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Social Services, Housing and Public Health Policy Overview Committee

Date: TUESDAY, 6 OCTOBER 2015

Time: 7.00 PM

Venue: COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW

Meeting Details: Members of the Public and Press are welcome to attend this meeting

Councillors on the Committee

Wayne Bridges (Chairman)
Teji Barnes (Vice Chairman)
Shehryar Ahmad-Wallana
Peter Davis
Beulah East (Labour Lead)
Becky Haggar
Manjit Khatra
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Co-Opted Member
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SOCIAL SERVICES, HOUSING & PUBLIC HEALTH

To perform the policy overview role outlined above in relation to the following matters:

1. Adult Social Care
2. Older People's Services
3. Care and support for people with physical disabilities, mental health problems and learning difficulties
4. Asylum Seekers
5. Local Authority Public Health services
6. Encouraging a fit and healthy lifestyle
7. Health Control Unit, Heathrow
8. Encouraging home ownership
9. Social and supported housing provision for local residents
10. Homelessness and housing needs
11. Home energy conservation
12. National Welfare and Benefits changes

Agenda

CHAIRMAN'S ANNOUNCEMENTS

1	Apologies for Absence and to report the presence of any substitute Members	
2	Declarations of Interest in matters coming before this meeting	
3	To receive the minutes of the meeting held on 3 September 2015 - to follow	
4	To confirm that the items of business marked in Part I will be considered in Public and that the items marked Part II will be considered in Private	
5	Review Of Hillingdon's Shared Lives Scheme - Update On Review Recommendations	1 - 6
6	Major Reviews in 2015/16 - Raising Standards in Private Rented Sector Accommodation - Witness Session 2	7 - 18
7	Forward Plan	19 - 24
8	Work Programme	25 - 28

REVIEW OF HILLINGDON'S SHARED LIVES SCHEME UPDATE ON REVIEW RECOMMENDATIONS.

Contact Officer: Sandra Taylor & Kim Jebson
Telephone: 0415 & 8313

REASON FOR ITEM

During 2014/15, the Committee conducted a review on the *'Hillingdon's Shared Lives Scheme'.* This report provides a brief overview of the Shared Lives Scheme and an update on the status of the five recommendations made by the Committee which were considered by Cabinet on 12 February 2015.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To note the progress made by officers on the Committee's recommendations.
2. To question officers on its content.

INFORMATION

The Shared Lives Scheme

The aim of the Shared Lives scheme is to provide accommodation, care and support for a vulnerable adult in a safe, appropriate manner in a family setting.

Within the placement service, users are able to achieve a positive outcome from Shared Lives, by way of their involvement and participation in family life, promoting a full and active life within the range that their physical and mental health and / or ability will allow. The scheme extends the range of housing and support options available to residents in Hillingdon, by providing a more personal form of care in family homes.

The scheme is open to adults aged 18 years or over with a learning disability, recovering mental problem, physical or sensory disability or someone who needs support because they are an older person.

Shared Lives: The Review

The Terms of Reference of the review were as follows:

1. To review how Shared Lives is developing in Hillingdon and other local authorities and to review current best practice.
2. To examine the opportunities presented by Shared Lives to prevent avoidable admission into residential and/or hospital, including assisting carers in their caring role.
3. To make recommendations that will help officers and partners address any identified gaps in the role and function of Shared Lives to support Hillingdon residents to remain independent and assist the Council in achieving cost savings.
4. To make any recommendations, with full costings to Cabinet to improve the efficiency and effectiveness of the service as appropriate based upon the findings of this review.

The review examined the effectiveness of the current arrangements for The Shared Lives Scheme and proposed improvements which could be made to enhance this important aspect of independent living to the Borough's residents.

Update Response to POC - recommendations

The Report of the Social Services, Housing and Public Health Policy Overview Committee 2014/15 on 'Hillingdon's Shared Lives Scheme' was considered by Cabinet on 12 February 2015. Cabinet welcomed the report and endorsed the recommendations made.

That Cabinet:

A) Welcomes the report from the Social Services, Housing and Public Health Policy Overview Committee (as in Appendix 1) on the review into Hillingdon's Shared Lives Scheme and;

B) Endorses the recommendations of the Policy Overview Committee as set out below:-

1. That the Committee commend the Shared Lives scheme to Cabinet and recognise the good work undertaken by Officers to develop a successful scheme that delivers much improved quality of life to the participants and has the capacity to deliver modest financial savings.

During the past nine months the scheme has reviewed how it recruits carers and offers placements with a proactive approach to increasing the size of the scheme. As identified during the major review, this can at times prove challenging predominantly due to the appropriateness of the available accommodation. However, the scheme has managed to increase the number of registered carers to 36, this is inclusive of carers who provide respite. This is an increase of 3 people who are fully registered and able to provide a service.

