HOUSING AND HEALTH: THE RELATIONSHIP
Review of the literature

1. Introduction

Residents from Islington’s community approached the Islington Local Involvement Network (LINk) with concerns about the impact of poor housing on their health and the health of their families. Following discussion by the LINk’s Core Group, a sub group was formed to consider how to investigate the relationship between housing and health in the borough. It was decided to adopt a two stage approach. The first stage would be to compile a report from published sources to present a summary of evidence and other information on the relationship between housing and health. If approved by the Core Group, there would be a second stage of qualitative research to explore with tenants (social housing and private sector) and owner occupiers the impact of housing on the health of Islington’s residents.

This report comprises the first stage of the LINk’s work on housing and health. Part A of the report summarises the evidence and other information from international, national and London sources on the relationship between housing and health. It provides information on the physical and social characteristics of the housing environment and how this can impact on the health of residents, adults and children. It includes evidence about the impact of homelessness on health, including for those leaving prison and those in temporary accommodation. Part B of the report refers specifically to information about Islington: the health of its residents and its housing stock. Islington NHS 2009/10 Joint Strategic Needs Assessment (JSNA) includes a chapter of housing and homelessness that draws together information on housing and health in the borough, and this has been used to identify the main impacts of poor housing on health and which groups in the population are most at risk.

PART A: WIDER RESEARCH PERSPECTIVE

2. The national context

A complex relationship
There is a wealth of research linking housing and health at regional, national and international levels, though the relationship between housing and health has not and never will be an exact science. The relationship between housing and health is known to be very complex and there are many different levels of interaction between housing characteristics and health\(^1\). Many academics and professional bodies identify a need for more long-term research to explore systematically the complex relationship between housing conditions and health\(^2\). Research to establish links between poor housing and ill health suffers from an inability to demonstrate or prove causation – that is the difficulty of being able to isolate housing condition as a cause of ill health from other factors such as poverty, deprivation and lifestyle choices. Many researchers have, however, been able to demonstrate that:
‘Poor housing influenced health status often by increasing the susceptibility of occupiers to a variety of health hazards even though it might not directly cause ill health’

Some academics have also suggested that this focus on trying to prove causality is ill founded.

The World Health Organisation (WHO) has conducted a long term comparison study of housing and health in eight European capitals (none in the UK) using assessments by professionals and research with residents to explore their perceived health. The WHO research supports the view that:

‘People with poor health and negative wellbeing are more likely to live in poor housing. Improving housing conditions will improve health and save money’

The possibility that poor health can lead to poor housing has been much less researched than the impact of poor housing on health. The British Medical Association (BMA) report of 2003 on ‘Housing and Health: Building for the Future’ refers to the fact that ill health may compromise regular employment and the purchase of life insurance, both required as common prerequisites for obtaining a mortgage. Even if they are able to obtain a mortgage, those with poor health may be restricted to the cheaper and less attractive part of the sector. Maintenance of the home may prove to be financially restricted and the installation of aids and adaptations may be impossible without charitable or other assistance. Poor health and long term health issues are associated with low income or poverty and this can impact negatively on the quality and maintenance of the home.

Governance and housing and health
The BMA 2003 report refers to an established history of research into the impact of poor housing on health. This includes the work of Edwin Chadwick in establishing a link between the ‘appalling living conditions of the poor and their ill health’ in Victorian Britain. In a presentation by the Chartered Institute of Environmental Health (CIEH) to a conference in September 2010, the findings from Edwin Chadwick were summarised as follows:

“In the poorest areas he found every room of a dwelling, from stuffy attics to waterlogged cellars, crammed full of men, women and children. Their homes were damp and unventilated with no drainage system for taking away the sewage and no water supply for drinking and washing. No wonder then that he reported that squalor and disease were rife. Sir Edwin estimated that the life expectancy of working class children born in any of the provincial cities was between 12 and 15 years”

Chadwick persuaded the government of the time to introduce the first public health acts in Britain in 1848 and 1875. Many of the most significant gains in health in the 19th and 20th Centuries have been achieved through the implementation of public health measures such as access to clean water, effective sanitation and reducing exposure to extreme cold.
the CIEH has highlighted in the early days the focus was on sanitation but later the focus was on large scale slum clearance, whilst current concerns are more focused on fuel poverty and social exclusion.

It was no coincidence that the responsibility for housing policy was initially under the direction of the Ministry for Health and this remained until 1951. The division of responsibility for housing and health policy took place with the transfer of housing to the then Ministry for Housing and Local Government and it has been commented that ever since the justification for state intervention in housing policy on health grounds has been severely limited. The BMA report also commented that, in the second half of the 20th Century, there was a declining political interest in the issues of poor housing.

The Building Research Establishment has calculated that poor housing costs the NHS at least £600 million a year\(^5\) and others have calculated the costs of the effects of poor housing on health at much higher with one estimate totalling a cost to the NHS of £3billion a year\(^6\).

The context in which health and housing services are delivered has changed significantly in recent years. There is an increased focus on prevention for the public health agenda and joint working through health and Supporting People encompasses housing, social services and the NHS. However, even as late as 1997, Round One of the Single Regeneration Budget funding did not specifically refer to ‘health’ outcomes although it did refer to ‘wellbeing’. Thus, the involvement of health in regeneration initiatives has been slow to develop and, even where health specific organisations have been involved, they have been relatively minor players compared to, for example, those agencies engaged in crime prevention and community safety.

The 1998 report from the Social Exclusion Unit was an important intervention for persuading those delivering regeneration initiatives that the focus must be more about developing capacity in communities than the physical environment, including ‘improving health and providing attractive and affordable local leisure activities for children and teenagers’\(^7\). Molyneaux in a presentation to the Unhealthy Housing: promoting good health conference in 2003 concluded that improving the health of those who experience the greatest inequalities needs to be central to regeneration programmes and residents – those who know best – need to have ‘a useful and fulfilling involvement in strategies to deliver health gain’\(^8\).

In 2008, the Chartered Institute of Environmental Health produced a toolkit for its practitioners entitled ‘Good Housing Leads to Good Health’. The aim of the toolkit was to show the links between housing and health but, most importantly in times of financial austerity, to demonstrate the cost-benefit of housing and health issues and of initiatives to improve the housing stock.
At Risk Groups
There is strong evidence that inequalities in income underpin inequalities in health and those on low incomes are also more likely to live in poor quality housing, especially in the private rented sector. The London Health Inequalities Strategy 2010 highlighted that London has greater levels of income inequality than other parts of the UK. Certain groups of Londoners, such as women, minority ethnic groups, disabled people, and those with learning disabilities were identified as those more likely to earn low incomes. Each year the Greater London Authority calculates a London Living Wage (LLW) that includes data on housing, transport and other costs, and it tends to be above the National Minimum Wage. The latest data reveals that 15% of full-time staff and 47% of part-time staff are still paid less than the London Living Wage.

