabilities on the housing register

Social rented property lettings to people with physical disabilities on the housing register		Lettings as % of physically disabled on register
Amber Valley	54	5.6%
Bolsover	34	Full details not available
Chesterfield	34	31%
Derbyshire Dales	60	9%
Erewash	51	6%
High Peak	15	3%
NE Derbyshire	87	71%
South Derbyshire	18	5%
	353	

Source: Disabled People's Housing Needs Study 2012 (ECORYS and CIH). Annex one. Derbyshire statistics only.

Challenges to providing homes suitable for disabled people through a move in the social sector:

- Insufficient supply of suitable properties in some areas
- No specialist officers or service matching people to properties

- Expectations and demands (e.g. for two bedroomed bungalows)_ are not always matched by the stock available (e.g. 1 bedroomed ground floor flats)
- The ‘spare room subsidy’ or ‘bedroom tax’ can affect disabled people under retirement age who need an extra bedroom for carers or equipment

Challenges to providing access to social and ‘affordable rent’ housing in general:

- In some areas, there is low demand and difficulty in letting properties. In other areas, even in the same district, many households would never be able to access a property due to high demand and/or few properties becoming vacant
- In some areas where priority is given to households becoming homeless, or to prevent homelessness – it can be perceived as “unfair” to those who have been “waiting patiently” without this priority.
- Social housing providers are becoming reluctant to let homes to very vulnerable tenants – those who are perceived as “difficult” , as there may be no ongoing services to support them
- Registering for and accessing social housing can seem complex and time-consuming in comparison to finding a privately rented property via a letting agency or “Rightmove” and similar websites.
- Matching housing register applicants to suitable properties designed for disabled people can be time-consuming for allocations teams and can lead to lengthy “void” periods, or inappropriate lettings.
- Choice Based Lettings and allocations systems vary between local authorities, with some being quite labour intensive. There are concerns that some vulnerable and older people are reluctant to use web-based systems.

There is currently work underway to assess how the schemes could work most efficiently and effectively, concentrating mainly on the computerised process and procedures, rather than the actual allocations policies.

Improving the home environment, health and wellbeing

First Contact signposting service

First Contact is a signposting service co-ordinated by Derbyshire County Council in partnership with other statutory and voluntary sector partners.

Professionals visiting people in their homes, or individual householders themselves, fill in one form which is then used to refer the person to a number of different organisations who can offer services, information and/or advice to support their independence, health and wellbeing. Those organisations then contact the person direct.

First Contact made referrals to agencies during the last year, in response to the following questions asked on the First Contact referral form – most relate to the home environment and suitabilty of the home.

Table 57: First Contact Referrals Housing/health Issues March 2015 to February 2016

First Contact referral service Questions asked, relevant to housing & health issues	Yes
Would you like information or support to help improve fire safety in your home?	668
Have you got any concerns about the security of your home?	299
Would you like advice about keeping your home warm?	312
Would you like to discuss your existing and future housing needs with a housing options advisor?	447
Would you like some help or advice about arranging repairs to your home?	265
Are you unsteady on your feet or have you fallen or slipped in the last 12 months? If yes, would you like a referral to the falls information service?	1,898
Do you have difficulty managing your daily living activities?	153
Would you like to be able to call for assistance at home if you get into difficulty by having a community alarm fitted?	1,725

Source: First Contact Referral records at March 2016

Private sector housing, housing renewal, housing standards, environmental health

Local housing authorities have a number of duties relating the condition of housing in their area, including taking action to address serious hazards to health and wellbeing, assessing hazards using the Housing Health and Safety Rating System. In relation to energy efficiency local housing authorities are required to report, every two years from 2013, the energy conservation measures that the authority – or group of authorities – consider practical, cost-effective, and likely to significantly improve the energy efficiency of residential accommodation in its area.

To meet their duties, local housing authorities usually have a housing renewal, housing standards or private sector housing team and/or employ specialists within their environmental health team.

All households, living in all tenures, can approach the service about their housing conditions or the wider neighbourhood environment, including poor housing conditions of other households, if they consider these to present a risk to their health and wellbeing. Referrals can also be made by other agencies, including social care teams, health visitors, housing advice/housing options services. The local authority services work closely with Home Improvement Agencies.

Typically customers will be tenants of private rented or social rented housing who require external intervention to improve their home, but members of the public can raise concerns about owner-occupied

homes. Many customers will also live in precarious housing circumstances, particularly tenants in the private rented sector who are likely to have a six months Assured Shorthold Tenancy.

Interventions on offer are a combination of preventive and reactive responses eg, to cold and damp, disrepair and other hazards, and poor management practice, and include:

- Liaising with landlords to ensure access is maintained and at least the minimum condition/ standards are met
- Liaising with the police to ensure tenants' safety is ensured
- Enforcement to raise physical and housing management standards in the private rented sector
- Selective licensing
- Licensing houses in multiple occupation and caravan sites
- Prevention of unlawful eviction and harassment (this is sometimes dealt with by housing options and housing advice teams)
- Bringing empty homes back into use (some teams have an empty property officer)
- Offering advice on sources of charitable funding to improve homes for those who cannot afford this

Specific interventions to improve energy efficiency and warmth are:

- Raising awareness with local people about the possible impacts of cold and damp homes, and fuel poverty, and ways in which services can assist them
- Providing impartial advice about options to secure improvements
- Enabling access to specific national initiatives such as the Energy Company Obligation (ECO)
- Attracting investment to pilot or fund local projects such as boiler replacement and draught proofing schemes
- Advising on getting a good deal from energy suppliers, including helping to switch supplier and promoting collective switching schemes
- Referring to agencies to maximise income to cope with fuel bills
- Proactively identifying homes and households particularly affected by cold, damp homes and/or fuel poverty and in most need of support

Some teams are also responsible for enabling grant-aided adaptations for disabled residents, discussed in a separate section.

The main point of service delivery is in someone's own home.

In the period 2014/15, services recorded 1,681 housing complaints or enquiries:

Figure 36: Number of housing complaints and enquiries to housing renewal/housing standards teams

Number of housing complaints and enquiries 2014-15	
Amber Valley	304
Bolsover	502
Chesterfield	246
Derbyshire Dales	44
Erewash	223
High Peak	196
North East Derbyshire	166
Totals	1,681
Information not available from South Derbyshire	

Source: Local authority records of housing complaints and queries 1.4.14 to 31.3.15.

Figures do not include removal of vermin or disabled facilities (home adaptation) works.

Having received a complaint about housing conditions, the local authority has a duty to assess the seriousness of any hazards to safety and health using the Housing Health and Safety Rating System (HHSRS). The seriousness of the hazard to health will determine what actions are taken by the local authority: action must be taken to ensure Category 1 hazards are dealt with, and some Category 2 hazards (these can be determined locally).

The local housing authorities are investigating the use of the BRE's Housing Health Cost Calculator (HHCC[lx]) to measure the quantitative health impact of their housing interventions.