There are currently 7 further applications in progress that will give the scheme 43 registered carers.

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Referrals:
In this period the Council received 28 referrals which it was able to match eight placements, this is broken down to one long, two short term and five respite placements, this includes two service users who were previously accessing Merrimans House buildings based respite.

This brings the current total number of people using the scheme to 33, an increase of 5 people.

Some of the reasons that a referral was declined over this period are that -

- History of violence and aggression and substance misuse
- Availability of ground floor accommodation
- Availability of stay at home carers during the day
- Level of care needs i.e. waking nights, two to transfer and mobilise
- Declined by service users to consider the scheme for placement

2. That there are potential challenges in the scheme, including safeguarding, and that any proposal to develop the scheme should ensure robust management such as is currently in place.

During the development of the scheme the level of support given to both carers and service users has not been compromised. Systems are in place to recruit new carers, assess any potential service users and ensure the matching process and monitoring of placements are completed to the highest standards. The Council are committed and feel confident that the increase to 40 service users using the scheme for placements with our current level of staffing remains achievable.

HSL is a CQC registered scheme and as such adheres to robust quality auditing and monitoring standards to ensure compliance. A full compliance inspection is due during 2015/16 and the registered manager reports that she is satisfied that the standards will be met. The Management oversight of this service via a QA monthly report indicates that the service is meeting standards and has robust safeguarding and QA checks in place.

3. **That the Cabinet Member for Social Services, Health and Housing and Leader of the Council, consider extending the scheme, as identified in the review, in the first instance by 100% (i.e. to total 40 Service Users) and that potential savings arising from this be investigated for inclusion in the MTFF from 2016/17.**

   There are currently 33 service users in either short, long term or respite placements within the scheme. The scheme has the capacity to increase the placements to 40 as identified in the major review and this work is ongoing.

   Savings to date are identified below. You will note that these are predominantly around cost avoidance, whereby, Shared Lives is delivering a service for less that would have been purchased otherwise for that person. The table below shows part year effect.

Placement Type	Head Count	Saving To 30/09/2015	15/16 Estimate	Full Year Saving
Permanent Saving	2	-272	-421	-297
Permanent Cost Avoidance	1	-9,243	-20,672	-22,794
Respite Saving	4	-2,830	-6,793	-6,793
	Total	**-12,345**	**-27,886**	**-29,884**

4. **That consideration be given to further development up to the optimal size (80 service users) once the initial extension has been successfully undertaken.**

   As part of the scaling up of the scheme, Hillingdon Shared Lives has commenced work with Shared Lives Plus to expand the scheme to 16+ young adults.

   By expanding the scheme to provide placements to service users with a learning disability from 16+ this will give opportunities in accommodation to a younger group in order to relieve the pressure on the current building based residential services and to encourage young adults to receive respite care within a family environment whilst focusing upon building semi independent skills to assist them to become independent in the future or consider the scheme for placement as opposed to residential care or supported living in the future.

   Some consideration was given to joining the West London Alliance shared lives working group to establish if collaboration was possible, however, this work has

yet to be completed and at this stage, it would not be in the interest of our scheme to move to this model.

Advertising & recruitment:

The team are working with Hillingdon Corporate Communications to explore further promotional and marketing ideas to raise awareness of the scheme and recruit carers as well as highlight the scheme as an attractive option for placement. Some of the ongoing work includes

- Adding HSL Advertisement to LBH Facebook Page and using social media
- Having a Full Length Banner in Reception Area at Civic Centre
- Revision of HSL Poster to include 16+ Placements
- Update and Enhance Shared Lives Website to include separate Log In area for Registered Carers to give them online access to Forms and Policies. Make Website more user friendly
- Testimonies from our current carers and service users to utilise within advertising.

5. **That any extension of the scheme is dependent upon appropriate matches being found in the community and that consequently the time frame needs to be flexible.**

To increase the numbers of carers that could provide placements for service users depends on the response the Council receives from its future marketing plan. The Council would like to attract people who would see this role as their main job, possibly after early retirement or similar, being flexible with the support that could be provided during the placement. The Council will be targeting people who have or are used to caring for young people for the 16+ group. Ground floor accommodation is also a key factor in accepting a carer as this is predominantly where our demand sits.