The BMA 2003 report on housing and health commented that vulnerable groups including those with long term ill health, the very young and the elderly are at greatest exposure to the hazards associated with poor housing because of the lengthy periods that they are likely to spend in their home. In addition, people with health problems are also disproportionately likely to live in the 'least health-promoting segments of the housing stock'.

3. Housing conditions and design

Decent Homes Programme
The UK government-commissioned Black Report, published in 1980, gave particular emphasis to housing as a health inequality issue with decent housing a key requisite for good health. In response, legislation required local authorities to ensure all social rented housing (including that of housing associations and other Registered Social Landlords [RSLs]) and 70 per cent of the accommodation in the private sector that is occupied by vulnerable households meet the Decent Homes Standard by 2010/11. This means that the accommodation must be warm, have reasonably modern facilities and be in an adequate state of repair.

In 1997, a national housing condition survey revealed that more than 2.1 million homes managed by local authorities and housing associations did not meet the national Decent Homes Standard. Through substantive investment over the years that totalled in all about £40 billion by 2010, it is anticipated that at the end of that year, 92% of social housing (managed by local authorities and RSLs) will have met the Decent Homes Standard. Many of the homes raised to this fitness standard have been in deprived areas. Although the proportion of Decent Homes increased in all tenures during the programme, the

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1 The Building Research Establishment estimates a more realistic percentage as between 70% and 80% because the government’s estimate fails to take account of homes where tenants have refused renovations or those that have slipped into non-decent after the start of the Programme in 2001 (Department of Communities & Local Government, Beyond Decent Homes, DCLG Select Committee 2010)
proportion of vulnerable people (defined as those on Benefits) living in non-decent homes is greater in the private rented sector than in any other tenure.\(^\text{13}\)

The following sections of the report give an overview of the many possible health effects that may be caused by various factors within the domestic setting, home and neighbourhood.

**Damp and mould**

A report from the WHO (2009) revealed that those living in homes that are damp and mouldy are at increased risk of experiencing health problems such as respiratory infections, allergic rhinitis and asthma.\(^\text{14}\) Some people are said to be more at risk than others from mould including babies and young children, elderly people, those with existing skin problems, such as eczema, or respiratory problems, such as allergies and asthma. Those who have or are undergoing chemotherapy may also be more at risk. The evidence of the health effects of damp and mould is strongest among children.

The prevalence of illness appears to increase with the level of dampness. Research has demonstrated that people living in well-insulated and adequately ventilated housing are less likely to visit their doctor or be admitted to hospital due to respiratory conditions than those living in damp homes.

Homes that are damp can have a variety of causes including from leaking pipes, wastes and overflows; rain seeping through the roof from missing slates or a blocked guttering and rising damp from a defective damp-proof course or the absence of a damp-proof course. Poor ventilation will contribute to the development of mould and the increasing use of measures to reduce draughts including installation of double glazing has contributed to a greater prevalence of problems from mould.

**Cold homes and Fuel Poverty**

A major contributor to fuel poverty\(^\text{ii}\) in Britain is the poor energy efficiency of the housing stock. Fuel poverty was first identified and highlighted as a significant social problem in Britain in the early 1990s when it was suggested that some 7 million households were unable to afford to adequately heat their homes. Data produced in 2001 identified a fall to 3 million households in fuel poverty and of these 2 million were said to be vulnerable. It has been suggested that the fall in the numbers over the years has been a consequence of falling energy prices.\(^\text{15}\)

The effects on health of fuel poverty are generally said to be twofold: the impacts of cold and that of dampness and mould growth (see previous section). Evidence of a link between fuel poverty and ill health are well evidenced and the consequence of fuel poverty as a

\(^\text{ii}\) Fuel poverty is defined as ‘a household is in fuel poverty if, in order to maintain a satisfactory heating regime, it needs to spend more than 10% of its income on all fuel including heating the home to a satisfactory standard of warmth’ from Fuel Poverty and Health: A Guide for Primary Care Organisations and Public Health and Primary Care Professionals, V. Press, National Health Forum 2003
major contributor to excess winter mortality (EWD). In England and Wales EWD rate is estimated at between 25,000 and 45,000 persons each year. England experiences levels of Excess Winter Deaths (EWD) that are higher than those experienced by northern European countries with more extreme winter climates and many of these cold related deaths are entirely avoidable.

Risk factors for excess winter mortality are households living in homes, which are poorly insulated and with inadequate or expensive heating systems and which they cannot afford to adequately heat on their existing incomes. It is also highly relevant that poor households, including pensioners, the unemployed, single parents, the sick and the disabled often have to heat their homes for much longer than those at work or otherwise out of the home for longer periods of time.

Exposure to house dust mites and other allergens
The exposure to house dust mites is exclusively housing-related and these airborne pollutants can trigger allergic symptoms such as eczema and conjunctivitis. Repeated exposure can lead to asthma and it appears that the severity of the asthma intensifies with the level of exposure to house dust mites as well as mould levels and increased humidity.

A paper presented to a conference on housing and health in 2003 identified that concurrent with the significant rise in the incidence of asthma during the latter part of the twentieth century was a fundamental change in the design, construction and use patterns of housing in the UK\(^{16}\). A variety of measures combined to make dwellings warmer and more humid; conditions in which the dust mite species thrives. The research concluded that this may in turn be the prime causal factor influencing the rising incidence of asthmatic symptoms in children.

Cockroaches have been known to thrive especially in urban housing equipped with central heating. The health effects may include allergic asthma.

Overcrowding
A research study to explore the evidence and literature on the impact of overcrowding on health and education was commissioned by the Office of the Deputy Prime Minister (ODPM) and published in 2004. It found good research evidence from over forty studies of the impact of overcrowding on the physical health of adults and children. However, given the research approach of these studies there was little evidence on people’s own perceptions of the impact of overcrowding on their health and well being. Nor was there strong evidence of studies measuring the impact of interventions to reduce overcrowding with health improvements.

The studies did suggest that there may be an independent relationship between overcrowding and child mortality, but the evidence was limited. Two studies provided some limited evidence of an independent relationship between overcrowding and adult mortality rates, particularly for women. There were studies that revealed a relationship
between overcrowding and adult respiratory diseases, although it is also possible that other housing or deprivation factors (such as dampness in the home, poor air quality, lifestyle factors such as smoking) provide more powerful explanations.

The relevance of overcrowding for the spread of infectious diseases such as tuberculosis (TB) is an important inter-relationship for housing and health. The poorest in urban societies are likely to be those experiencing the greatest degrees of overcrowding. The evidence and literature review conducted for the ODPM found strong evidence of an independent relationship between overcrowding and TB in children and in adults. Research in the UK and London boroughs found that TB rates were independently and significantly associated with overcrowding and a study in the United States found that overcrowding explained some of the ethnic variation in TB rates.

