

HEALTH IMPACT ASSESSMENT

of the

Leeds Landlord Accreditation Scheme

August 2007

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Executive Summary

The Leeds Landlord Accreditation scheme is a voluntary scheme that private residential landlords are encouraged to join.

The aims of the scheme are to encourage, acknowledge and actively promote good standards of privately rented accommodation and to assist landlords and tenants to undertake their respective responsibilities to each other.

The vision is that tenants will routinely seek to occupy properties owned by accredited landlords because they are guaranteed a certain (good) standard of accommodation.

Documented evidence shows that housing conditions affect the health and well being of occupants.

Those living in the private rented sector (PRS) tend to have poorer health than those in other housing tenures. The majority of PRS properties tend to be located in areas with the greatest levels of deprivation and accommodate those more vulnerable members of the population.

An examination of the condition of properties owned by LLAS members and non members shows that LLAS member properties are of a higher standard and their tenants are consequently experiencing better health.

The study shows that generally tenants are unaware of the scheme.

Very few properties in the areas of deprivation are covered by the scheme.

Recommendations are made with respect to enhancing and extending the scheme, thereby enhancing the health of a greater number of the population of Leeds and tackling health inequalities.

A Health Impact Assessment of Leeds Landlord Accreditation Scheme

1. The Leeds Landlord Accreditation Scheme (LLAS)

Leeds Landlord Accreditation Scheme is a voluntary scheme that private residential landlords are encouraged to join.

The aims of the scheme are to encourage, acknowledge and actively promote good standards of privately rented accommodation and to assist landlords and tenants to undertake their respective responsibilities to each other.

The scheme comprises an element of self-regulation and accordingly relies on a degree of goodwill and trust on the parts of landlords, tenants and the Local Authority.

It is a requirement of the scheme that the physical condition of properties, the level of provision of basic amenities and management practices, are fair and reasonable, and not liable to be prejudicial to the health, safety and welfare of tenants or the community.

Signatories to the scheme must ensure that in addition to complying with the requirements of the scheme, they also comply with their legal obligations in respect of the health, safety and welfare rights of their tenants.

Compliance with the scheme will ensure that:

- Landlords, tenants and community members enjoy the benefits of good property conditions, competent management standards and considerate neighbourly behaviour;
- Misunderstandings and disputes are reduced;
- Where problems do occur they are promptly resolved.

It aims to achieve this by giving landlords, who are accredited, a clear market edge over their non-accredited colleagues and thereby providing an incentive to become accredited.

Landlords failing to meet the compliance standards won't be accredited.

The vision is that tenants will routinely seek to occupy properties owned by accredited landlords because they are guaranteed a certain (good) standard of accommodation.

Consequently the demand for properties of non-accredited landlords who's property conditions have not been verified will fall, such that landlords will be forced to carry out improvements and gain accreditation or leave the market. This is acknowledged to be a relatively simplistic view as there are several other variables which might influence the demand for properties owned by unaccredited landlords.

2. Health Impact Assessment (H.I.A.)

2.1 Their Purpose

Based on an e-mail consultation and an international workshop¹ a consensus paper² defines HIA as *'a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population'*.

Ideally HIA's should be conducted prospectively, but they can be used retrospectively and concurrently with the policy, programme or project under consideration. A further emphasis within an HIA should be a consideration of impact of the activity on health inequalities, although this issue continues to be debated. It should be noted that the HIA concept provides a mechanism to assess the health impacts of an activity which may be at first be considered to have little or no direct relevance to health.

The function of the HIA therefore is largely twofold:

- to demonstrate to what extent an activity (see below) does or does not produce health benefits, or indeed whether it produces negative health impacts.
- to make recommendations to amend the activity to enhance the positive health outcomes or mitigate adverse impacts.

2.2 The Toolkit Approach

Whilst the LLAS has been in operation for ten years a HIA was deemed to be appropriate since the scheme was under review and there was an opportunity to make recommendations with respect to its impact on health.

There are several approaches to conducting a HIA and an increasing amount of literature about the HIA process. As such a user friendly 'HIA ToolKit for Public Health Practitioners' has been developed jointly by Leeds CC & Leeds PCT and has been employed for the first time in conducting the HIA of the LLAS. If Environmental Health Services wishes to use this tool to assess its work, staff from any of its teams could become involved with the process.

In the Toolkit the terms 'policies, programmes and projects' usually associated with HIA's have been replaced by the term 'activity/activities'.

The completed worksheets, which are a fundamental part of the Toolkit, can be found in Appendix 1.

Screening considered the aims & operation of LLAS and deemed it suitable for an Advanced HIA. **Scoping** identified the populations most likely to be affected by the activity and the stakeholders who would need to be involved or consulted. **Terms of Reference** were drawn up and a Health Impact Statement (HIS) subsequently produced. The **Appraisal** stage and **Recommendations** are described and discussed in subsequent sections of this report.

¹ Health Impact Assessment: from Theory to Practice. Report on the Leo Kaprio Workshop. Gothenburg: WHO European Centre for Health Policy & Nordic School of Public Health 2001.

² Health Impact Assessment: Main Concepts and Suggested Approach. Consensus paper. Brussels: WHO European Centre for Health Policy. <http://www.who.dk/hs/EHCP.index.htm>

3. The Leeds Context.

It is estimated there are over **45,000 households** in Leeds renting their homes from private landlords, around **14%** of all households compared to 7% in 1981.

Private rented housing provides a home for students, nurses and young professionals, low income households, benefit claimants as well as for households relocating from other parts of the country, migrating from outside the UK or seeking asylum.

Data on the private rented sector was gathered as part of the Leeds House Condition Survey 2001.

The private-rented sector showed a broad distribution across the city but was significantly concentrated in the North-West and East areas and within former Urban Renewal Areas. 32% of private rented dwellings in single occupation were located in the North-West Area together with 74% of private-rented dwellings in multiple occupation.

Over 40% of all private-rented dwellings were located in Urban Renewal Areas with particular concentrations in Armley, Beeston and Chapeltown.

Private-rented dwellings in multiple occupation were significantly concentrated in the Hyde Park URA (2,567 dwellings or 34% of the total).

Housing conditions were significantly worse within the private-rented sector compared to the other tenure groups. 9,239 private-rented dwellings (33.0%) meeting the requirements of the decent homes standard, the remaining **18,771 dwellings** (67.0%) being **non-decent**. There is no reason to believe that either the distribution or numbers of PRS dwellings has significantly changed since this survey. A 2007 stock condition survey is currently being undertaken which will provide updated figures, but the report will not be ready until December (see recommendations).

In recent years housing as an investment has performed well realising high financial yields. This has led to increasing levels of 'buy-to-let' purchasing either for commercial return or to provide pension income for those without long-term occupational provision.

Lower than average house price inflation in certain parts of the city have also made housing in those areas attractive to investors. This has led, in some parts of the city, to private rented housing being the dominant tenure.