Stakeholders describe the following challenges to delivering these services:

Demand

- A considerable amount of time can be spent on meeting the needs of households who do not want or are reluctant to have work completed – this could be as a consequence of a health condition
- Increase in demand and increase in more complex cases
- New initiatives and legislation are being introduced eg, widening criteria for mandatory Houses in Multiple Occupation, fire and smoke alarm regulations, and Right to Rent (landlords confirming the eligibility status of people from other countries): no additional resources to respond to this

Supply

- Work "in default" requires input from increasingly limited local authority budgets
- Limited capacity means that there is little time for proactive work.
- Small number of landlords can consume a significant proportion of time and resource eg, court action
- Referrals between agencies: consideration to the household's wider needs eg, health and wellbeing, need for support, or other interventions is not embedded across all agencies

In relation to energy efficiency and affordable warmth the challenges are:

Demand

- It can be difficult to pinpoint those most in need, although now some projects are tackling this.
- For some people, tackling the practical issues is easy, but persuading and encouraging them to have the work carried out can take a long time.
- Utility companies initiative often give discounts and reductions for interventions, but often something has to be paid by the householder, even if only access and remediation works.

Supply

- Expertise and capacity
    - Few full time or dedicated energy posts
    - Limited local funding for energy/affordable warmth/fuel poverty initiatives
    - Multitude of initiatives but not co-ordinated and likely duplication and inefficiencies, and often only funded in short term
- No replacement yet for national initiatives eg, the Green Deal
- Improvements to health and wellbeing after an intervention cannot always be *directly* pinpointed to that intervention, so some assumptions have to be made from client feedback.

<u>Other preventive services</u>

Derbyshire Healthy Home Project

Addressing cold and damp homes – targeted to those whose health is most affected

Purpose: To improve the homes of people with specific long term health conditions, which are made worse by living in a cold damp home	
Why the service was	The risks to health from cold housing are well evidenced and form the basis of recent

set up/ commissioned	NICE guidance on excess winter deaths and risks to health from cold housing. Experience gained by the Local Authorities Energy Partnership (LAEP) since 1996 shows that some vulnerable householders are too frightened to use their old, unreliable heating system because of high fuel costs or because they don't know how to use the system efficiently. This situation can lead to households on fixed incomes facing a 'food or fuel' crisis, leading to ill health, stress and pressure on carers. This scenario can prove especially dangerous for people with cardiovascular disease, respiratory problems or mobility issues and often leads to unplanned admission costs to the NHS of around £3,283 (Erewash CCG) per stay in hospital. Funding was obtained and the service set up by Derbyshire Public Health and LAEP to address these issues.
What does the service do, and for whom?	It identifies vulnerable people with specific health conditions, which may be made worse through cold or damp homes. GP practices write to this group of patients and invite them to take part in the project. Those who are interested can access the services which includes: • An energy efficiency assessment; review of income and affordable warmth issues with the client and assess their health and wellbeing needs. • Benefit checks, fuel tariff switching and other income maximisation options are also pursued where appropriate and clients are reminded to take up flu jabs and other recommended health interventions. Having completed an assessment staff commission, co-ordinate and follow up any necessary works such as installation of new heating systems or boilers, insulation or draft proofing. These essential improvements cost around £2,500 per household, at no cost to the client as the LAEP has secured a number of external funding awards to support the project. The service is flexible to deliver what is needed to ensure a warm and healthy home, rather than a prescriptive "suite of services". For example providing a loft hatch, in order to install pipework for a boiler, clearance of hoarding if it is preventing installation or repair of heating systems, spending time to encourage, explain and "hand-hold" to enable householders to agree to the necessary work. The services are offered to vulnerable people with specific health conditions which may be made worse through a cold or damp homes Also the service has developed a household guide and GP led video to raise residents' awareness about how the cold can seriously affect certain types of respiratory, cardiovascular and mobility related health conditions, leading to a deterioration of their health and increasing the risk of unplanned hospital admissions. Residents are advised that keeping warm is essential to keeping well, a vital but rarely explained health message.
How is the service is delivered?	The project: • Conducts data analysis to identify those at greatest risk and to make contact with and support householders to access existing energy company offers. • Supports those people who wish to access the existing energy efficiency offers but face barriers to achieving this. • Supports inward investment into the programme from energy companies to explore and support the future long term sustainability of the intervention
Where is the service delivered?	In people's homes. Throughout Derbyshire.

When is the service delivered, and for what period of time?	Clients who contact the project receive a tailored service involving an average of three half-day home visits, but more if necessary.
How is the service tailored for individual needs?	The service is tailored to the individual needs identified in the home visits
Evidence of success?	Key outcomes in the first operational period between March and September 2015: • Delivered a comprehensive service to 115 residents in 83 households, tailored to their specific needs and circumstances. • Helped 144 specific long term health conditions between the 83 households • Secured £303,000 of external funding for heating improvements • Provided a 2:1 return on investment from the council revenue contribution Independent Public Health evaluation: The service is receiving glowing reviews from its clients, who are being interviewed as part of an independent Public Health review of the project with householders from Bakewell Medical Practice and Lime Grove Medical Practice. The review includes one to one interviews with householders, project officers and representatives from the local energy partnership. Twenty householders agreed to take part in the review and nine householders have been interviewed. Initial feedback from the review suggests that: • All the householders rated the project as excellent. • The project officers were described as knowledgeable, friendly, polite, helpful, patient and able to offer expert advice. All householders spoke very highly of all the staff involved in the project. • Importantly the project officers acted as an intermediary between the householder, energy companies, boiler suppliers and other utility companies, giving householders the confidence to switch energy suppliers and make changes to their homes.
Partnership working and funding?	All 8 district councils and 5 CCGs in Derbyshire. Local GP practices (the programme has so far worked intensively with 7 GP practices across Derbyshire, has started working with another 11 and has a further 7 lined up and ready to get involved). Referral partners include local authorities, Fire & Rescue Service, Adult Care and Welfare Rights The programme has been particularly successful in attracting £303,000 in grants from government and charities to lever in capital funding for works. The targeting approach used by the project still proves attractive to energy companies obligated to spend capital on fuel poverty measures but less so as an opportunity to generate revenue investment as envisaged in 2013 due to changes in government policy regarding energy company obligations. The project is currently investigating other opportunities to generate revenue to support the long term sustainability of the project Core revenue funding provided by DCC Public Health. Funding secure until December 2016. External funding attracted by the LAEP: • All measures are installed at no cost to the client due to a combination of around £300k external 'capital' funding secured through competitive bidding by the LAEP to national funding schemes • Department of Energy and Climate Change DECC award of £101k for installation

	of heating and other improvements • National Grid award for £40k for installation of heating improvements • £162k awarded on 12th October 2015 from the National Energy Action 'Warm and Healthy Home Fund'.
Number of people assisted by the project	March 2015 to January 2016 Number of householders visited – 126 Number of householders *assisted – 192 *Only those with health condition(s) made worse by living in a cold home