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MAJOR REVIEWS IN 2015/16 - RAISING STANDARDS IN PRIVATE RENTED SECTOR ACCOMMODATION - WITNESS SESSION 2

Contact Officer: S Hajioff
Telephone: x 7574

REASON FOR ITEM

To enable the Committee to gather evidence as part of their Major Review into 'Raising Standards In Private Rented Sector Accommodation'

OPTIONS AVAILABLE TO THE COMMITTEE

1. Question the witnesses
2. Highlight issues for further investigation.
3. To make a note of possible recommendations for the review.

BACKGROUND

At the Committee meeting on 22 April 2015, Members discussed a number of potential review topics for 2015/16 and requested officers to prepare a scoping report on *Raising Standards In Private Rented Sector Accommodation'.*

At 3 September 2015 meeting, the first witness session provided a profile of the sector and its tenants and how this had changed for comparative purposes. It also provided an overview of the impacts of recent benefits and other relevant legislation, and gave an insight into the (financial) accessibility of the sector.

This witness session will focus on the health implications of poor housing.

INFORMATION

Housing and Health
Introduction

The World Health Organisation has defined health as “a state of complete physical, mental and social well being”. This report deals with the important contribution made to health and illness by the standard of accommodation..
Recognition of the impact of poor housing on health is not recent. In 1842, Chadwick established a link between the appalling living conditions of the poor and their ill health. Many of the most significant gains in health that followed stemmed from public health measures, notably clean water, sanitation, and reduced exposure to extreme cold and other factors associated with improved accommodation. The second half of the 20th century saw a widening recognition of the health consequences of poor housing. The government-commissioned Black Report [1] placed particular emphasis on housing as a health inequality issue and saw adequate housing as a prime requisite for health. The social and physical characteristics of the surrounding area are also vital in maintaining good health. If poor quality accommodation is situated in impoverished surroundings with few local amenities this could lead to vulnerable persons placing a greater reliance on domiciliary services.

Housing has long been recognised as an important mechanism for improving people’s health and sense of well-being and for reducing health inequalities between different groups. The relationship between housing and health is, however, a complex one as housing is inextricably linked with other key determinants of health such as the socioeconomic circumstances of individuals and locality factors.

Groups such as those who are already unwell, older people, people with disabilities and the unemployed are among those most likely to live in poor housing and also tend to spend long periods of time indoors exposed to potentially hazardous environments. Housing improvements among these groups may have the potential for greater health gain and may, therefore, be used as a tool for tackling the complex dynamic between poverty and poor health. It should also be noted that, while for some vulnerable groups their specific housing needs are self-evident (for example stair-free access for wheelchair users), for some it may depend on a clear understanding of their individual needs. A person with inflammatory bowel disease (Crohn's disease or ulcerative colitis) may have regular and urgent need for access to lavatory facilities and therefore may not be best served by shared bathroom arrangements, for example.

The following sections briefly describe specific health problems associated with common hazards found in poor housing.

[1] Black Report 1980 http://www.ncbi.nlm.nih.gov/pubmed/7118327

Indoor dampness and mould problems in homes

Dampness, moisture and mould in indoor environments have been associated with adverse health effects in population studies in Europe, North America and elsewhere. Most commonly reported health effects are airways symptoms, such as cough and wheeze, but other respiratory effects, and skin and general symptoms have also been reported. There is a relative lack of knowledge regarding the role of specific exposures in dampness and mould related health problems, largely due to their complex nature, the large variety of microbes that may play a role for the adverse health effects, and problems with quantitative exposure assessment methods for bio aerosols. Bio aerosols, i.e., particles of biological origin, may be found in elevated concentrations in the indoor air of damp and/or poorly ventilated buildings. Bio aerosols relevant to health in damp indoor environments include fungi (especially moulds and yeasts), fungal spores, hyphae, as well as fungal fragments and allergens; bacteria and bacterial spores; microbial toxins and pro-inflammatory components (e.g. mycotoxins, endotoxin, exotoxins, peptidoglycans); arthropod allergens (e.g. from mites); algae; and amoebae (Jaakkola 2012[2]). In addition to bio aerosols, indoor dampness may result in elevated concentrations of microbial volatile organic chemicals as well as increased chemical emissions of building materials, such as phthalates.

Reversible airflow obstruction, enhanced bronchial reactivity and chronic airway inflammation form the basis for current definitions of asthma. They represent the major pathophysiological mechanisms leading to the symptoms of wheezing, breathlessness, chest tightness and cough by which physicians clinically identify this disorder, together with lung function measurements. Associations with both new-onset asthma and asthma exacerbations have been documented especially in children, and to some extent also in adults.

Housing conditions and home injury

Injuries include burns, poisonings, ingestion of foreign objects, and fire-related injuries (including death from smoke inhalation), as well as drownings, falls, cuts and collisions with objects. Faulty gas and electricity installations can result in carbon monoxide poisoning and risk of fire.