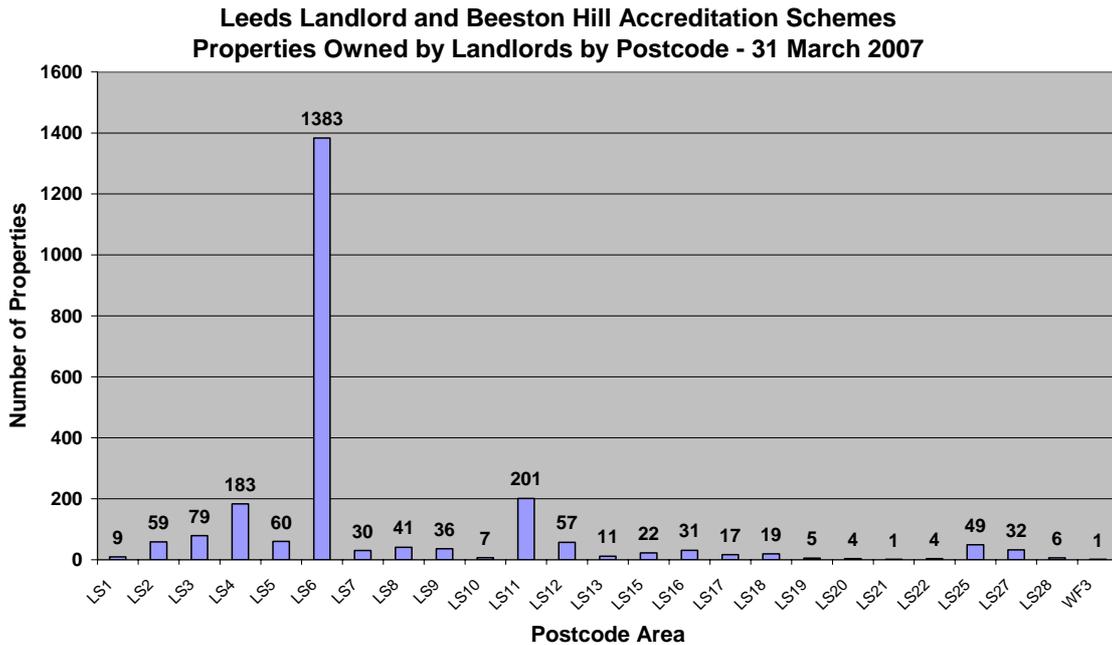
In Headingley ward the proportion is around 60% and in Beeston Hill, the proportion of housing privately rented is between 40 and 50%. The % of housing privately rented in Beeston Hill has tripled in the last three years.

Continuing increases in house prices, the flexibility increasingly required in the labour market and changing preferences are all likely to drive further expansion of the private rented sector in Leeds.

4. LLAS Profile

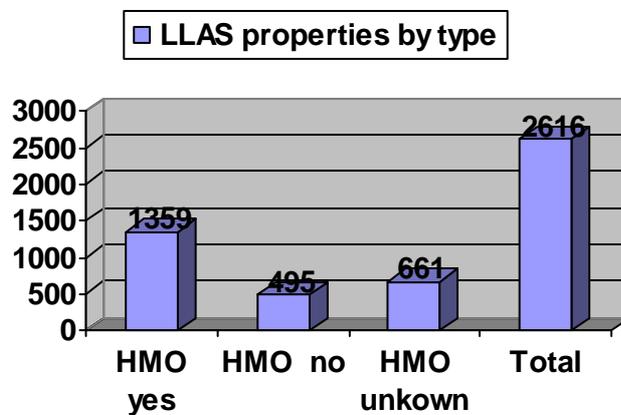
Membership of LLAS is open to any landlord provided they meet the schemes' conditions irrespective of property type or location. As of 31st March 2007, **2616** properties were covered by the scheme. **Table 1 & Map 1** show the distribution of accredited properties by post code. However the majority of members properties - 59%, are located in the Headingley area (LS6) of Leeds. The post code with the next highest concentration is LS11 with 8%. **Map 2** shows that only a few properties are located in the most deprived SOA's .

Table 1



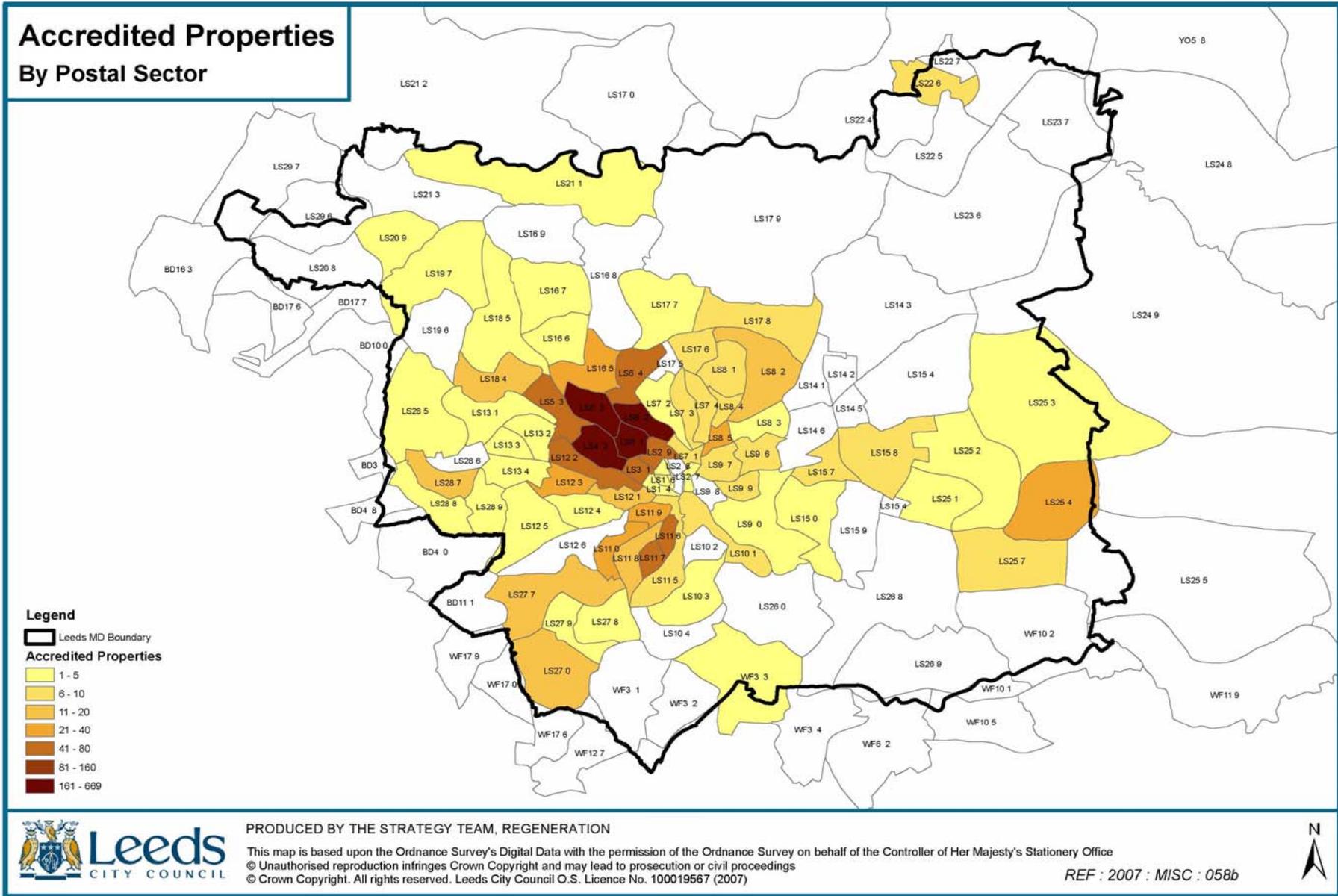
A significant number 52% of all accredited properties are Houses in Multiple Occupation (HMO's) (*see table 2*).