Source: Bill Purvis, Derbyshire Healthy Home Programme Manager. February 2016

Warm Homes Healthy Living – Metropolitan Home Improvement Agency

Purpose: to support those who, because of low income and health, to improve the heating and energy efficiency of their home	
Why the service was set up/commissioned?	Studies evidence that there is a clear connection between poor housing and health and wellbeing; health conditions can be exacerbated by cold weather; low Income and/or poor health are not age related The service was set up to tackle these issues and targets those that need support the most, yet still providing information and advice around other mechanisms to invest in their properties. It is about achieving a long term plan to enhance thinking about housing as a wider determinant and operationalise links so that health and social care professionals can make referrals to improve outcomes for clients outside the conventional clinical and social care models of provision. For example, supporting cancer patients to stay warm at home which supports NHS investment in their care and recovery.
What does the service do, and for whom?	It gives support and assistance to improve the heating and energy efficiency of homes to people in all life stages. The referrals into the Home Improvement Agency (HIA) can come from any source. The Project Workers will undertake a home visit within 15 working days to identify the help required. This could include boiler replacement or repair, installation of heaters; draft proofing etc. They check eligibility; identify cost by using contractors on their 'approved' list; put together a package of funding and arrange repairs/replacement to be undertaken as required. They inspect works on completion and seek feedback. The HIA also identify the need for home repairs/adaptations either through this intervention or other referrals from partner organisations or directly from homeowners that meet our criteria.
How is the service is delivered?	Partnership working is crucial in identifying those in greatest need. The HIA works effectively with Adult Care, local housing authorities, medical centres and voluntary organizations. There are a number of processes in place building relationships to ensure that offer of support is made to as many patients and carers as possible. Amber Valley in particular is very proactive and has effective networks in place that both promote their service, but also our effective joint working.
Where is the service delivered?	Across 6 of the 8 District & Boroughs predominately for home owners Amber Valley; Chesterfield; Derbyshire Dales; Erewash; High Peak; South Derbyshire
When is the service delivered, and for what period of time?	Through bids the HIA has secured around £50,000 it can allocate to individual cases, in addition the HIA has access to additional funding from Foundations Independent Living Trust (FILT), which provides up to 25% towards the cost of work. Plus some

	Boroughs having funding available. These packages of funding help to make the money go further.
How is the service tailored for individual needs?	The offer from the HIA is tailored to the needs of each client.
Evidence of success?	They are working with Sheffield Hallam university to measure the impact of the interventions for individuals that have accessed their SSE funding Studies have identified that poor housing affects people's health and wellbeing, but it is difficult to evidence direct saving from the service to health
What has been learnt from the project? How could this learning be used by other services?	The value of effective partnerships, to be able to have a flexible approach, review processes and adapt where necessary. To avoid duplication, as this causes confusion especially for frontline workers, which can lead to people not being referred.
Partnership working and funding?	Local District and Boroughs, Adult Care, close working with Social Workers, Occupational Therapists, indirectly NHS staff, Care Coordinators, through district and borough referrals, the voluntary sector, eg AgeUK, CAB. As an HIA they have access to funding specifically for HIA's (Health Through Warmth) and have secured other funding from the Gas Safety Council and Energy Company Obligation (ECO) funds from Scottish and Southern Electricity. In Amber Valley they work closely with the Borough Council who also provide funding for works along with other resources they have from the CCG & the Department of Energy and Climate Change (DECC).
Number of people assisted by the project	Total number of enquiries linked to heating/energy efficiency measures annum is 350-400 a year.

Source: Sue Falder Team Manager. Metropolitan Home Improvement Agency. February 2016

Healthy and Warm Homes – Amber Valley

In Amber Valley, the borough council and Metropolitan work in close partnership in delivering the borough council's Healthy & Warm Homes programme to identify those who, because of low income and health, need support and assistance to improve the energy efficiency of their home. The local authority have recognised the evidence of need as highlighted above, and that with limited resources, their own input has to be towards those who most need it, rather than those who can help themselves (with perhaps some assistance in navigating the various schemes such as ECO).

Whilst the delivery of the assistance is focused around the Home Improvement Agency as above, local authority housing renewal staff build relationships to ensure that the offer of support is made to as many people who need it as possible. They promote the 'offer' through presence and repetitive reinforcement at CCG meetings and existing networks and building on word of mouth. The local authority sees the identification of vulnerable patients by health and social care and referral for support with heating improvement and housing options as a core function. They work with NHS staff to raise awareness to alternatives to clinical solutions. There is increasing operational liaison with Social Workers and Care Coordinators and NHS employees generally. Referrals from other agencies include Age UK; Citizens Advice Bureau; Fire and rescue services; Police; Childrens' Services.

Amber Valley is exploring the expansion of the Healthy Housing Hub in Derby to ensure making referrals for health and social care is made easier.

Source: Dave Arkle. Housing Manager. Amber Valley Borough Council. February 2016.

Improving the suitability of the home environment for disabled people

Home adaptations, including through the Disabled Facilities Grant

Local housing authorities have duties to understand the housing needs of vulnerable groups, for example disabled people, in their assessments of their local housing market, and provide funding via a means tested disabled facilities grant for home adaptations (DFG)

Local authorities also often provide other services to meet the needs of this population, for example as a means to prevent ill health and to enable independence, and delay and reduce the need for social care.

Action by the local housing authority, often in partnership with the County Council, to improve suitability includes:

- Information, advice and guidance on home adaptations
- Assessment for the Disabled Facilities Grant
- Enabling a move to a more suitable property in the private sector or social sector (this has been previously discussed)

The provision of interventions varies across local housing authorities. In the period 2014/15, 370 DFGs were completed in Derbyshire via Derbyshire County Council processes. In addition to this, there are also DFGs completed via Home Improvement Agencies, as well as other adaptations funded by social landlords, and other works which are self-funded by the household.

Figure 37: Disabled Facilities Grants completed 2014/15 via Derbyshire County Council process

Disabled Facilities Grants completed in Derbyshire 2014/15		
	Disabled Adults	Disabled Children
AVBC	89	8
Bolsover	50	2
Chesterfield	44	4
Derbyshire Dales	7	3
Erewash	52	3
High Peak	23	1
North East Derbyshire	23	1
South Derbyshire	54	6
	342	**28**

Source: Information from Derbyshire County Council

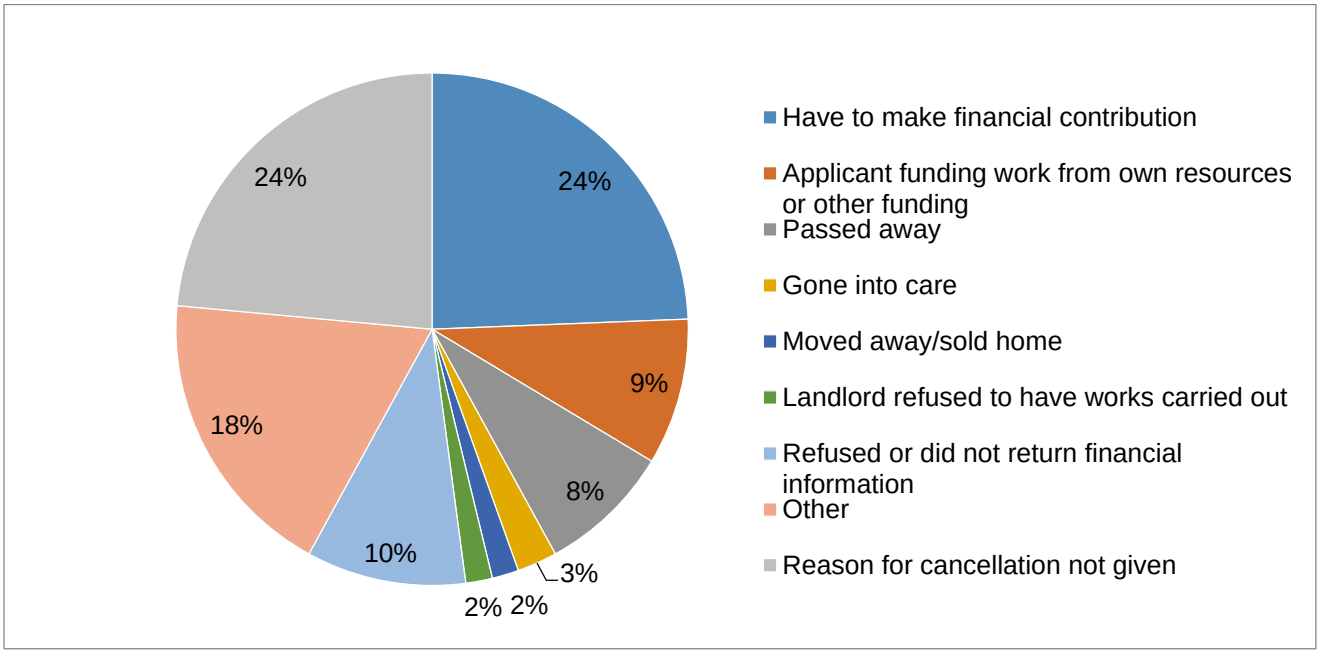
The current process for accessing a home adaptation through the provision of a providing DFG is:

- Initial contacts and enquiries routed through “Call Derbyshire”
- Referral to Adult Care or Children’s Services for assessment of need and advice
- Referral to Home Improvement Agencies and local housing authorities for the application for grant and financial assessments OR
- In some areas, referral first to a “Triage” organisation to assess all possible housing options and solutions – including consideration of moves to an alternative property
- Referral to Derbyshire County Council architects for design of adaptations needed
- Local housing authorities obtaining quotes for the work.

In 2015, there were 2,659 referrals to Adult Care and Children’s Services for assessment of need and advice. Following these, 1,859 applications for a DFG were made (1,754 for disabled adults, and 105 for disabled children)

At any point along this route, people will “drop out” for a number of reasons. For example, in South Derbyshire reasons for cancellation vary from people not wanting the works carried out as they would have to make a financial contribution, to landlords refusing to allow the works carried out.

Figure 38: Reasons for cancellation of Disabled Facilities Grant Application. South Derbyshire 2014-15



Source: Information from South Derbyshire. Records for 1.4.14 to 31.3.15.

There will be circumstances where a disabled person may be given more urgent priority. Priority of either routine or urgent is determined by a Quality Assessment Panel consisting of a Housing Officer from the district council and a Manager from Adult Care. Urgent priority is normally given to situations such as adaptations to facilitate hospital discharge or to allow access to facilitate attendance at hospital for life saving treatments. Persons with an urgent medical need to bathe, a terminal condition or an unstable and deteriorating condition will also be given urgent priority. Urgent priority will allow an application to be “fast tracked” through the DFG process allowing the adaptation to be provided sooner.

Having received a DFG enquiry, DCC Social Care (usually Occupational Therapy) assess whether an adaptation is necessary and appropriate to meet the disabled person’s needs; the housing authority assesses whether a particular home adaptation is “reasonable and practicable”.
The DFG is means-tested for adults but not for children. The recent Spending Review (February 2016) increased spending for home adaptations (this is paid through the Better Care Fund) and instructed upper tier local authorities that they must pass on the DFG allocation to the district – local housing authorities).

Amber Valley Metropolitan Triage for disabled people

Triage for disabled people referred to Adult Care where their home does not meet their needs regarding their physical disability

The service was set up in response to:

- long waits for a Disabled Facilities Grants;
- need to speed up the process;
- need for cost efficiencies, where possible
- to provide some assistance to people whilst they were waiting
- understanding that needs of some people on the waiting list could be more effectively met through moving homes.

The local Adult Care Prevention and Personalisation team duty occupational therapist receives referrals from Call Derbyshire and makes an initial assessment of need. This is then referred to the HIA Project worker who:

- completes the assessment
- helps and encourages applicants to consider alternatives to meet their needs – such as moving home – either in the social sector or home ownership
- helps people who would not be eligible for a DFG to explore alternatives including alternative ways of funding needed adaptations
- provide information and advice on equipment solutions
- completes a means test (as appropriate)

45% of the cases don't need to progress to a Disabled Facilities Grant.

Those who do, are assisted in:
- completing applications,
- accessing heating and other equipment based solutions whilst waiting for adaptations

The means testing assessment will have been speeded up.

The success of the project is evidenced through:

- The OT Lead for Amber Valley in Adult Care having assessed the scheme, having high confidence that the assessments carried out by the HIA are having the same outcome as if completed by an Occupational Therapist or Community Care Worker, but in a far more timely manner.
- Waiting times for assessment has dropped significantly
- Cancellations and aborted cases for DFGs are very low, therefore reducing waiting times for others as a result.
- Significant financial savings in a number of cases where clients have been encouraged to consider alternative options to adapting their current home.

The model in Amber Valley has been widened across the county with some success. However, in some areas, there had not been significant issues previously regarding the waiting time for assessment from Occupational Therapists, so this element of the triage system was not as valuable.

Challenges in enabling improved home suitability for disabled people include:

Demand
- Funding is insufficient to meet demand in some areas, whilst in others the allocated amount is not used
- Can't be certain that resources are being used to meet those most in need

- Challenge to enabling adaptations for disabled people in privately rented properties: the landlord might not want the work done; or the work is carried out, and then the landlord ends the tenancy.
- There are not enough alternatives available to DFGs, particularly for owner-occupiers.

Supply

- Gap in "hand-holding" left by the end of the Housing Options Services for Older People
- The DFG process can be too long: health and independence may worsen to the point that more costly services eg, residential care or health care are needed
- The timeliness and availability of information about options to improve suitability varies across the county, resulting in, in some areas
    - Insufficient active pursuit of alternatives such as self-payment and/or co-ordination of home adaptations, or a move to a more suitable property
    - Resources unnecessarily used to advise people who may "drop out" of the DFG process
- Court costs make it prohibitive to see repayment of DFG if the home is sold
- Impact of DFGs is not fully monitored or understood – in terms of general health and wellbeing, as well as the reduction in care services, or admission to hospital or care.

Challenges in encouraging disabled people to buy a more suitable home, (as an alternative to having their existing home adapted) include:

- Older disabled people and/or their families do not want them to sell the family home
- They may not want to "downsize" in monetary terms if it will release capital which will affect their benefits or care costs
- Equity from selling a house would not be sufficient to buy a more suitable bungalow
- The upheaval of moving and getting used to new surroundings is frightening
- People find it difficult to assess what would be suitable in terms of meeting their needs, location etc.
- Encouraging and advising people to move, takes a long time with some people, and the services are not there to do this "handholding"
- There is no one source of information to search for suitable properties for disabled people

Challenges to providing homes suitable for disabled people through a move in the social sector highlighted by services include:

- Insufficient supply of suitable properties in some areas
- No specialist officers or service matching people to properties
- People's expectations or demands for e.g. 2 bedroomed bungalow, are not always met by the stock available, which are more based on "needs" – e.g. 1 bedroomed ground floor flats
- The 'bedroom tax' can affect disabled people under retirement age who need an extra bedroom for carers or equipment

Challenges to the building of new homes suitable to meet the needs of disabled people highlighted by services include:

- The cost of land required to build larger properties and bungalows
- The additional costs to build to the standards required, mean a higher sale value, and for social housing, such costs have not always been reflected in additional grant from the HCA
- If building to meet the needs of a specific household, during the time taken to plan, fund and build, the circumstances for that household may have changed
- Requirement for disabled people's housing not included in some local plans or planning policies.
- Focus on just delivering "housing numbers" mean planning departments and committees are not able to promote, encourage or require disabled housing provision
- Planning permissions often do not stipulate the full specifications required for any disabled people's homes to be delivered, so these specifications are difficult to implement. So properties may not be suitable, or may require additional work, which can cause disruption, delays on moving in, and the cost to the buyer and/or local authority for a DFG.