Injuries in the home present an important health burden worldwide. In Europe, almost 110 000 people die each year as a result of a home/leisure injury and an estimated 32 000 000 are hospitalised (WHO 2011[3]). The 2003-2005

[2] Residential mould http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3492391/

[3] WHO Environmental Burden of Disease associated with inadequate housing 2011 http://www.euro.who.int/en/publications/abstracts/environmental-burden-of-disease-associated-with-inadequate-housing.-summary-report

home/leisure fatal injury rate is 22/100 000 over all Europe. The injury burden is particularly important for children: in Europe, home injury deaths are highest in children under 5 years of age and then sharply decrease, in contrast to road traffic deaths, which increase with age.

Overcrowding

Definitions on overcrowding include a normative judgement about the adequacy of personal space in a dwelling and an objective measure of number of people per room in a dwelling (Office of the Deputy Prime Minister, 2004[4]) The measurement of the extent of crowding and overcrowding also varies considerably. Some studies measure the number of people per dwelling whilst others focus on the number of people per room or persons per bedroom. The threshold whereby a property is deemed to be overcrowded also differs between studies. Overcrowding may have both direct and indirect effects. The latter are of course less easily measured. For example, children's education may be affected by overcrowding directly, through a lack of space for study, as well as indirectly because of school absences caused by illness, which may be related to overcrowding. Findings on the impact of overcrowding may also be subject to possible 'selection effects'. This can happen in two main ways. People with poor health may have difficulty holding down or securing employment and may not be able to afford housing appropriate to their needs. As a result they may end up living in overcrowded housing. Additionally, people with illnesses may live in overcrowded conditions as a result of their need for care and support from relatives. This was evident in Kempson's study[5] of overcrowding in Bangladeshi households in Tower Hamlets.

Overcrowding can lead to both physical illnesses such as tuberculosis from close contact with infected co-inhabitants and mental illnesses caused from stress due to invasions of privacy, noise and limited access to facilities. Noise from people in adjacent rooms or neighbours can have psychological adverse effects. Children may not be able to concentrate sufficiently to carry out homework and sleep may be disturbed. People with HIV or who are otherwise immunocompromised may find overcrowded properties detrimental to their health due to exposure to infectious agents which may exacerbate their illnesses. The risks to children from co-sleeping are covered in section 10.

[4] The impact of overcrowding on health and education, 2004, http://dera.ioe.ac.uk/5073/

[5] Ocercrowding in Bangladeshi Households http://www.bristol.ac.uk/geography/research/pfrc/themes/housing/overcrowding.html

Indoor cold and mortality

Cold indoor temperatures are caused by a combination of factors. Firstly, energy inefficient building design and/or heating systems can make homes difficult to heat. In conjunction with poor building characteristics, low household income and high fuel prices both further exacerbate heating affordability. Energy inefficient housing and difficulties with paying heating bills vary widely in Europe (Whyley, Callender, 1997[6]).

Temperature variations within a building can cause thermal stress on the respiratory and circulatory systems. Most excess winter deaths are attributed to cardiovascular and respiratory diseases (Khaw, 1995[7]). According to Khaw, the seasonal variation in blood pressure is more strongly related to indoor than to outdoor temperature. Cardiovascular conditions include ischaemic heart disease and stroke; respiratory conditions affected or exacerbated by the cold include influenza-like disease, asthma, Chronic Obstructive Pulmonary Disease (COPD), and respiratory viruses.

COPD accounted for more than 40% of emergency respiratory hospital episodes in one London Borough over a 4-year period (Rudge, Gilchrist, 2007[8]), where there was found to be a noticeable winter excess for emergency respiratory episodes in general.

People appear to be better protected going out from a warm house into cold outdoor conditions than from a cold house (Goodwin, 2013[9]), indicating the importance of the link between effects of indoor and outdoor conditions.

Indoor radon and lung cancer

Radon gas is an established carcinogen and the major source of natural ionizing radiation exposure in most countries. The evidence available to date suggests that indoor exposure to radon is a significant risk factor for lung cancer. Between 5 and 10% of all lung cancers can be attributed to radon,

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[6] Fuel Poverty in Europe http://fuelpoverty.eu/2014/06/01/measurement-in-europe-part-2/

[7] Seasonal Variations http://www.ncbi.nlm.nih.gov/pubmed/7508540

[8] Measuring the health impact of temperature dwellings, Newham, http://www.researchgate.net/publication/223489772_Measuring_the_health_impact_of_temperatures_in_dwellings_Investigating_excess_winter_morbidity_and_cold_homes_in_the_London_Borough_of_Newham