Table 2

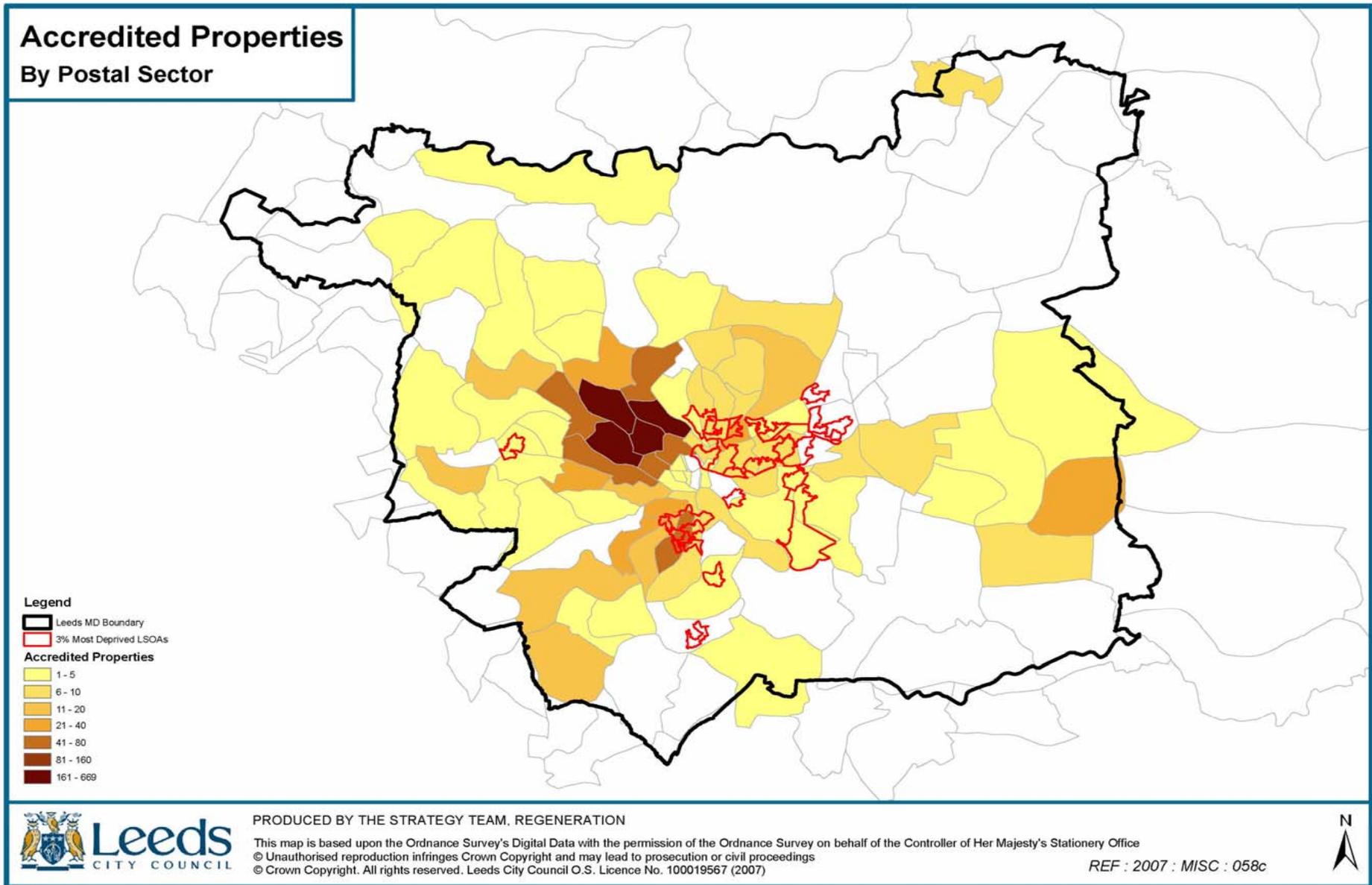


Map 1

Accredited Properties By Postal Sector



Map 2



The authority is currently developing a business case for selective licensing in two areas: Beeston Hill & Holbeck and Cross Green & East End Park. Information gathered to inform the business case included estimates of the total number of PRS properties in these areas. There are 500 in Beeston Hill & Holbeck (LS11) out of ~3,000 and 3,000 in Cross Green & East End Park (LS9) out of ~9,000. In the same areas there are 201 and 36 properties respectively, owned by accredited landlords.

As part of the Leeds House Condition Survey 2001 tenants of private-rented dwellings were asked if their landlord was in an accreditation scheme. 24372 tenants, or 93.1% were unaware of any scheme, 1109 tenants (4.2%) stated their landlord was registered in the Council scheme, 684 tenants (2.6%) stated their landlord was registered in the Unipol scheme.

5. Appraisal and Assessment of Potential Impacts

Appraisal is centred around developing and implementing a methodology to assess the health impacts of the activity. In this instance the LLAS. The application of a HIA in a socio/economic environment is largely a qualitative process as precise-cause effect relationships are difficult to prove. Key elements include a review of existing documented evidence, population and/or community profiling, and understanding the relationship between the activity and relevant health determinants. An important feature is the evidence gathered through consultation with appropriate stakeholders.

Primary stakeholders with regards to the LLAS are tenants of landlords who are members of the scheme. Consultation with tenants of LLAS landlords and non LLAS member landlords was by way of questionnaires and follow up interviews.

Property Improvement Plans (see below) have been used in the appraisal methodology. However no consultation with landlords took place. It is recommended that this is arranged as landlords are likely to be affected by the implementation of recommendations which have emerged, and their contribution is essential.

Assessment is a subjective perception as to the likelihood of an activity having a positive or negative impact on health. This is shown in yellow boxes in this report.

5. 1 Evidence base – Housing and Health

LLAS's aim is to encourage, acknowledge and promote good housing standards.

The relationship between housing standards and health has been investigated in many studies. Several major reviews have attempted to pull fragmented pieces of evidence from different disciplines together.

All these reviews draw attention to what are referred to as "confounding" factors i.e. people in poor housing suffer so many deprivations (unemployment, poor education, ill health, social isolation etc), that assessment of any one risk factor is almost impossible.