Over recent years, there has been an increase in TB in the east end of London and overcrowded housing, with several adults and children often sharing one bedroom, has been identified as a contributing factor. Research conducted in the London Borough of Newham that has one of the highest TB notification rates in the UK found a definite correlation between poor housing, poverty and the incidence of TB. Overcrowding and some other aspects of a poor home environment contribute to mental stress and to reducing people’s sense of general wellbeing. The review for the ODPM identified nearly twenty five studies that cover, directly or indirectly, the impact of overcrowding on adult or child/adult mental health. Three British studies each indicate a significant association between children’s mental health and both housing conditions and deprivation, though the evidence on overcrowding is less clear. A study in Northern Ireland found that children on one estate that had more severe housing problems had higher rates of self-reported psychological distress. Overcrowding was one of a number of housing factors, but the research did not assess the relative importance of each factor.

Research with children attending an accident and emergency department at a west London hospital that was quoted in the ODPM review concluded that there was an association between accidents in the home and overcrowding for all ethnic groups. There was, however, a much stronger association between accidents in the home and social class, including unemployment status of the mother, and tenure.

In 2006, the charity Shelter produced a report that reviewed the research on the impact of poor housing on children. Shelter reported that nearly a million children live in overcrowded homes and the number was increasing. The report cited research that showed one in three people who have lived in overcrowded housing at the age of seven suffered from a respiratory disease in their thirties. Commenting on the report, the Meningitis Research Foundation said that it supported other evidence that overcrowding and social deprivation can be factors in increased risk of meningitis.
Item 4a

Rodent and other pest infestations
Rat infestations in particular are an indication of a disadvantaged and neglected environment and studies have shown an association with: older housing in poor condition; homes in multiple occupation; ageing infrastructure; and poor environments in neighbourhoods of social and economic deprivation. Rats and other pests carry a wide range of parasites contributing to disease with risks especially high for those already with a lower health status and for children.

Prevalence to slips, trips, falls and other accidents
Overall 45% of accidents occur in the home and accidents are in the top ten causes of death for all ages. More than 4,000 people die each year in the UK following an injury in the home and more than a third of all adult injuries take place in the home. Each year about a million children under the age of fifteen attend hospital following an injury in the home. Data from the Office of National Statistics reveals that injury rates for children in the lowest socio-economic group are more than three times those of children in the highest socio-economic group.

Older people are another high risk group and they are more likely to suffer injuries during an accident. Each year there are about 1,500 fatalities from a fall in the home among those over 65 years of age. A 2006 study in the Netherlands estimated the cost of different forms of injury (costs for hospital stay, ambulance and other transport, GP visits and physiotherapy sessions) and found that hip fractures were the highest costing injury. The likelihood of a fall within the home can be reduced by providing a safer environment including the provision of adaptations.

Home injuries are considered to be a major health issue of inadequate housing conditions, with high policy relevance for both children and elderly. The home environment is the main site for accidental injury and death for young children less than four years of age and the children of low income families are especially susceptible to burns, scalds, falls and swallowing objects or poisonous substances. As disabled children are statistically more likely to be in low income families, this places them at high risk.

Faulty cooking and heating equipment in association with poor ventilation can affect health. Injury and fatality rates are highest in the private rented sector with poorly maintained and faulty gas appliances emitting carbon monoxide. Low levels can trigger influenza like symptoms and higher levels can be fatal.

Lack of housing aids and adaptations for independent living
There are about six million adults in Britain with a significant physical impairment and one in seven households includes someone with a disability. Although there is a strong link between ageing and disability, there are also many younger disabled people in society. The housing environment can contribute negatively to the health of children with impairment and also to the wellbeing of their parents and siblings.
Item 4a

The increasing numbers and proportion of older residents in the UK is associated with problems from restricted mobility and a rise in stroke and heart disease, all increasing the need for aids and adaptations to enable people to remain living independently in their home. If a person is unable to easily remain living independently in their home and faces everyday problems when wanting, for example to bath or shower, this can significantly reduce their sense of wellbeing and increase their sense of isolation and fuel depression. Not having a safe environment in the home can itself be the cause of accidents and ill health. There is evidence that even ‘low level interventions’ such as minor housing adaptations can improve health and reduce the need for hospital admission and social care.21

Noise disturbance
The health effects of noise are twofold: auditory and non-auditory. The first is about hearing impairment and occurs almost exclusively in industrial settings as environment noise levels do not generally produce these effects. Non-auditory effects from noise disturbance including those occurring in domestic and other environmental settings include, mental pressure and stress that can trigger irritation and aggression, sleep disturbance, interruption of speech and social interaction, disturbance of concentration (and hence of learning and long-term memory), and cardiovascular effects. The Chartered Institute for Environmental Health (CIEH) comments that there is no real evidence that noise per se induces mental illness, though there is some evidence to suggest that noise-sensitive people are more prone to mental illness and that the effects of noise may be more pronounced in mentally ill people.

Domestic noise is the commonest cause of complaint to Environmental Health Officers. The latest evidence from a survey of noise nuisance 2008/9 by the CIEH found nearly 120,000 complaints had been made by domestic occupiers, 70% of all complaints.iii There is evidence that people living in social rented homes are more likely to live in noisier areas. Some kinds of housing are also more likely to be at risk of noise disturbance than others. In London 45% of households live in flats, and the number is growing, whereas in England overall 83% of households live in houses.

4. Housing Tenure
Housing tenure is very relevant to the health and housing debate in the UK.

Social housing
The 2010 Spending Review settlement published in October 2010 included £2.1bn capital funding from 2011/12 for the Decent Homes programme. Of this, £1.6bn will be available to council landlords to help tackle the backlog of homes that are not meeting the Decent Homes standard. A Briefing Paper published by the Parliamentary Office of Science and Technology commented that whilst most homes in the public sector meet the Decent Homes standard, ‘the estimated cost to reach the target of 100% is £3.2billion, double the allocated funding’22. That Paper also identified that the other main issues for public sector

iii This data was from 46% of local authorities in England, Wales and Northern Ireland.
Item 4a

housing was the level at which the standard was set and how well it was monitored and enforced locally with some Councils and RSLs aiming to meet only minimum standards and others aiming much higher.

The social housing sector increasingly provides accommodation for those ‘in greatest need’ and has become characterised by deprivation and social exclusion with many tenants dependent on state benefits to meet part, most or all of their living expenses. Those in employment are often on low incomes and many employed in occupations that are physically demanding with health-related impacts, especially in later years and after retirement. Almost two thirds of all workless households in London live in social housing, and almost half of all working age households in social rented homes are not in employment23.

Private Sectors
Over 70 percent of UK housing is in the private sector and while the majority of landlords and home owners maintain properties to a good standard the private sector is also home to some of the most unhealthy and unsafe properties. In 2002, the Decent Homes target was extended to the private sector with the target to ensure 70% of private homes where financially vulnerable people live (i.e. defined as on benefit) will meet the standard. This national target of 70% was downgraded to an optional local target in 2007.