- Housebuilder reluctance/refusal to build to anything other than their standard house plans
- Inexperience of housebuilders and architects in the design of homes to meet the needs of disabled people

Other preventive services

Adaptations to the home, and advice, for people with dementia

Purpose: to enable people with dementia to live independently in their own home through the use of home adaptations	
Why the service was set up/ commissioned?	• Community Concern Erewash (CCE) consulted with various key partner organisations across Derbyshire and Erewash and identified a gap in service provision, which would enable people with dementia to remain living in their own homes for longer. • Dementia can cause confusion and many suffers simply forget where rooms and items are in the home. • People with dementia often have a different visual perception than those without dementia Dementia is the one of the biggest health and social care challenges of the present day. In Derbyshire the numbers of people with dementia is expected to grow by 58% by 2025[6]. In Derbyshire there are 9,800 people predicted to have dementia. By 2025 the number of people over 85 in Derbyshire is expected to rise by 76%. As there is a positive relationship between the number of older people and the number of people with dementia, Derbyshire can expect to see approximately 15,400 people with dementia by 2025[7]. Figures provided by Alzheimer's Society in 2013 reported 1500 registered persons with dementia in Erewash. The Society during 2014 saw approximately 40 persons with dementia per quarter from the Erewash area.
What does the service do, and for whom?	For people with dementia of any age in any household type, adaptations can include: • Signage, for example a picture of a toilet on the toilet door; picture of socks/pants on bedroom drawer. • Changing colours, for example – painting bathroom walls different colour from the bathroom suite, vibrant toilet seat helps people find toilet. • Removing mirrors, which cause confusion, removing mats and rugs that the person thinks is an object to climb over, or a hole they might fall down. • Better lighting to avoid confusion and reduce risk of falls • Glass doors so can see contents • Dementia friendly flooring – shiny floors may appear wet; patterned carpets may look like shapes or things which are frightening.
How is the service is delivered?	By giving advice on adaptations and minor adaptations. Should the person with dementia / carer have additional needs, which cannot be catered for via CCE other services, they would be referred to DCC via it's First Contact scheme.
Where is the service delivered?	In people's homes. Piloting currently just in Erewash
When is the service delivered,	Home assessment and then revisit with equipment.

[6] Derbyshire Dementia Strategy 2010 to 2015
[7] Derbyshire Dementia Strategy 2010 to 2015

and for what period of time?	The pilot in Erewash runs for 8 months from December 2015
How is the service tailored for individual needs?	The service is tailored to the individual needs identified in the home visits
Evidence of success?	There will be ongoing monitoring on a monthly basis during the project duration via a telephone evaluation post-work completion, to enable us to report on a quarterly basis
What has been learnt from the project?	Project only commenced December 2016.
Partnership working and funding?	CCE has consulted with Erewash Borough Council, Derbyshire County Council, Medequip, Handyvan Service, Alzheimer's Society, Age UK, Public Health, Erewash Clinical Commissioning Group and Metropolitan Housing who said they are interested in referring into the project. Making contact with clinicians who diagnose dementia Funding from Public Health Derbyshire.
Number of people assisted by the project	This project should assist a minimum of 80 persons with dementia over a 6-month period.

Source: Andrew Raynor, Public Health Manager, Derbyshire County Council. March 2016

Enabling the development of new homes to meet needs, including affordable homes

Increasing the supply of healthy homes is one way to improve health and wellbeing amongst the population. However, the rate of building (0.5% of the total housing stock per annum) will not benefit a significant number of households: most households will live in homes that have already been built for the course of their lives.

Every local housing authority is required to have a Local Plan, which sets out a vision and a framework for the future development of the area, addressing needs and opportunities in relation to housing, the economy, community facilities and infrastructure – as well as a basis for safeguarding the environment, adapting to climate change and securing good design. Local plans are also a critical tool in guiding decisions about individual development proposals, as (together with any neighbourhood plans that have been made) they are the starting-point for considering whether applications can be approved. It is important for all areas to put an up to date plan in place to positively guide development decisions, including development that contributes positively to health and wellbeing. Without a Local Plan or five-year supply of housing land in place, local authorities are at risk of development that does not meet their needs.

All local planning authorities (the district councils) have a planning service to develop and enable the Local Plan to be achieved. The services work in partnership within the local authorities, eg, with housing colleagues, and with external organisations for example housing associations.

In addition to ensuring that the Local Plan and supporting policies promote health and wellbeing through development, the planning services:

- Inform and influence developments led by private organisations and individuals
- Work with housing colleagues and partners to enable social housing to meet needs

Table 58: New homes completed in each local authority area

New homes completed April 2014 to March 15								
Local authority	Total number of new homes	Of which						
		Number of affordable homes	Affordable homes as a percentage of total new homes	New homes to standard Lifetime Homes	New homes to Lifetime Homes ready for disabled/older	New homes to Wheelchair standard	Affordable new homes - 4 bedrooms or more	Specialist housing – number of units
Amber Valley	271	35	13%	0	0	0	0	0
Bolsover	240	10	4%	Info not available	Info not available	Info not available	Info not available	Info not available
Chesterfield	184	62	34%	Info not available	Info not available	Info not available	Info not available	Info not available
Derbyshire Dales	117	34	29%	5	5	5	0	0
Erewash	189	71	38%	22	1	4	2	0
High Peak	137	54	39%	Info not available	Info not available	Info not available	0	0
North East Derbyshire	400	151	38%	53	0	5	2	7

South Derbyshire	438	97	22%	0	0	2	0	0
Derbyshire	**1,976**	**514**	**26%**	**80**	**6**	**16**	**4**	**7**

Source: Information from individual local authority planning officers and strategic housing officers. February 2016

The Derbyshire Planning and Health group, consisting of planning, strategic housing and public health officers is taking forward a strategic statement and action plan to co-operate across agencies to ensure that new homes and neighbourhoods are places which provide the opportunity for people to live a healthy and fulfilling life.

The challenges to delivering more and healthy homes through the planning system are many, including:

- Developers can pick and choose which sites to develop and don't want to develop "difficult" sites (for example which require some remediation)
- Developers will only want to build in the highest value areas, and high value properties which will maximise their profits: there is little building in lower value areas, or of lower value homes
- In some areas, which have no Local Plan, there has been a great deal of development, with developers taking advantage of the window of opportunity. However, these homes are not necessarily in the location or of the type needed to meet needs.
- In other areas, where a local authority cannot demonstrate a five-year housing land supply – they have had to encourage planning applications to increase the supply. This has meant that local authorities are granting permissions with, for example, much lower percentage of affordable housing.
- Once permissions are granted, unless clauses are included in the permissions, the sites are not getting built. This may be because developers are not interested in the inflated land prices expected by landowners; because developers are concentrating on building in other areas, or are "land banking", waiting for house prices to increase; or developers are struggling to get the labour and materials to build.
- The uncertainties around new government initiatives such as starter homes, are delaying some planning applications and/or the development of sites
- New Homes Bonus consultation indicates that local authorities will be "penalised" for refusing planning applications, as would they would not get New Homes Bonus on sites which only won planning permission at appeal. As local authorities would normally only refuse a permission because the scheme was, for example, not providing sufficient or suitable community benefits, or of poor design or not meeting needs, the importance of such factors seem to be being overridden.
- For some local authority planning officers, committees and councillors the only focus is on the "number" of new homes, regardless of whether these are meeting needs, or the impact on communities, health or wellbeing. This focus appears to be encouraged by central government.
- Currently, each local authority works separately to deliver homes, which can be fairly inefficient, and developers can "pick off" individual local authorities. Whilst there are conversations between local authorities, and some joint working, this is not widespread. A combined authority (ies) in some form would be useful, but there is no clear steer yet as to how this would work. There still appears to be mistrust and reticence over perceived loss of power and influence by some districts with regard to planning (although such powers and influence may/is being reduced by central government actions anyway).
- Developers are not keen on the government's starter homes initiative: will only attract people who would have bought anyway. New homes with discount are more expensive than second hand homes: just an additional choice, although the latter market has competition from buy to let landlords.