The direction of cause and effect is often unclear - e.g. people with ill health may tend to live in substandard housing by virtue of low income. Furthermore indices designed for measuring health and the quality of housing tend to be relatively unsophisticated and are not applicable to all of the above factors. Similarly methodological issues have been compounded by contrast between subjective and objective assessments.

Despite these difficulties the association between housing conditions and physical and mental ill health is now accepted and a broad range of specific elements relating to housing are known to adversely affect health (*reviewed by Bonnefoy et al., 2004*):-

- Agents that affect the quality of the indoor environment such as indoor pollutants (e.g. asbestos, carbon monoxide, radon, lead, moulds and volatile organic chemicals).
- Cold and damp, housing design or layout (which in turn can affect accessibility and liveability), infestation, hazardous internal structures or fixtures, noise.
- Factors that relate more to the broader social and behavioural environment such as overcrowding, sleep deprivation, neighbourhood quality, infrastructure deprivation.

- Factors that relate to the broader policy environment such as housing allocation, lack of housing (homelessness, whether without a home or housed in temporary accommodation), housing tenure, housing investment, and urban planning.

There has been much debate as to why research has struggled to prove a direct causal relationship between specific housing issues and ill health.

Diane Wilkinson concludes in her paper *Poor Housing & Ill Health - A Summary of Research Evidence*, that:

- it may be more productive to accept that associations exist,
- housing has a role to play in both physical and mental health, and
- some types of house condition such as cold and dampness are more hazardous than others.

This was subsequently borne out by the statistical research underpinning the Housing Health & Safety Rating System which became a mandatory standard in the 2004 Housing Act.

However gaps do remain in the evidence base as identified in the NICE 2005 study – *Housing and public health; a review of reviews for interventions for improving health*.

There is a lack of review-level evidence of the effectiveness of interventions:

- involving re-housing or housing improvement combined with neighbourhood regeneration initiatives in improving health outcomes.
- involving general refurbishment initiatives in improving health outcomes.
- in reducing the risk of injurious falls in older people through modification of the home environment compared with control measures.
- that aim to reduce exposure to house dust mite allergen in the home in improving health outcomes in people with mite sensitive asthma.

Assessment	Action	Health Impact	Likelihood
1	Improving housing standards	Positive	Probable

N.B. Further links between housing and health are described in Appendix 2.

5.2 The Private Rented Sector (PRS) and Health Inequalities

Housing tenure has consistently been observed to be associated with measures of health. “People who live in houses which they own have lower rates of mortality than those who rent their homes from private landlords, who in turn have lower rates than those who are tenants of local authorities”³

Chandola’s study confirmed that this remains the position into the twenty first century, stating “housing tenure is more predictive of mortality than social class”⁴.

³ P Townsend & N Davidson (Ed) *The Black Report* included in *Inequalities in Health*, Penguin.1988.52

⁴ T Chandola,, (2000) Social class differences in mortality using the new UK National Statistics Socio-Economic Classification, *Social Science and Medicine*, 50(5): 641-9

Following their study on housing tenure and health in the West of Scotland, Macintyre et al interpreted their findings as indicating that tenure may be associated with health not only because it is a marker of income and or psychological traits, but because features of tenure may directly promote or damage mental and physical health e.g. perception of safety, dampness, ability to keep warm, provision of central heating, etc.

These latter two issues relate to fuel poverty. In Leeds there is a clear indication that fuel poverty is greatest in the PRS and is particularly marked in those areas of the city where multiple deprivation factors exist. See **Table 2**.

Table 2: Percentage of private sector in Fuel Poverty in Leeds electoral wards by rank order 2005

Rank	Wards	% of Fuel Poverty
1	Gipton & Harehills	48
2	Hyde Park & Woodhouse	40
3	Middleton Park	36
4	City & Hunslet	34
5	Burmantofts & Richmond Hill	34
6	Killingbeck & Seacroft	33
7	Beeston & Holbeck	30
8	Armley	30
9	Headingley	26
10	Farnley & Wortley	25

The Fuel Poverty Advisory Group in their 2005 report observed that *“the barriers to energy efficiency in the private rented sector are so great that clear-cut regulation is likely to be the only solution – unless the HHSRS (see below) and HMO powers can be made effective on energy efficiency”*.

Assessment	Action	Health Impact	Likelihood
2	Renting in the Private Rented Sector	Negative	Probable

5.3 UK Policy Context

The government’s commitment to promoting health and tackling health inequalities through policies concerned with housing, regeneration and sustainable development is clearly defined in *Tackling Health Inequalities: a programme for action* (Department of Health, 2003). It states that actions likely to have the greatest impact over the long term include improving social housing conditions and reducing fuel poverty among vulnerable populations. Key interventions that will contribute to closing the life expectancy gap include improving housing quality by tackling cold and dampness.

Similarly, those that will contribute most to closing the gap in infant mortality rates relate to improving housing conditions for children in disadvantaged areas. The Housing Health and Safety Rating System (HHSRS) is now the government's approach to the evaluation of the potential risks to health and safety from any deficiencies identified in dwellings. The HHSRS is evidence based – it is supported by extensive reviews of the literature and by detailed analyses of statistical data on the impact of housing conditions on health (ODPM, 2004a).

Assessment	Action	Health Impact	Likelihood
3	Central Government Housing Standards Policies e.g. HHSRS	Positive	Probable
4	Tackling Health Inequalities: a programme for action	Positive	Probable

5.4 Community Profile

Section 4 above describes the areas of Leeds where the LLAS is operating. Whilst it is a city wide scheme it is evident that its major sphere of influence and impact is only in a few areas. The main focus is the student community, followed by Leeds 11. This is reflected in the fact that properties of the majority of accredited landlords are HMOs. The landlords of many properties in the PRS, and which are in some of the most deprived areas of Leeds, remain outside the accreditation scheme.

Enhanced management practices and improving the external appearance of a property may also produce benefits for the local community. So improvements unique to the LLAS should be noted:

- Removal of “To Let” signs – enhances amenity
- ‘Prompt’ provision of gas & electrical safety certificates – demonstrates that appliances & installations are safe.
- Tidy gardens & overhanging vegetation – enhances amenity value & security by improving defensible space.
- Insulation advice – impact on fuel poverty, warmer homes if advice is followed.
- Burglar alarm nominate key holder – reduced incidence of noise nuisance to tenants and residents – stress & anxiety
- Refuse – enhanced amenity, removes harbourage for pests, burglary reduction

Assessment	Action	Health Impact	Likelihood
5	Landlord is part of the scheme	Positive	Probable
6	Landlord has not joined the scheme	Negative	Speculative
7	The distribution of properties associated with the scheme	Negative impact on health inequalities	Speculative
8	Awareness of the scheme amongst tenants	Potentially - positive Practically - negative	Speculative
9	Additional environmental conditions of LLAS	Positive	Probable

5.5 New evidence

Having regard to the existing evidence, the view was taken that although difficult to quantify, housing conditions are an important health determinant and it is reasonable to presume that any improvements in poor housing conditions will have positive health benefits for the occupants. (See assessment 1 above)

No studies on the health impacts of landlord accreditation schemes were found. Discussions on such schemes have concentrated on resource implications and problems of enforcement in the PRS. e.g. Stewart's 'academic look at the benefits of landlord accreditation scheme' did not mention health at all. (Env. Health Journal Vol 110/04 April 2002, 104-107.)