[9] The impact of home energy efficiency … http://www.nets.nihr.ac.uk/projects/phr/11300531

although varying local conditions may lead to even higher (or lower) estimates (WHO 2011[iii])

Residential second-hand smoke exposure and lower respiratory infections, asthma, heart disease and lung cancer

Breathing in other people's tobacco smoke (second-hand, passive or involuntary smoking) is known to cause a range of disorders from minor eye and throat irritation to heart disease and lung cancer. Children are particularly vulnerable to the effects of second-hand smoke and exposure increases the risk of cot death, glue ear, asthma and other respiratory disorders, including emphysema later in life. The Royal College of Physicians[10] has estimated that every year in the UK children's exposure to second-hand smoke results in:

- over 20,000 cases of lower respiratory tract infection
- 120,000 cases of middle ear disease
- at least 22,000 new cases of wheeze and asthma
- 200 cases of bacterial meningitis
- 40 sudden infant deaths – one in five of all SIDs

Each year, these cases generate over 300,000 UK GP consultations and about 9,500 hospital admissions, and also cost the NHS about £23.3 million. Other people who are particularly at risk from the effects of second-hand smoke include pregnant women and people with pre-existing heart or respiratory illnesses.

Household carbon monoxide poisoning

Carbon monoxide (CO) is a toxic gas that is colourless, odourless, tasteless and non-irritating, and thus without warning properties. CO is produced by the incomplete combustion of carbonaceous materials including vehicle and heating fuels. Without appropriate ventilation, indoor levels of CO can reach harmful or even life-threatening concentrations, sometimes within minutes. CO inhalation leads to tissue hypoxia and toxicity through several mechanisms. CO in indoor air are the most common cause of intoxication. In several developed countries, 50- 64% of CO poisoning occurs in the home (Sam-Lai et al., 2003[11]). Accordingly, CO is a highly relevant risk related to inadequate housing conditions. Unintentional CO poisoning in the home is related to inappropriate or faulty heating, cooking or other combustion appliances and the entry of vehicle exhaust from attached garages. Gas

[10] Passive Smoking, RCP, 2010, https://www.rcplondon.ac.uk/publications/passive-smoking-and-children

[11] Carbon Monoxide Poisoning Monitoring Network, 2003 http://www.tandfonline.com/doi/abs/10.1081/CLT-120022001

heating and cooking can be significant contributors to CO concentration in homes (Bruinen et al., 2004[12]).

Individuals with greater susceptibility to CO exposure include pregnant women, infants and small children, the elderly and persons with underlying cardiopulmonary disease. Additionally, certain homes or residential areas (e.g., those with older/poorly maintained heating systems) are at significantly higher risk for both episodic CO elevations and/or chronically higher CO concentrations.

Housing quality and mental health

There are several potential reasons why poor housing quality might impact mental health. Housing symbolizes self identity and thus inadequate housing may lead to stigmatization and feelings of inadequacy. Poor housing is stressful in several respects: more worries about hazards and safety (particularly if children or frail elderly are involved), hassles with maintenance, and financial worries related not only to housing itself but also things like utility bills. Some types of housing (e.g., high rise buildings) may foster social isolation.

For many people, their home is a refuge, a place to recover from the stress and strain of daily life and work. But for those with inadequate housing, the home may mean more difficulties, not a place of refuge (Evans, 2003[13]). Two key aspects of parenting, responsiveness to children's needs and monitoring, can be disrupted when parents must contend with chronic housing difficulties. Many of the features of poor quality housing are beyond the control of the occupants and thus may lower self- efficacy and feelings of mastery over the environment.

Infectious Diseases

Features of substandard housing, including lack of safe drinking water, absence of hot water for washing, ineffective waste disposal, intrusion by disease vectors (e.g., insects and rats) and inadequate food storage have long been identified as contributing to the spread of infectious diseases (Krieger, 2002[14]). Overcrowding is associated with transmission of tuberculosis

[12] Personal Carbon monoxide exposure levels 2004, http://www.ncbi.nlm.nih.gov/pubmed/15254478

[13] The built environment and mental health, 2004, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3456225/

[14] Housing and Health, 2002, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447157/

and respiratory infections. Norovirus can be transmitted easily due to its contagious nature and often cause residential and nursing homes to close when the virus is circulating