The Building Research Establishment estimates that it would cost £17.6billion for 100% to achieve the standard for Decent Homes in the private sector. No funding has been specifically allocated in the Spending Review for Decent Homes work in the private sector. The independent PostNote Paper published by the Parliamentary Office of Science and Technology commented, however, that ‘the lack of ring fencing on other funding means that local authorities may use that for improving private sector housing’. The Briefing Paper also commented that ‘lack of investment in homes now may result in increased costs in the future. 80% of current housing will still be in use in 205024.

Owner occupation
The English house condition survey 2008 identified that 70% of households live in owner occupied housing, nearly 15.6 million households. The owner occupied sector has changed over the years with its expansion now includes many people on lower than average incomes. Fifteen per cent of owner occupiers (2.2 million in England) are said to be financially vulnerable25. As a consequence and especially in times of recession and budgetary constraints, stress and hardship resulting from mortgage debt, arrears and repossession is a major health issue26.

More than a half of older people are owner occupiers and there is evidence that many cannot afford to adequately adapt their home or keep it in good repair. A presentation on home ownership and poor housing to the Unhealthy Housing- promoting good health conference in 2003 revealed that nearly three quarters of those in the lower income band and living in the worst housing were older owner occupiers. It was estimated that by 2011,
there will be over six million older owner occupiers in the UK and nearly one million older people will be living in accommodation that is at least 90 years old and in need of substantial improvement.

Private rented sector

The English house condition survey in 2008 identified that 12% of households in England live in privately rented housing. The private rented sector has the highest proportion of non-decent homes. The 2011 Parliamentary Briefing Paper identified key issues linked to poor housing were the short duration of private sector tenancies – typically six months – and lack of security of tenure. It notes that there are concerns that both these features of the private rented sector may contribute to mental health problems and discourage tenants from ‘taking up home improvement initiatives; reporting problems to a landlord, for fear of being evicted; and investing in rented homes’. In most local authorities, there are schemes in place for private landlord accreditation that are in place to help improve housing qualityiv.

London’s private rented sector has seen significant growth in the last 15 years and one in five of London’s households now live in privately rented accommodation27. Over half of the households in London that move home each year move into privately rented housing. There has been a surge in recent years in ‘buy to let’ activity and, in 2006, an estimated two thirds of newly built homes were bought by investors, although the deterioration in financial circumstances has meant that this scale of investment has decreased recently. Although London’s Housing Strategy 2010 describes most privately rented homes as ‘good quality and well managed’, it states that 45% of privately rented accommodation fails to reach the Decent Homes standard.

There are currently 82,000 empty homes in London, some 2.5% of the total housing stock. About 66,000 of these empty homes are in the private sector. The Housing Strategy drew on research to reveal that an empty property can devalue neighbouring properties by as much as 18% and a fifth of those living near an empty home believe that the empty properties attracts crime. There is evidence that fear of crime and for personal security and the security of the home contributes to stress and ill health.

iv There are two broad types of landlord accreditation schemes - one type focuses on checking the person managing the property and the other on checking the condition of the property. Most accreditation schemes combine the two types. Most local authorities run an accreditation scheme that sets the standards to become an accredited landlord. These standards vary depending on the authority. Some schemes have set high standards from the outset while others have tried to raise standards gradually over time. There is a London Landlord Accreditation Scheme in place, developed by the boroughs, and focuses on improving the quality of landlords’ management, providing them with information, training and professional development.
Houses in Multiple Occupation

Some of the worst housing conditions in the private rented sector are to be found in houses that are in multiple occupation (HMOs) or shared housing. Occupiers are more likely than in other types of accommodation to be on low income and are often vulnerable. The Housing Act 2004 introduced a mandatory national system of licensing for all houses that are in multiple occupation and HMOs are broadly defined for the purposes of licensing as:

- is shared by five or more people
- has three or more storeys (including basements, attics and shops)
- does not consist only of self-contained flats
- is not owned/managed by a housing association, local authority or by police/health services

In 2010, the Government announced that councils will have greater flexibility to manage concentrations of HMOs in their area.

The poor conditions in HMOs can include disrepair, inadequate means of escape from fire, lack of basic amenities and unsatisfactory housing management. Those living in HMOs are four times more likely to suffer injury and twice as likely to die in a fire as those in single occupied dwellings\(^{28}\). HMOs need to be properly managed; problems can occur in common areas, and where facilities are shared but no individual tenant has overall responsibility.

5. Homelessness and living in temporary accommodation

Rough sleepers and those in temporary accommodation

There is evidence that homelessness leads to poorer physical and mental health and premature death is more prevalent amongst the homeless and formerly homeless\(^ {29}\). People sleeping rough appear to have significantly worse health than other homeless people in hostels and other temporary accommodation and are more at risk of chronic chest, dermatological and mental health problems. The life expectancy of people who sleep rough is 40.2 years, similar to life expectancy in the Middle Ages, compared to 77/82 years (men/ women) nationally\(^ {30}\). There are also significant problems when homeless people want and need to access a general practitioner and other primary health care.

As the BMA 2003 report on housing and health highlighted, not only does homelessness exacerbate poor health but ill health may be causally involved in a person becoming homeless. Ill health, substance misuse or alcoholism may impact on a person’s ability to gain and sustain employment to pay for their living expenses including for housing and may also be a factor in relationship breakdown. There is evidence from research with homeless people that some of those suffering from mental illness became ill before becoming homeless.

Though only around 500 people may sleep rough on any one night, reliable data shows that the number of different people rough sleeping in London rose to 3,472 between April 2008
and March 2009. Nearly a fifth of the people rough sleeping in 2008/9 were from Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary and the Czech Republic.

Quoted in a 2009 report from the St Mungo’s charity, 76% of homeless men and women who lived on the streets or in hostels reported that they had some form of mental health problem either diagnosed by a doctor (65%) or self identified (11%). The same charity’s survey with their hostel clients found that 69% had a mental health need and 61% had both a mental health need and a substance use problem (either drugs or alcohol or both).

That St Mungo’s report concluded that:

‘only by concerted and effective action to meet the mental health needs of people who experience, or are most vulnerable to, street homelessness will the (then) Government have a chance of meeting its own target of reducing rough sleeping to zero by 2012’

A November 2010 report on research conducted by the umbrella group Homeless Link compared the health needs of homeless people and the general population. From interviews with 600 homeless people in the first six months of 2010, Homeless Link found of those that had attended Accident & Emergency, nearly 38.6% had gone because of physical injury or accident compared to 16.5% of the general population in 2008/9. It found that 2.6% of the general population was treated for breathing problems in 2008/9, compared to 15.6% of homeless people. On the basis of the data, Homeless Link calculated that homeless people cost the NHS an extra £85 million a year as twice as many are admitted to Accident & Emergency compared to the general population.