In relation to affordable rented homes – homes below the private market rent - local authorities assess the need for these homes through their Strategic Housing Market Assessments or Housing Needs Studies. In practice there are many things, which might affect the delivery of these.

Local authorities can influence, enable or ensure that such homes are built through: -

- The Local Plan and supporting policy framework, which sets out the requirements for affordable housing, and how these will be achieved.

- Granting planning permissions which require housing developers to provide a percentage of new homes built, to be built as social housing, to be sold to a social landlord
- Housing associations and local authorities can find and acquire sites, and build or commission the build of new social homes, with funding from the Homes and Communities Agency (HCA), and/or their own resources and lending.

The number of social homes built varies considerably between local authorities, related to the overall housing market, values and viability, and planning policies.

Table 59: Social Homes built – number, and as a percentage of all homes built 2014-2015

	Social homes built, completed April 2014 to March 15	All homes built, completed April 2014 to March 2015	Social homes completed as a percentage of all homes built, completed April 2014 to March 2015
Amber Valley	35	271	12.9%
Bolsover	10	253	4.0%
Chesterfield	62	184	33.7%
Derbyshire Dales	34	117	29.1%
Erewash	71	189	37.6%
High Peak	54	137	35.8%
North East Derbyshire	151	400*	37.8%
South Derbyshire	97	438	22.1%
Totals	460	1852	25.3%

Source: Local authority planning team information. February 2016

The challenges to delivering more social homes in the future are many, including:

- Government focus on redefining “affordable” homes as homes for first time buyers, rather than rented
- Possibly little or no funding available for the development of new rented homes – either from the HCA, or from housing associations and local authorities, due to a variety of recent central government actions.
- Government pressure to remove Lifetime Tenancies and replace with fixed term
- Focus from government on a market led housing market, leaving little opportunity for local authorities to focus on meeting needs, or providing more security for tenants
- Difficulty in persuading developers to provide social homes and, in some areas, they feel they do not have very localised and current information to strengthen the case
- Financial and other pressures prevent the building of new social homes to meet needs – eg. 4 bedroomed houses, older people’s bungalows
- In some areas, can meet needs – lots of 1 bedroomed bungalows and ground floor flats, but people demand 2 bedroomed.
- For some local authority planning officers, committees and councillors – the only focus is on the “number” of new homes, and therefore social housing provision is has to take a back seat. This focus appears to be encouraged by central government.
- In some local authority areas, from some councillors and senior officers, there is still a “prejudice” against social housing – either as undesirable, or unnecessary.
- Rent cut has drastically reduced stock-holding local authorities capacity to build.
- HCA audit process makes very difficult to. empty homes and conversions (and currently no funding for these).
- Fears that there will be little or no social housing built in the future

Annex F Evidence based approaches and interventions – national perspective

This Annex presents the main sources of evidence-based recommendations and guidance on approaches to improving health through the home, and makes reference to examples of services and interventions elsewhere in the country that are able to demonstrate these approaches in practice, and are potentially relevant to the Derbyshire context.

Unhealthy homes

The focus of national published guidance has been on:

a) Temperature related risks to health and wellbeing
b) Unintentional injuries in the home

Temperature

The following provide recommendations for commissioning and interventions:

- Excess winter deaths, illness and health risks associated with cold homes (NICE)
- The Cold Weather Plan and supporting action cards, evidence and literature review (PHE)
- The Heatwave Plan for England (PHE)

These recommendations are particularly relevant to the Derbyshire context given the evidence of the scale and nature of the relationship, that there is no strategy in place to tackle cold homes or over-heating homes in Derbyshire and that the service offer to those at risk from cold homes inconsistent across the county:

- The Health and Wellbeing Board should develop a strategy to address the health consequences of living in a cold home (and/or over-heating home), which should include targeted action towards those who are known to be at greatest risk (action should be taken to identify these households), and draw on the contributions of organisations including 'blue light' services such as Derbyshire Fire and Rescue, and the voluntary and community sector
- Commission a single-point-of-contact health and housing referral service for people living in cold homes, offering tailored solutions [see also home improvement agency role in next section]
- Raise awareness amongst practitioners and the public about how to take action on cold homes, and make every contact count, developing workforces who have the opportunity to identify if someone is living in a cold home to a) recognise the issue eg, on discharge from hospital or during a home visit, and b) to take appropriate action

Key to preventing health risks from temperature is year-round planning and preparedness ie, not waiting until the temperature changes before taking action.

Related to the development of a single-point of contact health and housing referral service it would be worth applying DECC's recently published affordable warmth and health impact evaluation tool to the existing local services to understand which models and interventions are most effective.

Although there are numerous examples of services that work towards addressing temperature-related risks (primarily cold) they take different approaches to meeting the local needs that they feel are the priority ie, there is no one-size fits all and identifying a perfect model for Derbyshire to replicate simply isn't possible. Given the geographical proximity, that national bodies such as the LGA and the CIEH have recognised the service for its positive practice, and that local partners such as South Derbyshire Clinical Commissioning Group consider services worth investing in, Derby's Healthy Housing Hub is a potential model to build on in Derbyshire (in addition to existing provision). An up-to-date evaluation of this service is due in 2016/17 but in 2013/14 it reported that clients with a history of falls who received services from the Hub, saw a reduction of 39.5% in their use of A&E and 53.8% in acute hospital stays.

Unintentional injuries

The following provide relevant recommendations for commissioning and interventions:

- Preventing unintentional injuries in under 15s (NICE)
- Reducing unintentional injuries in and around the home among children under five years (PHE)

Given the evidence of the scale and nature of the relationship eg, levels of overcrowding, and that there is no strategy in place to prevent unintentional injuries across the county (the only information found on this topic is Derbyshire and Derby's Safeguarding Children Boards 'Family Safety Advice Guidance', dated July 2014: this is only applicable to families who will be supported by practitioners to complete the early help assessment and Social Care single assessment), these recommendations are particularly relevant to the Derbyshire context:

- Working in partnership, identify and prioritise households at greatest risk of unintentional injury as a consequence of the home environment, for example because they live in overcrowded homes or rented accommodation, and co-ordinate the delivery of home safety assessments and interventions
- Integrate home safety into other home visits

Unsuitable homes

NICE guidance has been published on topics where suitable housing, particularly the role of home adaptations and good design, is important. These are:

- Dementia, independence and wellbeing
- Falls prevention in older people
- Enabling transition from hospital to home for adults with social care needs
- Older people: enabling independence and mental wellbeing
- Older people with social care needs and multiple long term conditions

The role of home adaptations as a preventive intervention has also been recognised in government policy, including in the recent announcement to increase the Better Care Fund (which incorporates the Disabled Facilities Grant), in order to deliver an additional 70,000 adaptations by 2020. A series of briefings have been published by Care and Repair England, on behalf of Public Health England, that explain the contribution home adaptations can make to health and wellbeing outcomes, and suggest how these can best be commissioned and implemented, drawing on a number of practice examples that are considered the best in the country (they have been endorsed by the Home Adaptations Consortium). NHS England has also recently published a guide to 'better use of care at home' aimed at Clinical Commissioning Groups which highlights the important role of adaptations - and home improvements – in preventing hospital admissions and ensuring timely transfers of care from hospital.