The question then arises as to how to demonstrate that the LLAS does deliver positive health benefits and to what extent? The approach agreed upon by the working group, as outlined in section 5 above, involves two elements; the use of Property Improvement Plans and questionnaires.

5.5.1 Use of Property Improvement Plans

When a landlord applies to join the LLAS a sample of their properties are inspected to see if they comply with the schemes' conditions. Where they don't a PIP is drawn up which identifies the remedial work required to bring the property up to standard and a timescale for completion.

If LLAS didn't exist these properties would probably remain in their present condition as the local authority would only have reason to visit them if a complaint was received from a tenant about their condition.

Furthermore several of ***the LLAS conditions exceed minimum legal housing standards*** and therefore have additional benefits which in turn are likely to bring additional health gains. This higher standard could only be achieved through voluntary compliance.

The HHSRS can be used to estimate the impact of the improvements. As well as looking at the dwelling defects, it enables their impact on the health and safety of potentially vulnerable occupants to be assessed.

Hazard scores are generated according to the likelihood that a hazard will result in harm being caused. This is generally expressed in terms of 'chance' e.g. 1 in 1000 chance of something happening. Factors that increase risk are also considered. A hazard is something that has the potential to cause harm and is categorised according to the perceived severity of the illness/injury it may cause. Taken together these variables are used to calculate an average score for each identified hazard.

When inspecting a property, surveyors are required to judge whether:-

- conditions in the property are likely to increase the risk of harm occurring
- factors exist that might increase the severity of the harm above the average.

Scores are expressed as bands ranging from A to J. With A-C being the most hazardous and termed Category 1 and D-J less serious referred to as Category 2.

For enforcement purposes a local authority has a duty to deal with Category 1 hazards and the discretion to deal with Category 2 hazards.

Analysis of PIPs

21 PIP's were randomly selected from LLAS records. 17 properties are Category B HMOs of which 9 are licensable. 1 is a Category A licensable HMO and 3 are single dwellings.

The following table illustrates the items specified in the PIPs by property, the hazard category for each item and the principal route of compliance.

Table 3

	Property Type	Items on PIP	HH&SRS Category	Compliance route	
				LLAS	HMO licence
1	Cat B (L) – LS6	Gas safety certificate Alarm test certificate Upgrade fire doors Additional kitchen facilities	6 24 24 11	✓* ✓* - -	✓ ✓ ✓ ✓
2	Cat B – LS6	Interlinked & mains wired AFD Rebuild boundary wall Cut back over-hanging branches Repair stair tread	24 29 - 21	✓ ✓ ✓ ✓	- - - -
3	Cat B – LS6	Interlinked & mains wired AFD Repair damp plaster work Tidy garden	24 1 -	✓ ✓ ✓	- - -
4	Cat B – LS6	Fire blanket Fire extinguisher Extractor fan to kitchen Thumb turn locks to exit doors Upgrade fire doors Renew guttering Electrical certificate Alarm test certificate	24 24 1 24 24 1 23/24 24	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	- - - - - - - -
5	Cat B (L) – LS6	Inadequate fire safety Additional WC Burglar alarm key holder	24 11 -	- - ✓	✓ ✓ -
6	Cat B (L) – LS6	Provide fire doors Box in fuse box	24 23	- ✓	✓ -
7	Cat B (L) – LS6	Provide fire doors Convert bedspace to WC & shower	24 11	- -	✓ ✓
8	Cat B (L) – LS6	Thumb turn locks to exit doors	24	-	✓
9	Cat B (L) – LS6	Thumb turn locks to exit doors	24	-	✓
10	Cat B – LS6	Fire blanket Fire extinguisher Thumb turn locks to exit doors Provide fire doors Interlinked & mains wired AFD Gas certificate Electrical certificate Extractor fan to kitchen Insulate pipe work in lift Loose handrail	24 24 24 24 24 6 23/24 1 2 21	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	- - - - - - - - - -

11	Cat B (L) – LS6	Thumb turn locks	24	-	✓
		Upgrade fire alarm	24	-	✓
		Fit cold smoke seals	24	-	✓
		Gas certificate	6	✓*	✓
		Electrical certificate	23/24	✓*	✓
12	Single dwelling – LS8	Gas certificate	6	✓	-
		Interlinked fire alarm	24	✓	-
		Electrical certificate	23/24	✓	-
		Burglar alarm key holder	-	✓	-
		Insulation advice	-		
13	Single dwelling - LS8	Interlinked fire alarm	24	✓	-
		Fire blanket	24	✓	-
		Gas certificate	6	✓	-
		Burglar alarm key holder	-	✓	-
14	Cat B (L) – LS6	Extend fire alarm	24	-	✓
		Escape windows cill height	24	-	✓
		Electrical certificate	23/24	✓*	✓
		Dispose of sofa bed	-	✓	-
15	Cat B (L)-LS6	Gas certificate	6	✓*	✓
		Electrical certificate	23/24	✓*	✓
		Leaking WC waste pipe		✓	-
16	Cat A (L)-LS11	Provide additional bathroom	11	-	✓
		Electrical certificate	23/24	✓*	✓
		Furniture regulations	24	✓*	✓
17	Cat B (L)-LS6	Bathroom facilities	11	-	✓
		Gas certificate	6	✓*	✓
		Electrical certificate	23/24	✓*	✓
		Burglar alarm key holder	-	✓	-
18	Cat B (L)-LS6	Gas certificate	6	✓*	✓
		Electrical Certificate	23/24	✓*	✓
		Fire extinguisher	24	-	✓
		Thumb turn locks	24	-	✓
		Remove "To Let" sign	-	✓	-
		Remove bricks from garden	-	✓	-
19	Cat B (L)-LS16	WHB to WC	17	-	✓
		Interlinked & mains wired AFD	24	-	✓
		30 min route of escape		-	✓
		Thumb turn locks to grilles	24	-	✓
20	Single dwelling-LS13	Gas certificate	6	✓	-
		Electrical certificate	23/24	✓	-
		Fire blanket	24	✓	-
21	Cat B-LS6	Fire extinguisher	24	✓	-
		Fire doors	24	✓	-
		Gas certificate	6	✓	-
		Electrical certificate	23/24	✓	-
		Handrail to staircase	21	✓	-
		Damp plasterwork	1	✓	-

Category 1 – Major hazard

Category 2 – Minor hazard

The fact that so many properties are licensable is significant. In such instances where a property has been inspected and failed to meet LLAS standards and the failures would constitute a breach of HMO licensing conditions, the improvements are left to be secured through licensing rather than a PIP. Consequently the landlord is allowed to join the scheme in the knowledge that the license conditions will at a later date require the defects to be remedied. Any issues outside licensing which are addressed through a PIP will be directly attributable to LLAS.