Impact of poor housing on children's health

Living in substandard housing can have an impact on a child's physical and mental development, with implications for both their immediate and future life chances. The lifecourse of an individual can therefore be adversely affected if ill health develops at an early age from poor housing (Harker 2006[15]). The evidence is particularly strong on the effect of cold, damp and mould. Cold temperatures lower resistance to respiratory infections; damp conditions are favourable to bacteria and viruses; and mould and fungi produce allergens that can lead to asthma and other respiratory problems. Damp and mould impact more strongly on children than adults. Reviews of the evidence in the UK and other countries have concluded that children living in damp, mouldy homes are between one and a half and three times more prone to coughing and wheezing – symptoms of asthma and other respiratory conditions – than children in dry homes. Such symptoms can lead to sleep loss, restrictions on children's daily activities, and absence from school, all of which have long-term implications for a child's personal development. Children living in overcrowded housing are up to 10 times more likely to contract meningitis, and as many as one in three people who grow up in overcrowded housing have respiratory problems in adulthood.

Living in cold, damp housing may well have an impact on children's mental health too, increasing children's chances of experiencing stress, anxiety and depression. It is hard to isolate a causal link though, because children living in poor housing conditions have often experienced considerable adversity besides substandard housing. Nevertheless there is some evidence to suggest that improving housing conditions can lead to measurable mental health gains. Rehousing may also have a positive impact on mental health, but this has not been proven unequivocally. A link has been demonstrated between unfit and overcrowded housing and psychological distress in eight- to eleven-year-olds. Living in such conditions children may have difficulty coping, feel angry, anxious or depressed, or have difficulty sleeping.

Poor housing conditions also affect children's recreational opportunities. A study undertaken by Shelter of 505 families living in overcrowded conditions found that four-fifths of families felt that there was not enough room in their

[15] Chance of a lifetime, 2006, http://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/policy_library_folder/chance_of_a_lifetime_-_the_impact_of_bad_housing_on_childrens_lives

homes for their children to play. Children living in temporary accommodation often face limited space to play and some studies suggest that this can lead to depression or aggressive behaviour.

Where parents sleep with young infants because of limited space or for other reasons, (co-sleeping) there is an increased risk of infant death. The risk of infant mortality can also be increased from second hand smoke where parents do not smoke outside.

Impact of poor housing on older people

- Older people living in cold, damp homes are at greater risk of (Oldman[16]): Arthritic symptoms and rheumatism, which can result in prolonged immobility, making it even more difficult to keep warm;
- Domestic accidents and falls, including fatalities;
- Social isolation;
- Mental health problems.
- Neighbourhood effects

Physical housing conditions may be a determining factor of health, but there is evidence that the wider neighbourhood – the level of antisocial behaviour, fear of crime – are also important.

Loneliness and exclusion is a reality for millions of older people according to a report from Age UK which states that 11% of people aged 65 or over are often or always lonely and that neighbourhoods that exclude older people can exacerbate isolation and feelings of loneliness.

The tables below list the 29 recognised hazards and related health conditions.

[16] Housing in Later Life, Oldman, 2014
http://www.ageuk.org.uk/search1/?keyword=housing+in+later+life&nation=ageuk_en-GB

Hazard	Key housing factors contributing to hazard	Main health problems linked to hazard
Damp and mould growth	– Heating and thermal insulation – Ventilation – Damp proofing – Disrepair allowing water penetration – Exposed water tanks and pipework – Condition and design of water using amenities – Small room sizes/overcrowding	– Respiratory disease – Allergic symptoms (eg asthma, rhinitis) – Infections (mainly fungal) – Nausea and diarrhoea – Depression and anxiety
Excess cold	– Energy efficiency (heating, thermal insulation and fuel) – Dampness – Ventilation	– Cardiovascular conditions – Respiratory diseases – Rheumatoid arthritis – Impaired thermoregulation (hypothermia)
Excess heat	– Thermal insulation – Heating controls – Area and orientation of glazing	– Cardiovascular conditions – Genito-urinary disease
Asbestos and MMF	– Presence of asbestos – accessible position or unsealed – Presence of MMF – accessible position or unsealed – Disrepair to asbestos-based material	– Respiratory problems, pleural disease, lung cancer, mesothelioma – Dermatitis
Biocides	– Use/misuse of chemicals to treat timber and mould growth	– Varies depending on the chemical used
Carbon monoxide and fuel combustion products	– Disrepair to flueless appliances (including cookers) – Inadequate ventilation or flues – Disrepair to flues or ventilation	– Headaches and dizziness to unconsciousness and death – Damage to nervous system – short-term memory loss – Respiratory problems – Aggravation of asthma
Lead	– Lead water pipes – Lead paint	– IQ deficiency – Lead poisoning
Radon (radiation)	– Design and repair of floors	– Lung cancer – Other cancers (leukaemia, skin, gastrointestinal)
Uncombusted fuel gas	– Condition, design and siting of gas supplies and appliances	– Asphyxiation
Volatile organic compounds	– VOC-emitting materials or treatments used – Inadequate ventilation	– Allergic reactions involving eyes, nose, skin and respiratory tract – Headaches, nausea, dizziness and drowsiness
Crowding and space	– Level of occupancy – Size of kitchen in relation to occupancy and use – Sharing of amenities	– Psychological distress – Reduced concentration – Reduced tolerance – Poor hygiene – Increased risk of accidents – Spread of contagious disease
Entry by intruders	– Defensible space – External lighting – Natural surveillance – Locks to windows and doors – Condition of windows and doors – Concierge/entryphone for flats	– Emotional stress (from fear of crime or as a result of burglary) – Injuries from aggravated burglary
Lighting	– Size, shape and position of windows – Obstruction of windows – Adequate artificial lighting and controls	– Depression and psychological conditions – Eye strain
Noise	– Situation of dwelling – Sound insulation – Repair of windows and external doors – Noisy/badly sited equipment or facilities	– Psychological stress – Sleep disorders – Anxiety and irritability – Cardiovascular conditions
Domestic hygiene, pests and refuse	– Repair/design allowing ingress of pests – Refuse space (internal and external) – Refuse chutes (flats)	– Gastro-intestinal disease – Asthma and allergic rhinitis – Emotional distress – Depression and anxiety
Food safety	– Repair/design of sinks, worktops, cooking provision, food storage facilities – Ratio of facilities to occupants – Sharing of facilities	– Food poisoning (mild to fatal)