Common features of services considered to be effective in enabling people to remain independent in their own home (typically described as home improvement agencies), are:

- They also respond to 'unhealthy home' issues eg, improving energy efficiency and removing other hazards ie, there is a single service responded to both unhealthy and unsuitable housing issues as a means to enabling independence, health and wellbeing
- They promote independent living through a combination of approaches including the use of a 'shop front', housing options information and advice
- They offer targeted services eg, to enable timely transfers of care from hospital, to prevent falls amongst those most at risk, to people living with dementia
- The use of technology in service delivery eg, telehealth and telecare, and in enabling efficient access to services
- Services are funded through a combination of a pooled budget from the local authorities, funding from health care and social care commissioners to deliver specific services eg, hospital discharge, and they also offer services to self-funders

Home improvement agency/home adaptation practice examples of particular relevance to Derbyshire are (these are described in the earlier links):

- Suffolk: a housing association delivered (Orbit) home improvement agency delivers home adaptation and improvement services on behalf of the County Council and six district councils
- Cornwall: although now a unitary authority, Cornwall was a county with three home improvement agencies. These were amalgamated into one agency, and it was expanded to include the occupational therapists and housing options services. This has enabled the whole customer journey to be included within a single organisation, preventing the common communication problems and forming a unitary approach to the customer.
- West of England Care & Repair: this operates across four unitary authorities, using a pooled budget

Derbyshire is in the early stages of reviewing its approach to home adaptations: NICE recommendations and sector- produced guidance will be relevant to this process, as will emerging evidence from the Centre for Ageing Better.

On the topic of hospital discharge and delayed transfers of care, NHS England's Better Use of Care at Home guide is one source of information on this topic, and cites a number of practice examples, for example the 'discharge to assess' model is gaining support in a number of areas as a means to more effectively assess a patients longer term needs; the assessment is completed in a person's home rather than in an acute setting, and if there is a problem with housing suitability, temporary accommodation or step-down facilities may be a suitable environment for this assessment. NHS England is expected to deliver a 'housing and health' programme of support to CCGs in 2016/17, building on the guide and enabling access to positive practice in other areas.

Precarious housing and homelessness

NICE guidance has been published on the topic of tuberculosis, incorporating action for people who are particularly at risk eg, homeless people, and recommending that housing needs are addressed for those where it will present a barrier to treatment completion. Guidance on Dual diagnosis is due in November 2016: the scope includes people who experience homelessness.

Recognising the importance of the home environment to successful completion of drug and alcohol treatment Public Health England's 'joint strategic needs assessment support' for local authorities includes a number of good practice prompts relating to housing and homelessness, which suggest that:

- The housing needs of alcohol and drug users in the community, prison and residential treatment have been identified and are used to inform local commissioning plans for housing, homelessness and housing-related services
- The housing needs of alcohol and drug misusers and their families and carers (where appropriate) are assessed to prevent homelessness and/or to enable move-on to a suitable home (this includes those in prison, in residential services and those living in their own home but at risk of homelessness.)
- Good quality housing information and advice is readily available
- There are a range of suitable housing options to meet different needs including: emergency bed spaces; direct access accommodation; refuges for those fleeing domestic abuse; supported housing; floating support available to those in their own home; accommodation specifically for women or young people, housing for people with complex needs eg, Housing First
- Alcohol and drug misusers who are rough sleeping are able to access emergency accommodation and appropriate support
- The health needs of homeless alcohol and drug users been identified and they are supported to access primary and other healthcare [see later]
- Frontline housing staff (working in local authority services, for social landlords and housing support providers) are trained in working with alcohol and drug users to meet their housing and related needs
- There is a homeless hospital discharge policy and procedure in place for homeless alcohol and drug users (and others) to enable access to a pathway to suitable housing

Recognising that local areas find it difficult to understand the health needs of their homeless population, PHE commissioned Homeless Link to revise the 'homeless health needs audit tool' in 2015 (originally commissioned by Department of Health in 2010); over 40 local areas have or are in the process of completing this audit to inform their local housing, health care and social care commissioning for their homeless population.

There are opportunities to prevent homelessness in community and other health care settings, identified by Homeless Link on behalf of PHE in a rapid evidence review. These are described under four typologies:

1. Welfare Rights and consumer advice (includes housing advice) (primary prevention)
   Advice within primary care settings such as GP surgeries; Targeted welfare advice for patients leaving secondary care; Holistic advice services (including debt, mental health) to young people in a non-health setting (eg youth advice services)

2. Holistic in-tenancy support (secondary prevention)
   Support and services available to people living in their own home/tenancy to help them live independently and successfully maintain accommodation. Usually targeted at those who are at risk of losing their homes Known 'at risk' groups are vulnerable to repeat homelessness including those with mental health problems and in treatment programmes.

3. Targeted support and advocacy to people leaving institutions (secondary prevention)
   Targeted support to plan and respond to known 'transition' points from institutions. Could include housing and income support for psychiatric patients pre discharge; residential programme for young people leaving care Leaving institutions and the transition back into the community presents a trigger point where there is greater risk of homelessness and repeat admissions occurring, e.g. hospital, psychiatric care, prisons and care system

4. Critical time intervention (CTI) targeted at groups in the community (tertiary prevention)
   CTI is targeted at groups in the community who have already experienced homelessness and their characteristics and circumstances mean that once they are back living in their own accommodation are more likely to become homeless again. The model recognises that there are 'critical times' where support is needed to prevent homelessness for those who also likely to experience multiple needs including substance misuse issues, fleeing violence, offending history and mental health needs.

Annex G Analysis of assessment to inform recommendations

Health and social care performance – for improvement	Scale and nature	National context	Local framework for homes and health	Evidence based interventions
Across the life course				
See life course stages: a number of measures relate to cold housing in each life course	• Nationally the evidence of the cost of poor condition to health and wellbeing is the most robust, with a recent figure of up to £2bn per annum to the NHS in England (BRE 2015) – cold is the biggest factor • In Derbyshire, some local authorities have very out-of-date information about housing conditions (does not meet duty) • Available evidence suggests that housing in poorer condition in Derbyshire than for England. • The rate of fuel poverty (12.8%) is higher than the national average (10.4%) • Poor condition housing is known to have significant impact on physical and mental health and wellbeing, particularly people who spend a lot of time at home: children; disabled people and people with other long-term conditions; older people; carers.	• From a health perspective, preventing, delaying and reducing the need for social care and health care are priorities but the focus of policy and funding remains on treatment of ill-health rather than prevention • Expectation that integration and devolution will enable shift (with Better Care Fund a mechanism to encourage this) • Policy of addressing cold homes has been driven by carbon-reduction targets, not health. Recent schemes to address fuel poverty ended and not known yet what will replace these • Local areas encouraged to evaluate impact of schemes, potentially to identify benefits to health and social care	Within local housing strategies: • Although the main focus of local housing strategies is the relationship between unhealthy housing conditions, health and wellbeing, they don't reflect any depth of understanding of specific health impacts. • There is a particular emphasis on older households in terms of identifying the problem and available solutions	• Health risks from cold homes is one of only two housing specific NICE guidelines and quality standards ie, the issue is 'good enough' evidence of 'what works'. • The Derbyshire offer to residents does not meet the offer described in NICE guidelines eg, a single point of access There are a number of services/interventions in Derbyshire but: • The impact of 'core' local authority services (private sector/environmental health/enforcement) is not measureable, and these services are limited in their capacity to be proactive • The Derbyshire Healthy Home project shows promise but it is only funded until December 2016 • The offer to residents is not consistent across the county: there is also a home improvement agency operating across six of the eight local areas, and a specific programme in Amber Valley