It maybe that some landlords implement improvements identified in a PIP prior to applying for a licence but this is unclear. In 11 cases electrical and gas certificates were provided promptly by the landlord on receipt of a PIP as indicated in the table by an asterisk.

A feature of the scheme, which provides added value, is that prospective accredited landlords are required to declare their property portfolio. From the information provided by the landlord it is possible to identify licensable HMOs, the details of which are subsequently referred to the HMO licensing team.

For non-licensable HMOs & individual dwellings the situation is different, as improvements identified in the PIPs must be agreed to and implemented as a condition of membership. ***These would not be secured through any other avenue unless a complaint was received*** i.e. there is no licensing safety net. As such securing voluntary compliance in these properties is where LLAS is having the greatest impact on housing conditions and therefore by association securing improvements in health.

Between them the landlords, of the 21 properties issued with a PIP, actually own a total of 138 properties. In a number of cases the LLAS manager advised that landlords have agreed to extend the improvement works identified in the PIPs to their other properties with similar deficiencies as part of a refurbishment programme. This is certainly borne out in some of the correspondence. In one notable instance a company with a portfolio of 45 properties has agreed to instigate a *“programme of necessary improvements over a period of 4 years on the basis that a 6 monthly progress report is provided detailing the properties improved in each period”*.

However it's not possible to quantify the 'knock on' impact of issuing a PIP to a landlord with other properties in their portfolio that aren't subsequently inspected to confirm the works have been undertaken.

Health conditions addressed by PIPs

Table 4 below provides a brief overview of the health effects attributable to poor housing by hazard rating category. The categories illustrated encompass all of the items identified in the 21 PIPs. As can be seen items relating to fire safety were the most common with means of escape from fire (MOEFF) improvements recommended at 18 properties inspected.

Of the 21 PIP's examined deficiencies relating to damp and mould growth were identified and subsequently remedied in 5.

Of the 21 PIP's 11 certificates were received shortly after the issue of a PIP. As such the contribution the LLAS makes to safety and wellbeing by requiring the production of up to date gas safety certificates is relevant.

Table 4

Hazard category	Description	HHSRS average	No. of Properties affected
1	Damp & mould growth -under 15's - Reduces thermal insulation, increased chance of fungal attack, production of fungal spores (allergens), increased humidity can increase dust mites and mould growth, increased respiratory problems, consequential adverse affect on mental health and social well-being.	I	5
2	Excess cold – over 60's - Prolonged temperatures below 18°C increase risk of respiratory infections, bronchitis, heart attacks and strokes. Prolonged temperatures below 10°C can cause hypothermia particularly in the elderly.	C	2
6	Carbon Monoxide - all ages-Carbon monoxide from poorly installed or maintained gas appliances can kill in a matter of hours. Odourless & colourless symptoms of poisoning are headaches, nausea and drowsiness.	J	10
16	Food safety – all ages - in the general UK population there are approximately 86,000 cases of food poisoning annually, just over half are formally notified, the rest being through other sources.	J	1
17	Personal Hygiene – under 5's- inadequate sanitation can lead to a risk of infection in particular from dysentery (<i>Shigella sonnei</i>).	J	5
21	Falls on the stairs – over 60's - it is estimated that in the UK each year 57,000 older people experience such falls. 1,500 individuals die as a consequence, and a further 22,000 experience serious injury, suffering a fracture, concussion or otherwise requiring admission to hospital for more than a day. Falls are likely to become an increasing problem, with the changing age profile of the population. <i>Loughboro University 2000</i>	F	3
24	Fire safety – over 60's – see below	G	18
25	Electrical hazards – under 5's - annually about 1,900 electric current home accidents result in hospital attendance, and, in recent years, under 20 have caused fatality.	J	12

Further explanations with regard to the health effects of the above conditions are found in **Appendix 2**

With respect to fuel poverty the following are existing conditions of the scheme:

4.13 *Energy efficiency improvements are incorporated, where practicable, into refurbishment schemes.*

4.14 *Tenants are given advice upon request, on how best to heat their accommodation and use hot water in an energy efficient way using the facilities provided*

But as seen in Table 2 large numbers of Leeds residents experience fuel poverty and this is likely to increase due to recent fuel price rises. Many of the most vulnerable people could be supported out of the fuel poverty trap by existing mechanisms available in the city, aided by agencies working in cooperation and partnership with each other to identify and support the households at risk.

This is where LLAS could have a more prominent role working with landlords who own properties in the worse wards to remove some of the barriers. However this requires recruiting new members as currently relatively few accredited landlords operate in these wards.

The majority of PIP's listed work items associated with improving MOEFF. For licensable properties this will be dealt with through licensing but there are many properties where this won't be the case.

Consequently it is clear that improving fire safety in a significant number of HMOs will have an impact in terms of reducing both the occurrence of fires and the severity of any injuries that might arise from being exposed to a fire. Knowing that what is potentially a high risk property has been inspected and provided with adequate means of escape also reduces stress and anxiety to the occupant

Retaliatory Evictions

There is increasing evidence that tenants are reluctant to complain to their local housing authority about the condition of their properties when repairs aren't carried out.

The law offers little protection to tenants on periodic tenancies who can be evicted under section 11 of the 1988 Housing Act with just 2 months notice.

In a recent survey of local authorities (EHJ 2007 vol 22), all respondents reported that tenants are 'often or sometimes' put off from asking councils for help because they don't want to lose their homes. Over 80% said tenants definitely needed more security in order to exercise their statutory rights. According to housing charity Shelter, the end of an assured short hold tenancy is the third main reason people give for being made homeless.

Because landlords are approaching the local authority themselves through the LLAS properties in need of repairs are being identified without the tenant getting involved. This removes the potential for retaliatory evictions and means properties are being repaired that otherwise would have remained in a sub-standard condition.

Even with well intentioned landlords misunderstandings can arise. Many tenants find it difficult to approach their landlords to discuss disrepair issues and don't always communicate their concerns in the best way. This can lead to friction and puts the complaint in a more personal rather than business context. Once this happens the landlord/tenant relationship can breakdown increasing the likelihood of retaliatory evictions

Assessment	Action	Health Impact	Likelihood
10	Issuing Property Improvement Plans as part of the process to comply with LLAS standard	Positive	Definite
11	Improving property above legal minimum standard	Positive	Probable
12	Minimising risk of retaliatory evictions	Positive	Probable
13	Giving advice e.g. re energy efficiency & food safety	Positive	Probable

5.5.2 LS6 project

Tables 1 and 2 above show that the largest proportion of properties whose landlord is a member of the LLAS are HMOs in the Leeds 6 postal area. They are primarily occupied by students.

As part of the requirements to complete his degree course in Environmental Health a student undertook to compare the compliance with the HHSRS by members and non members of the LLAS in the LS6 area.