Those living in bed and breakfast accommodation

The severe shortfall in the availability of social housing can mean that families and individuals in priority housing need (for example those with substance misuse problems or mental health issues) may be placed in bed and breakfast hotels until suitable accommodation becomes available. This was more a feature in the 1980s and 1990s than today, although this may change in the future given the acute and rising demand for social housing and the impact of job losses and benefit changes leaving households unable to meet their mortgage and rent payments. There have been reports that some London Councils have block-booked bed and breakfast accommodation outside London in anticipation of a rise in the number of homeless families who will be unable to meet their private sector rent payments following the introduction of a cap on housing benefit payments.

The standard of bed and breakfast accommodation varies but families often have to live in one room with little or no private cooking or washing facilities. There is evidence that bed and breakfast accommodation presents particular risks to the health and development of children. Behavioural problems can develop with poor sleep and insecurity. Infections
and gastrointestinal problems are especially common. There are also similar health implications for the adults in bed and breakfast accommodation, and gaining access to primary care services can also be problematic.

**Those released from prison**

Those leaving prison on completion of their sentence are often faced with acute housing problems and many also have mental health issues. The Prison Reform Trust providing evidence for the St Mungo's report revealed that 72% of male and 70% of female prisoners experience mental health issues and, the Sainsbury Centre for Mental Health identified that 66% of those in custody have a personality disorder compared to just over 5% in the general population.

Evidence from the Revolving Doors Agency identified that 43% of released prisoners with mental health problems have no fixed abode on the day of their release from prison. The Ministry of Justice data reveals that 8% of men and 10% of women were homeless when they entered custody. More than an third of St Mungo’s clients approaching the charity for assistance as homeless have previously been in prison. Offenders who have a home prior to commencing their prison sentence are likely to lose their tenancy because of an inability to pay the rent or because of a lack of support. When people leave prison and are offered accommodation, they are often settled with little or no support and are faced with severe financial difficulties in meeting their living costs.

6. **The Neighbourhood**

It is not only conditions in the home that impact on a person’s health but also the social and physical characteristics of their neighbourhood. Although access to health, social care and other social support services clearly make a difference, the relationship between neighbourhood characteristics and health is complex and interactive.

Poor housing is often situated in neighbourhoods that are disadvantaged including through a lack of amenities, meagre access to good quality open space and leisure facilities and unsafe streets. Poor accommodation and a disadvantaged environment have an inter-relationship and each contributes to the other’s negative impact on health.

**Lack of access to exercise**

The principal cause of obesity is an imbalance between energy intake and energy expenditure. There is growing recognition that, as well as individual characteristics, the place of residence or the neighbourhood may be associated with health outcomes including obesity and health related behaviours including a person’s willingness to participate in physical exercise.

Research across Europe found that those who were living in environments that contained high levels of greenery were more likely to be physically active is significantly higher and the likelihood to be overweight and obese was significantly lower. Those living in
environments with little greenery and with high levels of incivilities such as litter and graffiti were much less likely to be physically active with the consequences of being more likely to be overweight and obese.

Addressing community safety concerns
Feelings of insecurity when out and about in the neighbourhood and concerns for the safety of the home can help generate stress and depression among residents. Research conducted in Sheffield identified a direct link between improving the security of a group of dwellings to make them more robust against burglary and a reduction in the number of residents with clinical depression\textsuperscript{35}. That research calculated that the Decent Homes Programme in Sheffield would save the NHS £300,000 annually by providing enhanced security to dwellings.

**Part B: Health and Housing in Islington**

7. Islington’s Health

The Joint Strategic Needs Assessment (JSNA) process describes the main health and wellbeing issues in Islington and brings together the wide range of factors that directly influence health and wellbeing, such as employment, housing, education and the environment.

Overall the health of residents in the Borough is worse than the average for England. Within London, Islington has the lowest life expectancy for men and one of the lowest for women. For both genders, this is lower than the average for England. Within the borough, those living in deprived areas have a lower life expectancy than those living in less deprived areas.

A range of health outcomes and wellbeing indicators vary according to ethnic origin and migrant status. Some are as a result of genetic predisposition such as sickle cell disease; others may be a result of lifestyle factors such as diet or difficulties in accessing services due to language and other barriers. There is a higher prevalence of cardiovascular disease, cancer, tuberculosis and mental ill health amongst certain BME groups as well as a difference in terms of educational attainment, unemployment and homelessness.

Although death rates for all causes have fallen over the last ten years, all rates for Islington are higher than the national average. Despite the improvements in death rates, nearly half of all deaths in 2006/08 were premature (i.e. in those aged less than 75 years) and therefore potentially preventable\textsuperscript{36}. Cardiovascular disease (CVD) was the leading cause of death in Islington and the second major cause of premature death after cancer.

Smoking was a risk factor in one in five deaths in Islington and remains a major factor leading to early death. Smoking prevalence in Islington was significantly worse than the
average for England. The number of 'smoking quits' recorded by Islington's Stop Smoking Service was one of the highest in London (55 per 1,000 adult smokers in 2009/10). Less than one in ten Islington residents exercise regularly and nearly a fifth if Islington residents are obese, these levels are no different than the averages for England.

The infant mortality rate in Islington is no different that in London and England. The major cause of infant mortality in Islington (13 infant deaths a year) was poverty. Deprivation was also a contributing factor to other risk factors for infant mortality. For example, overcrowding was identified in Islington’s Public Health Report 2010 as increasing the risk of Sudden Unexplained Death in Infancy (SUDI) as does the sleeping position and the smoking status of the parent.

There were on average 95 new cases of TB per year 2006/08 and this yields a crude rate that is much higher than the average for England.

In 2009/10, less than 1% of the resident population registered with an Islington general practitioner had dementia and 1% was diagnosed with schizophrenia, bipolar disorder or other psychoses. The borough’s Public Health Report 2010 states that Islington has higher rates of mental health need because of its comparatively young adult population, substantial inequalities in socio-economic status, and 'low levels of community cohesion and social capital'. These are said to be all risks for hazardous drinking, substance misuse and suicide. Suicide and alcohol-related death rates in Islington are higher than the averages for London and England.

In Islington, there are 15% more deaths in winter than in summer and an average of 56 excess winter deaths each year. Generally it is the vulnerable elderly who are most at risk and particularly those living in fuel poverty and with long term conditions. Islington has similar average rates of excess winter mortality to London as a whole and England. The relationship of factors contributing to the risk of excess winter mortality is complex and the risk has been shown to vary little by socio-economic group. However, it is correlated with poorly heated housing and low household income is a determinant of low indoor temperature. There appears to be a lack of a relationship between excess winter deaths and deprivation and it is thought that this may be because those in social housing may benefit from newer and better maintained housing stock that is easier to heat.