Hazard	Key housing factors contributing to hazard	Main health problems linked to hazard
Personal hygiene, sanitation and drainage	– Ratio of facilities to occupants – Adequate supplies of hot and cold water – Disrepair to facilities – Drainage – Sharing of facilities	– Gastro-intestinal illness (mild to fatal) – Anxiety and depression
Water supply for domestic purposes	– Quality of water supply – Water tanks protected against contamination	– Gastro-intestinal illness (mild to fatal) – Legionnaires disease
Falls associated with baths etc.	– Design and condition of baths/showers – Size and layout of bath/shower rooms – Poor lighting/glare	– Physical injury (cuts, swellings, fractures, death) – Deterioration in general health for elderly
Falls on the level	– Trips steps or steep slopes – Uneven surfaces – Disrepair to surfaces – Inadequate drainage of surface water – Poor lighting/glare	– Physical injury (cuts, swellings, fractures, death) – Deterioration in general health for elderly
Falls associated with stairs or steps	– Design and state of repair of stairs/steps – Provision and condition of handrails and guardrails – Poor lighting/glare – Size/design of landings – Projections to stairs at foot of flight	– Physical injury (cuts, swellings, fractures, death) – Deterioration in general health for elderly
Falls between levels	– Design and state of repair of windows – Design and state of repair of balconies – Height above ground – Hardness/projections on ground	– Physical injury (cuts, swellings, fractures, death) – Deterioration in general health for elderly
Electrical hazards	– Age/disrepair of electrical installation – Number and location of socket outlets	– Electric shock (mild to fatal)
Fire	– Location of heater/cooker – Adequacy and repair of heating – State of repair of electrical installation – Number and location of socket outlets – Fire protection to escape routes – Detectors/alarms – Fire fighting equipment	– Inhalation of smoke/fumes (mild to fatal) – Burns (mild to fatal)
Hot surfaces and materials	– Unprotected hot surfaces or flames – Temperature of hot water to taps – Poor layout or inadequate space to kitchen	– Burns and scalds – Psychological distress
Collision and entrapment	– Design, location and disrepair to doors – Design, location and disrepair to windows – Unprotected gaps in banisters – Low headroom, beams or ceilings	– Physical injury (cuts, piercing, trapping, bruising, crushing)
Explosions	– Design and repair of gas supply and appliances – Design and repair of hot water systems – Inadequate or defective LPG storage	– Physical injury (crushing, bruising, fractures, death)
Position and operability of amenities	– Space and layout of kitchen amenities – Space and layout of washing and WC amenities – Design/repair of taps, windows and doors	– Physical injury (strains, sprains, bruises, fractures)
Structural collapse and falling elements	– Structural movement or cracks – Disrepair to external fabric (esp. chimneys and cladding) – Disrepair to internal fabric (esp. ceilings and stairs)	– Physical injury (minor to fatal)

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CABINET FORWARD PLAN

Contact Officer: Charles Francis
Telephone: 01895 556454

REASON FOR ITEM

The Committee is required to consider the Forward Plan and provide Cabinet with any comments it wishes to make before the decision is taken.