Twenty properties were randomly selected from HMO licence applications submitted to Leeds City Council by Jan 2007, 10 were from LLAS members and 10 from non members. Selection was adjusted to enable like for like properties to be compared.

9 of the 29 hazards identified in Part 1 of the 2004 Housing Act were selected for comparison. (see below)

Inspections of all properties took place. Supplementary information about occupiers' perception of conditions was gathered from questionnaires sent to the occupiers.

Damp & mould growth: 60% of LLAS properties were better than their neighbouring non member properties.

Excess cold: 70% of LLAS properties were better than their non member neighbour, although 3 LLAS properties required mandatory improvements.

Excess heat: It was concluded that this hazard had little relevance in this instance.

Carbon monoxide and fuel combustion products: 80% of all the properties were satisfactory with 2 non member properties being worse than their accredited neighbouring property.

Crowding and space: No evidence of overcrowding was found in the survey.

Entry by intruders: This hazard had little impact on the majority of properties inspected in this study.

Noise: 90% of non member properties scored worse than their neighbouring member property.

Falls associated with stairs and steps: 90% of non member properties were worse than their neighbouring LLAS property. However one LLAS property was worse and required mandatory action – as did 6 of the non member properties.

Fire: 60% of non accredited properties scored worse than their LLAS neighbours. 20% of LLAS properties were worse than their non member neighbouring properties.

The over-riding conclusion from this study is that properties of landlords who are members of the LLAS present fewer risks to health and safety than similar properties owned by landlords who are not members of the LLAS.

However it was pointed out that much good practice and high standards are observed in properties of landlords who are not members of the LLAS. This begs the question as to why landlords do not join the scheme.

Assessment	Action	Health Impact	Likelihood
14	Property owned by LLAS member compared to ownership by non member	Positive	Probable
15	Property owned by landlord who is not member of LLAS	Negative	Speculative

5.5.3 Questionnaire

In order to assess the perception of tenants, as stakeholders, with regards to the effects of the LLAS, a questionnaire was devised. (see Appendix 3)

The questionnaire sought to identify any differences between those who live in properties owned by members of LLAS and those tenants who live in properties where the landlord is not a member of the scheme.

Issues raised were about the awareness of the scheme, facilities, standards and costs of heating, perceptions as to the condition of the dwelling and how quickly landlords responded to complaints of disrepair and finally some indication as to the effect of the dwelling on the tenant’s health.

Properties were selected in postal districts other than LS6 in order to reach a wider range of tenant.

Some twenty four properties from the LLAS were identified and the same number of properties, in the same streets but whose landlord was not in the scheme, were selected.

Questionnaires were hand delivered to all properties and included a stamped addressed envelop to aid the return of completed forms. In the event, some 18 questionnaires were returned, mainly as a result of follow-up visits to the properties. This included from one tenant in one LLAS HMO and from one tenant of a non member HMO. Thus the majority of properties were single family occupancy.

The following information was gathered:

Awareness of the scheme: 90% of tenants of LLAS did not know if their landlord was in the scheme. 87.5% of other tenants did not know if their landlord was in the scheme. In door step discussions tenants generally were not aware of the existence of the scheme.

Occupancy: Full information was not given in the replies. From that given it seems that in LLAS properties there is a similar number of males and females; predominantly adults. There seems to be more single females and children in properties of landlords who are not members of the scheme.

Ethnicity: Full information was not given on all the forms received. While the majority were British there appeared to be more other Europeans in the LLAS sector than those of African or Caribbean origin, whilst the latter seemed to be more prevalent in the non member sector.

Facilities/amenities: All tenants said cooking and personal hygiene facilities were provided , with which they were satisfied.

Smoke alarms: Fitted in 80% of LLAS properties and 62% of non LLAS properties.

Annual Gas checks: LLAS property – 60% were aware that checks were carried out, 10% said it wasn't others did not know. Non LLAS property – 50% said checks were made, 50% said there had been no checks.

Electricity supply checks: 70% of LLAS properties, 37% of non LLAS properties.

Heating:

	Properties of LLAS members	Properties of non member
Method	100% central heating	50% central heating One not working. Gas or electric fires No heating in one property
Costs	£10-20/wk 70% £21-£30/wk 20%	<£10/wk 38% - but don't use it too much to save money £31-£40/wk 12% £41-50/wk 12%
Perception by tenants	40% very good 50% good 20% satisfactory	38% good 24% satisfactory 38% very poor

Perception of Structure & Repairs

	Properties of LLAS members	Properties of non member
Exterior	40% very good, 50% good, 10% satisfactory.	13% very good, 25% good, 25% satisfactory, 25% poor 12% v poor
Internal	30% very good, 40% good, 20% satisfactory, 10% poor	12% very good, 13% good, 12% satisfactory 38% poor 25% v poor
response to requests for repairs	. Ranged from same day to six weeks – average 1-2 weeks	ranged from 'no problems' to 18 months – average 32 weeks
Satisfaction with response	90% yes,	90% no

Accidents in last 12 months: one minor accident in a LLAS prop.

Perception of safety of the dwelling: LLAS props. 50% v safe, 50% safe
 Non member props. 12% v safe, 38% safe, 25% un safe, 25% dangerous.

GP visits: Full details not given but more tenants of non member landlords appear to visit their GPs more times per year than those tenants of non member landlords.

Stress/asthma. These were not significant features for the tenants of the properties in the study.

Assessment	Action	Health Impact	Likelihood
16	Awareness of the scheme	Negative	Speculative
17	Living in property of LLAS member	Positive	Probable
18	Tenant selection by members of LLAS	Negative	Speculative

During the exercise the condition of two non accredited landlord's properties were referred to Environmental Health for further investigation and possible enforcement action.

6. Conclusions

- Housing standards affect the health and well-being of occupants.
- Raising housing standards increases the health and well being of occupants.
- The poorest housing conditions are found in the Private Rented Sector.
- The LLAS is a positive influence in raising standards in the PRS over and above the legal minimum.
- The health benefits of the LLAS, whilst difficult to quantify, are definite.

It does remain difficult to offer any precise numerical estimate of health benefits.

Unfortunately the number of PIPs issued isn't recorded. If this figure was known, by extrapolating from the work done in this appraisal it would have been possible to estimate the number of category 1 hazards dealt with proactively through LLAS. (and made some comparisons with improvements and consequent health benefits of existing enforcement performance.)

- LLAS is securing improvements to properties that have hazards identifiable under the HH&SRS.
- Without LLAS many of these properties would have continued to be occupied by tenants who would have suffered worse health outcomes as a result.

Most LLAS properties are HMOs located in LS6 occupied by students – students for the purposes of HH&SRS are not classed as a vulnerable group. Very few accredited properties are located within the most deprived SOA's this is shown by **Map2**.

- There is the potential for LLAS to be more effective by targeting landlords with properties in those Super Output Areas with the worst Index of Multiple Deprivation Scores, thereby improving housing conditions for the most vulnerable.
- There is a potential for LLAS to exacerbate health inequalities by failing to attract landlords who cater for the more vulnerable groups.