Analysis by place of death reveals that the numbers of deaths occurring in winter in residential or nursing homes and at home was significantly higher than in the summer months. Islington’s Annual Public Health Report 2010 suggests that this 'most likely reflects the vulnerability of residential or nursing home populations as well as elderly people who are living on their own in fuel poverty and/or poor housing'.
8. Islington’s Housing

In 2009, there were nearly 195,500 people living in Islington and this is set to rise to over 213,000 by 2019. Islington has a relatively young population with only 9% of the population aged 65 and over, compared with 11% for London and 16% for England. In 2009, 44% of the resident population of Islington was aged 20 to 39.

In terms of households, 16% in Islington contain only people of pensionable age and 18.7% contain children. The average household size was 2.06 persons with the largest households found in the private rented sector where the average household size was 2.12.

Households containing older people were particularly likely to live in owner-occupation without a mortgage, or social rented housing. In the 2008 Housing Needs Survey, a quarter of older people stated that they would like to move into sheltered or supported housing in the next two years.

The 2009/10 Islington Joint Needs Strategic Assessment (JNSA) described the borough as:

'A small, densely populated, inner London borough with a growing, diverse population that is relatively young. Islington is home to a wide range of ethnic groups including those from Irish; Somali; Bengali; Turkish; Arabic; Albanian; Portuguese; Spanish; Nigeria; and Ghanaian communities. Many residents were born outside the United Kingdom. The population is highly mobile and there is considerable annual churn'

Nearly a third of Islington’s residents were born outside the United Kingdom. Of the 50,000 or so Islington residents who identified themselves as being from a Black and Minority Ethnic (BME) group in 2009, 20% were Black African, 17% were Black Caribbean, and 11% were Bangladeshi. Islington’s BME populations are relatively young with 29% estimated to be younger than 15. In particular, the Bangladeshi population is young, with 37% aged less than 15 years.

There were significant differences in tenure between the BME groups, although in general BME households were more likely to be living in private rented housing and had generally lower levels of income and savings.

There are no routinely available data on the breakdown of the population by sexual orientation. Local knowledge and sexual health data suggest that Islington has a relatively large Lesbian, Gay, Bisexual and Transgender (LGBT) population. Islington’s LGBT population have a higher incidence of a number of risk factors such as smoking and drug misuse and are disproportionately affected by HIV compared to the general population.

There is also very little information on the direct relationship between faith and health and wellbeing. It is likely that behaviour and attitudes towards suicide, serious mental illness
and use of alcohol and drugs vary according to faith. Religious attitudes towards sex, contraception, abortion and sexuality are also important in relation to sexual health.

Overall it was estimated that there are approximately 88,000 households in the borough. Of these households and in 2007, 31.5% were owner-occupiers and 44.0% living in the social housing sector (Council tenants 30.8%, RSLs and others 13.2%). There were 21,512 households living in the private rented sector, accounting for 24.4% of all households.

The private rented sector has grown over the past five years and seen more vulnerable and low income households placed into private tenancies. The NHS Islington 2009/10 JSNA commented that ‘the Council will need to work more closely with private landlords to ensure tenancies can be sustained by families, and to work on improving the quality of homes in the sector’. It also stressed the importance of encouraging private sector landlords to participate in the Islington Landlord Accreditation Scheme.

The Parliamentary Office of Science and Technology Post Note on housing and health referred to the concern of the National Housing Federation, Shelter and others about the changes to Housing Benefit and Local Housing Allowance announced in 2010. From April 2011, changes to Housing Benefit 'may result in more social tenants struggling to maintain their tenancies'. It has also been voiced that proposals to stop providing tenancies for life may also decrease security of tenure and this could lead to increases in stress and mental health problems.

From April 2011, the Local Housing Allowance (housing benefit for private rented sector) will be capped and there are concerns that this may lead to an increase in the proportion of economically vulnerable people seeking lower-rent accommodation in the private rented sector, including in HMOs, and could lead to overcrowding with implications for health. It is thought that this will affect homes in the south east and London the most, private sector rents in Islington are higher than the London average and significantly higher than the national average. The new caps are £250 a week for one bedroom property, £290 for two bedrooms, £340 for three bedrooms and £400 for four bedrooms.

The stock of housing in Islington is heavily skewed toward smaller dwelling types such as flats. An estimated 81.0% of households live in flats, which is significantly above the national average of 16.7% and the average for Greater London of 44.9%.

The 2007 Islington Housing Needs Survey gave the following summary statistics on the borough’s housing stock:

- 28.5% of households had lived in their current accommodation for less than two years. The most mobile tenure was the private rented sector, where 65.0% had moved in the same period.
- There are 6,110 overcrowded households (6.9%) which is greater than the national average
Item 4a

- Average house prices in Islington (at £449,855) are more than double the national average and more than a quarter higher than the Greater London average\(^{v}\)
- Entry-level prices ranged from £261,500 for a one bedroom property up to £618,000 for a four bedroom. The cost of a terraced house in Islington (at £799,294) is 134.1% greater than the average for London
- Data from the Land Registry shows a definite north/south divide. Postcode areas in the south of the Borough are generally the highest priced areas with those postcode areas to the north being the lowest priced areas.
- Entry-level rents in the private sector in 2008 varied from £893 a month for a one bedroom property to £2,004 for a four bedroom.
- The total future need for affordable housing is estimated to be over 5,000 units each year in a range of property sizes

The vast majority (87%) of Islington’s residents fall within two main lifestyle groups: 45% are people renting flats in high density social housing and 42% are well-educated city dwellers, many living in owner occupied accommodation or in privately rented housing. There is no distinct pattern in the geographical spread of these two groups in Islington because, at street level, people with very different characteristics often live side by side\(^{39}\).

Most Council homes in Islington are managed by Homes for Islington (HIF). An additional 7,000 tenanted and leasehold homes are managed through Partners for Improvement in Islington (RSLs) and nearly 4,000 are managed by 26 tenant-run organisations (tenant management organisation or tenant management co-operative) in partnership with HFI.

Islington is ranked the fourth most deprived borough in London and the eighth in England. Two thirds of Islington residents live in areas classified as being in the most deprived fifth of the areas in England\(^{40}\). The 2010 Annual Public Health report identified deprivation as the overarching determinant of health within the borough and deprivation ‘substantially impacts on behavioural and clinical risk factors’ including for the development of cancer and for early presentation and utilisation of services.

2007 Survey data suggests that 15,899 households (18.1%) in the borough were living in unsuitable housing, the main reasons being overcrowding, special needs and need for repairs. In terms of overcrowding, households with a person or persons of pensionable age account for the smallest proportion of overcrowded households, whilst households with children account for nearly two thirds of overcrowded households.

At the end of March 2009, 75% of council homes had met the Decent Homes Standard. In order to be decent, a home should be warm, weatherproof and have reasonably modern facilities.