Health and social care performance – for improvement	Scale and nature	National context	Local framework for homes and health	Evidence based interventions
				• The Nottinghamshire and Derbyshire Local Authority Energy Partnership has been hugely effective in attracting external resources to the area but this appears to be despite a clear strategy, rather than because of
Starting and developing well				
Hospital admissions due to injuries	• Little specific data beyond within homeless families approaching district councils for housing advice/homelessness response (adults are the client) • Evidence of overcrowding and poor quality homes in private and owner occupied sectors • Evidence nationally that if don't act on homelessness then affects life chances eg, increase likelihood of complex needs	• Education is part of national policy to achieve economic security • Strategy to improve life chances expected	• Only real consideration is given to homeless families with dependent children and young people aged 16/17 years (owed a duty) • There is no strategy in place to prevent injuries	• Health risks from home hazards to the health of children (injuries) is one of only two housing specific NICE guidelines ie, the issue is significant and there is evidence of 'what works' • In Derbyshire there are no specific services on offer to prevent and reduce injuries in the home • Few outputs from home improvement agencies related to children and young people
Living and working well				
• Successful drug treatment • Alcohol related hospital admissions • TB treatment completion • Suicide	• Particular risks to health and potential impact on economic contribution for: ○ Those living in the private rented sector , as a consequence of insecurity (this is main the population	• Economic security is the priority for the government and related to this, reducing unemployment and reliance on low pay/welfare assistance • From a health perspective, preventing ill-health in later life is a priority	Little consideration to this population unless • Homeless & parents of dependent children (owed a duty) • Adults with additional needs related to substance misuse or	• Housing advice/options services are the main contact point for this population but it isn't possible to know if these services are effective in improving health and wellbeing, and addressing issues which may be impacting on their

Health and social care performance – for improvement	Scale and nature	National context	Local framework for homes and health	Evidence based interventions
• Levels of admission for residential and nursing care for 18 – 64 year olds	in this tenure) ○ Disabled working age adults - estimated that around 40% living in unsuitable housing ○ Those with multiple needs including homelessness, mental health, alcohol or drug, criminal justice experience • The largest group approaching district councils for housing advice/homelessness, just over half did not have dependent children. Nothing known about their health and wellbeing • Relationship breakdown and financial problems are main reasons for approaches: known to present a risk to wellbeing and to mental health • These households generally not owed a homeless duty – may have unmet needs • Rough sleeping: official figures suggest decrease but other services suggest otherwise (national picture is rising problem)	• Government expected to propose a change in legislation to prevent homelessness for all households and at an earlier stage • Government spending on single homelessness is for outcomes-based Social Impact Bonds	mental ill health Some implied consideration to people who have a long-term health condition or disabled people	ability to work • Whilst there are some apparently good services in place for the working age population without dependent children who are at risk of/actually homelessness and may have other needs eg, (Healthy Futures and Pathways of Chesterfield), these are at the more 'acute' end of the problem. More preventive housing support services have been reduced: the impact of this is not known locally but evidence from similar decisions elsewhere suggests it will have a negative effect. • Assessment didn't look in detail at the effectiveness of all services available to adults with multiple and complex needs commissioned outside 'housing' eg, treatment, offender resettlement etc.

Health and social care performance – for improvement	Scale and nature	National context	Local framework for homes and health	Evidence based interventions
	• Service data suggests a demand for home adaptations and community equipment from this population			
Ageing well				
A number of measures shared with the NHS eg, • Mortality from respiratory or cardiovascular diseases considered preventable • Excess winter deaths • Falls in over 65s (particularly over 80s) • Hip fractures • Levels of admission for residential and nursing care for over 65s	Far fewer older households approach housing advice services compared to other populations, but of those that have • They have the most diverse range of needs of all populations • Financial matters are a greater proportion of reasons for the approach • A higher proportion of those approaching are homeless The lower number of approaches may be a consequence of these households accessing other services for housing advice and information, perhaps alongside social care Although the private rented sector is commonly thought of as home to younger households, there's evidence that older households live here, and that some want to move (17% of older households on the Housing Register live in the PRS)	• The focus of government attention is the increasing demand for health care and social care from an increasing older population. • Integrating health care and social care by 2020 as a means to responding to rising demands is the top priority relevant to this population. • Statutory guidance to the Care Act 2014 states that housing is a preventive health service: commissioning and delivery of health care and social care must integrate with housing. The Better Care Fund underlines this intention with the inclusion of the Disabled Facilities Grant for home adaptations • With the pension age rising, and government ambition to operate a surplus, it is also important for the future older population to have a healthy, disability free, quality of life: public health priorities are focussed preventing ill-health	Main focus on local housing framework is on meeting older people's needs as they relate to: • Cold and energy inefficient homes • Unsuitability, for example the home does not enable mobility or independence There is just one reference in 44 documents to homelessness in later life.	• Given the demand for health care and social care from this population, it has been the focus of much recent NICE guidance, on topics such as falls, dementia, and hospital discharge. • Common to this guidance is the need for: ○ Suitable housing – adapted or specifically designed for use ○ The use of technology ○ Information and advice to inform patient/customer choice ○ A frontline workforce that is able to recognise risks to health and wellbeing and take action ○ Partnership working across sectors, joint strategies and agreed pathways and protocols • The provision of home adaptations is a mandatory requirement of local district authorities, Across the nine authorities are eight different

Health and social care performance – for improvement	Scale and nature	National context	Local framework for homes and health	Evidence based interventions
	Given the greater numbers of older people and fewer young adults and children In Derbyshire compared with other authorities, and the associated demand for services to enable independence, social care and health care, combined with the focus of local strategies and interventions on the older population, it is unsurprising that there is more information about risks to health from unhealthy and unsuitable homes: • The proportion of disabled people living in unsuitable homes increases with age • The main customers of home improvement/adaptation services are older people	amongst the working age population eg, prevention of dementia		district council services, plus two home improvement agencies, and two Derbyshire services: Call Derbyshire and social care. Compared to effective practice elsewhere this is an overly complicated and likely costly approach that does not provide a clear pathway to outcomes for customers. Derbyshire has recognised this an is in the early stages of reviewing and revising the model • There is assistive technology service with potential for this to be scaled for use by other organisations, if this is not already the approach • There appear to be multiple sources of information and advice, general or specifically relevant to older or disabled people, but it isn't clear how effective any of this is in enabling better health outcomes through the home. There is only one specific housing options service for older people in Derbyshire Dales (this was a larger scheme but the funding ended)

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