OPTIONS OPEN TO THE COMMITTEE

1. Decide to comment on any items coming before Cabinet

2. Decide not to comment on any items coming before Cabinet

INFORMATION

1. The Forward Plan is updated on the 15th of each month. An edited version to include only items relevant to the Committee's remit is attached below. The full version can be found on the front page of the 'Members' Desk' under 'Useful Links'.

SUGGESTED COMMITTEE ACTIVITY

1. Members decide whether to examine any of the reports listed on the Forward Plan at a future meeting.

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Ref	Decision	Further information	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Private decision?

Council Departments: RS = Residents Services CYPS =Children and Young People's Services ASCS= Adult Social Care Services AD = Administration FD= Finance

Cabinet meeting - 22 October 2015

Ref	Decision	Further information	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Private decision?
Council Departments: RS = Residents Services CYPS =Children and Young People's Services ASCS= Adult Social Care Services AD = Administration FD= Finance									
63	**Safeguarding Adults Partnership Board Annual Report**	The Annual Report of the Safeguarding Adult Partnership Board will be presented to Cabinet. The report details the partnership's activity and performance in safeguarding adults at risk and its priorities for the year. The report is set in the context of national guidance and policy.	All		Cllr Philip Corthorne	ASCS - Steve Ashley (Independent Chairman) / Tony Zaman	Policy Overview Committee		

Ref	Decision	Further information	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Private decision?
Council Departments: RS = Residents Services CYPS =Children and Young People's Services ASCS= Adult Social Care Services AD = Administration FD= Finance									
Cabinet meeting - 19 November 2015									
54	**Carers Strategy - progress update**	As requested at it's meeting in April 2015, Cabinet will receive an updated on progress implementing the Carers' Strategy and Delivery Plan.	All		Cllr Philip Corthorne	AD - Vicky Trott			

Ref	Decision	Further information	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Private decision?
Council Departments: RS = Residents Services CYPS =Children and Young People's Services ASCS= Adult Social Care Services AD = Administration FD= Finance									
Cabinet meeting - 17 December 2015									
61a	**The Council's Budget - Medium Term Financial Forecast 2016/17 - 2020/21** **BUDGET & POLICY FRAMEWORK**	This report will set out the Medium Term Financial Forecast (MTFF), which includes the draft General Fund reserve budget and capital programme for 2016/17 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration.	All	18 February 2016 or 25 February 2016 (reserve date)	Cllr Ray Puddifoot MBE & Cllr Jonathan Bianco	FD - Paul Whaymand	Public consultation through the Policy Overview Committee process and statutory consultation with businesses & ratepayers		
Cabinet Member Decisions - December 2015									
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of decisions each month on standard items - details of these standard items are listed at the end of the Forward Plan.	Various		All	AD - Democratic Services	Various		

WORK PROGRAMME 2015/16

Contact Officer: Charles Francis
Telephone: 01895 556454

REASON FOR ITEM

This report is to enable the Committee to review meeting dates and forward plans. This is a standard item at the end of the agenda.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To confirm dates for meetings

2. To make suggestions for future working practices and/or reviews.

INFORMATION

All meetings to start at 7.00pm

Meetings	Room
2 July 2015	CR 5
30 July 2015	CR 5
3 September 2015	CR 5
6 October 2015	CR 6
4 November 2015	CR 6
20 January 2016	CR 6
23 February 2016	CR3/3a
24 March 2016	CR 6
20 April 2016	CR 6

Social Services, Housing and Public Health Policy Overview Committee

2015/16 - DRAFT Work Programme

Meeting Date	Item
2 July 2015	Major Reviews Topics 2015/16
	Work programme for 2015/16
	Cabinet Forward Plan

30 July 2015	Budget Planning Report for SS,Hsg&PH
	Scoping Report for Major Review
	Work Programme
	Cabinet Forward Plan

3 September 2015	Major Review - Witness Session
	Cabinet Forward Plan
	Annual Complaints Report
	Adults Safeguarding
	Work Programme

6 October 2015	Major Review - Witness Session
	Update on previous review recommendations (Shared Lives Review)
	Cabinet Forward Plan
	Work Programme

4 November 2015	Major Review
	Public Health Report
	Consideration of Second Major Review
	Cabinet Forward Plan
	Work Programme

20 January 2016	Budget Proposals Report for 2016/17
	Cabinet Forward Plan
	Work Programme

23 February 2016	Cabinet Forward Plan
	Work Programme
	Witness Session

24 March 2016	Cabinet Forward Plan
	Work Programme
	Witness Session

20 April 2016	Cabinet Forward Plan
	Major Review Second Final report

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