\(^{v}\) The 2009/10 JSNA states that, in July 2009, the average property price in Islington was £380,628, compared to the national average of £155,885.
It is estimated that 22.1% of private sector households\textsuperscript{vi} in Islington are living in fuel poverty\textsuperscript{iv}, an increase on the 2003 estimate of 17.3%\textsuperscript{vii}. Those in the private rented sector were most vulnerable, with 31% of tenants experiencing fuel poverty. The 2008 Private Sector Stock Condition Survey (PSSCS) estimated that 53% of single pensioners were living in fuel poverty. Other groups most vulnerable to fuel poverty tend to be people on low incomes, lone parents and unemployed people.

Islington Council’s 2008 PSSCS estimated that 15.3% (8,050) private sector dwellings had a Category 1 hazard (i.e. defined using the Housing Health & Safety Rating system Category 1 hazards include excess cold, fire hazards, risk of falling on stairs, damp and mould, and leaking roofs). Older dwellings appeared particularly likely to be ‘hazardous’ Vulnerable households are more likely to be living in Category 1 hazard homes, 21.0% compared with 14.2% of other households. The 2008 survey suggested that 26.4% of dwellings in the private sector failed the Decent Homes Standard.

The 2004 Islington Private Sector Stock Condition Survey defined 8,288 buildings as Houses in Multiple Occupation (HMOs), about 15% of the total housing stock in the borough and much higher than the average for England at just over 5%\textsuperscript{iv}. Nearly 40% of HMOs were found in the private rented sector. Nearly all HMOs were in buildings dating from before 1919 and more than two thirds were assessed to be not suitable for human habitation.

More than one in seven (or 15.7%) of all older people households suggested they had problems with maintaining their homes compared to 9% of all general households in Islington.

At August 2008, 10,400 Islington residents were receiving disability living allowance, equivalent to 6% of the borough’s resident population. This compares to 4% for London and 5% for England.

There are an estimated 17,174 households (19.5%) in Islington with one or more members in an identified special needs group. The biggest cause of need is physical disability, followed by frail elderly. Households containing people with special needs were more likely to contain older people, more likely to live in social rented housing, and more than twice as likely than average to live in unsuitable housing, and had household incomes and savings significantly lower than average. The most requested housing improvements and services were for lower level shower units and for extra handrails.

2007 data from Islington Council identified a total of 1,042 homeless households in temporary accommodation including nightly paid accommodation (300), hostels (150) and in private sector accommodation either leased by the Council or by RSLs (583). At that time, there were no households paid for by the Council and in bed and breakfast

\textsuperscript{vi} Owner occupiers and those in privately rented housing
\textsuperscript{iv} Fuel poverty is defined as households who spend more than 10% of their income on heating their homes
accommodation. This information was updated in the 2009/10 JSNA identifying that levels of statutory homelessness in Islington have reduced overall since 2001/02 by about 78%. At the end of March 2009, Islington had 875 households placed in some form of temporary accommodation, including 329 households in hostel or annexe accommodation.

The 2009/10 JSNA stated that compared to neighbouring boroughs the numbers of rough sleepers in Islington have been low. It refers to the London-wide street count, carried out across the capital on one night in November 2009, when it was reported that there were four rough sleepers located on the streets of Islington.

The 2009/10 JSNA comments that homelessness and overcrowding are a consequence of the lack of good quality affordable housing for low incomes families. The Islington Housing Needs Assessment 2008 estimated that 18% (about 15,500) Islington households are living in unsuitable accommodation. Of these, approximately 10,000 households require a move to alternative accommodation but are unable to do so without some financial assistance. Households in the rented sectors, particularly the social housing sector, account for more than 90% of this need.

Appendix One in this report summarises from the 2009/10 JSNA some of the services provided by Islington Council for those in housing need, including those homeless.

9. The Relationship between Housing and Health in Islington

Islington NHS 2009/10 Joint Strategic Needs Assessment (JSNA) includes a chapter of housing and homelessness that draws together information on housing and health in the borough. The chapter begins with a statement that reinforces the impact of poor housing on residents’ physical and mental health:

‘Decent affordable housing is a cornerstone of good physical and mental health and a major determinant of health inequalities. Badly designed and poorly-built houses with inadequate heating, damp, lack of space, poor lighting and shared amenities are a major contributor to poor health. Poor housing and homelessness are not just a housing problem. They have profound implications for the health and social and economic wellbeing of the people affected, and for society as a whole’

Using information from the 2009/10 JSNA and other national research linking housing and health, the table below summarises for Islington what are likely to be the main impacts of poor housing on health and which groups in the population are likely to be most at risk.
### Housing features with health implications

<table>
<thead>
<tr>
<th>Islington specific data</th>
<th>Likely health impact and most at risk</th>
</tr>
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<tbody>
<tr>
<td><strong>Damp and mould – prevalence of illness appears to increase with level of dampness</strong></td>
<td>Increased risk for those with respiratory infections, asthma and allergic rhinitis; and with skin problems such as eczema</td>
</tr>
<tr>
<td>In 2009, 75% of council homes had met the Decent Homes Standard – including warm and weatherproof but 25% did not. 26.4% of dwellings in the private sector failed the Decent Homes Standard.</td>
<td>Most at risk: babies and young children, older people</td>
</tr>
<tr>
<td>In 2008, there were 8,050 private sector dwellings with Category 1 hazards that could include excess cold, damp and mould, and leaking roofs.</td>
<td>Vulnerable people are more likely to live in a home that is a Category 1 hazard</td>
</tr>
</tbody>
</table>

| **Cold homes and fuel poverty** | Increased risk including for those with respiratory infections. |
| It is estimated that more than a fifth of private sector households in Islington are living in fuel poverty. Those in the private rented sector were most vulnerable, with 31% of tenants experiencing fuel poverty. In 2008, it was estimated that 53% of pensioners living alone were living in fuel poverty. | Excess Winter Deaths |
| There is an average of 56 excess winter deaths each year in Islington | Most at risk: low income households, including pensioners, the unemployed, lone parents. Sick and the disabled often have to heat their homes for much longer than those at work or otherwise out of the home for longer periods of time. |

<p>| <strong>Exposure to house dust mites and other allergens</strong> | These airborne pollutants can trigger allergic symptoms such as eczema and conjunctivitis. Repeated exposure can lead to asthma or increased severity of asthma. |
| | Most at risk: children, those on low incomes |</p>
<table>
<thead>
<tr>
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<th>Likely health impact and most at risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcrowding</td>
<td>Islington has an overcrowding rate of 6.9% equating to 6,100 overcrowded households, mostly concentrated in the social rented sector. The majority of overcrowded households live in flats, and two thirds of overcrowded households contain children. Islington has higher rates of mental health need partly because of its comparatively young adult population and substantial inequalities in socio-economic status.</td>
<td>Overcrowding is associated with increased physical and mental health problems and poor educational achievement by children. It can also have an impact on family life and relationships and lead to family breakdown. Overcrowding is also associated with the spread of infectious diseases such as TB. Those most at risk: Families including those with young children, Black and ethnic minority households</td>
</tr>
<tr>
<td>Rodent and other pest infestations</td>
<td>Older and poorly maintained housing - More than one in seven (or 15.7%) of all older people households suggested they had problems with maintaining their homes compared to 9% of all general households in Islington.</td>
<td>Rats and other pests carry a wide range of parasites contributing to disease with risks especially high for those already with a lower health status and for children. Most at risk: Those on low income Living in HMOs Living in older and poorly maintained housing Babies and young children</td>
</tr>
<tr>
<td>Inadequate housing leading to higher risk of slips, falls and other accidents</td>
<td>In 2008, 8,050 private sector dwellings had a Category 1 hazard (i.e. defined as including fire hazards and risk of falling on stairs)</td>
<td>The home environment is the main site for accidental injury and death for young children and especially those of low income families. As disabled children are more likely to be in low income families, this places them at high risk. Older people are the other most at risk group</td>
</tr>
<tr>
<td>Housing features with health implications</td>
<td>Islington specific data</td>
<td>Likely health impact and most at risk</td>
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<tr>
<td>Lack of adaptations for independent living</td>
<td>17,174 households (19.5%) in Islington have one or more members in an identified special needs group. The most requested housing improvements and services were for lower level shower units and for extra handrails.</td>
<td>The biggest cause of need is physical disability, followed by frail elderly. Most at risk group – older people, those on low incomes and those with physical disabilities</td>
</tr>
<tr>
<td>Noise disturbance</td>
<td>Noise disturbance is more likely to occur in high density housing, including flats, especially in the social housing sector. In Islington an estimated 81.0% of households live in flats, which is significantly above the average for Greater London of 44.9%.</td>
<td>Mental pressure and stress that can trigger irritation and aggression, sleep disturbance, interruption of speech and social interaction, disturbance of concentration and cardiovascular effects.</td>
</tr>
<tr>
<td>Houses in Multiple Occupation</td>
<td>The council reviews changes in private sector housing by carrying out a stock condition survey of a sample of at least 1,000 dwellings every five years. In addition, street surveys are carried out in at least three wards each year to identify HMOs.</td>
<td>Those living in HMOs are four times more likely to suffer injury and twice as likely to die in a fire as those in single occupied dwellings. Health problems associated with poor housing conditions including lack of repair and maintenance, overcrowding and noise disturbance. Most at risk: vulnerable residents, those on low incomes, children, black and ethnic minority households</td>
</tr>
<tr>
<td>Homelessness &amp; those living in temporary accommodation</td>
<td>At the end of March 2009, Islington had 875 households placed in some form of temporary accommodation, including 329 households in hostel or annexe accommodation.</td>
<td>People who live in temporary accommodation are at significantly higher risks of experiencing depression, relationship problems, suicide attempts and alcohol and drug misuse.</td>
</tr>
<tr>
<td>The 2009/10 JSNA stated that compared to neighbouring boroughs the numbers of rough sleepers in Islington have been low.</td>
<td>Most at risk: vulnerable people and those with special needs, children and families, those from black and ethnic minority communities</td>
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<td>There are acute problems of homelessness for those living prison – there are two major prisons (Holloway for women and Pentonville for men)</td>
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<tr>
<td>Islington has the second lowest amount of open space of any local authority in the country. However, Islington’s densely built form has resulted in a network of predominantly smaller local open spaces.</td>
<td>Those living in environments with little greenery are much less likely to be physically active with the consequences of being more likely to be overweight and obese</td>
<td></td>
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<tr>
<td>In Islington for the year 2009/10, residential burglary fell by over 5%, robbery fell by nearly 10% and knife crime fell by over 11%. There were reductions in the levels of serious youth violence, which fell by more than 20%. Importantly for fear of crime - research showed that 70% of residents did not realise that crime was falling in the borough. Hate crime is harassing, intimidating or abusing someone because of their race, faith, religion, disability, gender, or because they are lesbian, gay, bisexual or transgender. In 2009/10, incidents of hate crime in Islington have increased, particularly those related to domestic violence.</td>
<td>Feelings of insecurity when out and about in the neighbourhood and concerns for the safety of the home can help generate stress and depression among residents. This can be greater for older residents. Women are much more likely than men to be the victims of domestic violence and this often affects children in the household. Black and minority ethnic residents are more likely to be the victims of hate crime because of their race or faith.</td>
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</tbody>
</table>
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APPENDIX ONE

Extract from the NHS Islington 2009/10 JSNA – Services provided for housing in Islington
There are a number of services in Islington aimed at addressing housing needs. These include:

**Housing and homelessness services**
There are a number of services available in Islington that help people who may be faced with homelessness or are seeking housing assistance. The Council’s housing solutions team will provide advice on the options available to people facing the potential loss of their home or insecure housing. These include:

- 18 outreach surgeries with different communities and locations across Islington
- Home visits for 16 and 17 year olds facing homelessness
- A private sector opportunities scheme in which households can take up accommodation in the private rented sector as statutory homeless households or through a rent deposit scheme.
- A home shelter scheme for victims of domestic violence
- An advice service, Pulse, providing guidance on housing options for younger people

**Services to address overcrowding in Islington**
Include:

- Minor Works Pilot
- Smart Move mutual exchange scheme
- De-conversions
- Under-Occupation Initiative
- Islington has been in receipt of pathfinder money from the Communities for Local Government which has been used to fund two overcrowding officers who work with existing tenants and in tandem with an under occupation officer to identify practical solutions to overcrowded households
- The Council is using a combination of Greater London Authority funding and its own capital money for de-converting and extending smaller properties into larger homes. This will produce 55 extra bedrooms by March 2012.

**Schemes to improve the standards of poor quality housing in Islington**
Include:

- Capital investment in council housing stock, such as the decent homes programme delivered through Homes for Islington
- Private sector renewal grants
- Action to address fuel poverty
- The Council’s Private Housing Partnerships section arranges meetings of the Landlords Forum three times a year. This highlights issues of importance to landlords including fire safety and benefit changes. Training events are also provided for landlords.

**Housing Need Assessment**

The Housing Development team work closely with the Planning Department to identify the level of housing need in the borough, including the Council’s social housing requirements. The Council aims
to maximise the number of affordable housing units, and within that to maximise the number of larger, family-sized units, built under the affordable housing eligibility criteria. The ratio of property sizes for affordable units is 20% one bedded units, 40% two bedded and 40% with three or more beds.

Developments are negotiated on an individual basis. A Local Area Agreement target has been set to increase the overall number of affordable homes in the borough by 1,900 in the three years to 2011.

The Housing Needs Assessment is a key piece of housing evidence base for the developing Core Strategy (Local Development Framework). This strategy establishes the overall framework for new developments in Islington.