In Table 2 which ranks fuel poverty by ward, Headingley is 9th. The HH&SRS starting average for Excess Cold in older properties is C and the vulnerable group is the over 60s.

- There is the potential for the LLAS to have more impact on fuel poverty and related issues in the PRS if members could be recruited in wards such as Gipton & Harehills and Hyde Park & Woodhouse. As we have seen the private rented sector is viewed as 'hard to reach' in terms of addressing fuel poverty. Any improvements in this sector no matter how small would be valued. Accreditation could be a useful way of reaching this market by providing access to landlords.

There is scope to provide specific Information & advice to raise awareness among landlords & their tenants of the issue and what can be done to address it e.g.

- Improving the SAP rating of properties with specific guidance on how to achieve this.
- Promoting the availability of Warm Front Grants to tenants over 60
- Alternatives to pre-payment meters
- Switching to suppliers with lower tariffs
- Claiming winter fuel payments

It is interesting to note that deficiencies relating to cold were only identified in 2 PIP's. This suggests that provisions to deal with excess cold are generally to a good standard in accredited properties and further demonstrates the impact accreditation can have. The questionnaire findings confirmed this view.

As a general note, the tone of correspondence relating to PIP's was open and conciliatory. The LLAS process has good communication channels and encourages dialogue. This has led to a clearer understanding of what each party is trying to achieve, and consequently less suspicion of each others motives.

Landlords have a voice and can influence how the scheme operates and are consulted on relevant matters e.g. the LLAS review, setting of amenity standards.

One of the objectives of the LLAS is to enable prospective tenants to have the choice to occupy a high standard dwelling which, as this HIA shows, will be of greater benefit to their health and well being. However existing evidence and the evidence gathered in the appraisal have shown that :

- Tenants (and therefore prospective tenants?) are not aware of the LLAS.

This situation must be addressed if greater health benefits are to be secured for occupants in this sector.

Clearly housing conditions and standards are being improved in this sector by a) landlords who are not part of the scheme and b) by enforcement action. With respect to these issues:

- a) Market forces and incentives may have to be assessed if more members are to be recruited.
- b) A comparative cost benefit/action outcome would have to be conducted which is outside the scope of this HIA

7. Recommendations

The following recommendations have arisen from the HIA process. Some of the recommendations will be reflected in current reviews of the scheme. The HIA gives the added health dimension to some of the suggested actions.

Recommendations should be discussed by the originator of the HIA i.e. the management team of Environmental Health Services.

i) Ensure the outcomes of the HIA are made known to LLAS landlords other landlord organisations and tenants of LLAS members.

Actions: publicity, forums etc.

Time scale: Following approval of the HIA report and recommendations

By whom:

ii) Increase awareness of the LLAS amongst prospective tenants and promote member properties as good quality affordable housing.

Actions: Consider how best to publicise the scheme and make prospective tenants aware of its existence and the benefits it can bring to them. May need to look at more creative ways of reaching prospective tenants, explore the reasons why tenants might be reluctant to move into private rented accommodation including barriers to choice. Promote the private rented sector as a source of affordable housing.

By whom: ?

Time scale: Following approval of report and recommendations

iii) Promote a 'whole' council approach to accreditation.

Actions: Investigate current and future incentives/benefits of membership. Take a 'whole council' approach to growing accreditation. Ensure departments are working together to the benefit of accreditation, particularly in terms of not pursuing heavy handed enforcement action which can alienate members to the detriment of the informal LCC / LLAS partnership that the scheme is dependent on.

By whom: LLAS members themselves
LCC
Leeds Initiative partners

Time scale: programme of targets and targeting methods over next 5 years.

iv) Raising energy efficiency standards

Action: Liase with the Fuel savers team to develop practical guides for landlords on improving SAP ratings according to property type.

By whom: LLAS members, Fuelsavers

Timescale: from April 2008

v) Tackle Health Inequalities

Actions: Grow LLAS to increase market penetration into the 3% most deprived SOA's. Examine market factors and scheme criteria to determine how landlords of properties in the worst SOA's can be encouraged to participate. This will increase the number of vulnerable tenants benefiting from improved property conditions. A cross departmental approach will be needed to develop incentives that prove sufficiently attractive to landlords. Currently the PRS market in these areas is such that demand for properties exceeds supply and the 'market edge' that accreditation schemes offer is not in itself sufficient reason for such landlords to join.

The following have been suggested as incentives that could motivate more landlords to become accredited:

- negotiated enforcement for LLAS members i.e. write in the first instance and prosecute as a last resort.
- offer an exemption on council tax whilst landlords are renovating properties to the decent homes standard.
- one hours free legal advice per year per member through legal services by appointment and unlimited landlord & tenant advice through Homelessness Advice & Prevention.
- a priority service to deal with Local Housing Allowance enquiries including a telephone hotline and an enhanced benefit rate for tenants occupying properties owned by LLAS members.
- enhancement of the LLAS refuse disposal concession to include beds, settees and furniture which are currently chargeable and can have a significant negative visual impact on the area when placed in yards.
- establish rent deposit or guaranteed schemes administered by the council.
- free advertising on the Leeds Homes website and associated flyer.
- fast tracking of accredited landlords into future selective licensing schemes where they have properties in the area covered by the scheme.
- discounts for pest control treatments.
- introduce the safeguard that where the Council has formal arrangements with landlords to house vulnerable people they should be accredited.

By whom: Include working with PCT & LCC Departments

Time scale: Determine programme to tackle and include current non member landlords of properties in specific SOAs over next five years.

vi) The Stock Condition Survey 2007

Action: Whilst anecdotal evidence suggests little change we should never the less compare both the number & distribution of PRS properties with the 2001 survey data used in this HIA.

By whom: the authors of this report

Time scale: from January 2008

vii) Review progress of these actions after 12 months in accordance with the HIA process.

The HIA Working Group:

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APPENDIX 1

TOOLKIT WORKSHEETS

APPENDIX 2

**HEALTH EFFECTS
OF
HOUSING CONDITIONS**

Damp & Mould

In 2004 the US National Academy of Sciences' Institute of Medicine published its review of literature on the relationship between moisture and mould in the indoor environment and adverse health effects. The report presents a number of significant conclusions about the health impacts of moisture in homes and other buildings:

- Dampness and moisture in homes and other buildings is a public health problem.
- The most effective way to combat mould and other moisture-related problems is to reduce or eliminate dampness in buildings.
- There is a significant association between damp indoor spaces and asthma attacks.
- Dampness is associated with range of problems, not just mould. Dust mites flourish in damp spaces, as do bacteria.
- Exposure to toxic irritants produced by mould in damp buildings is associated with respiratory problems.
- People with compromised immune systems are more likely to suffer ill effects from mould and other products of damp indoor environments.
- Some building materials can emit chemicals or small particles when damp, which may be a health concern.

The number of people in the UK who are diagnosed with asthma has been climbing fast since the 1970s. In 1973, 4% of the population were diagnosed as asthmatic. In 1996, the number was 21%, 750,000 of whom are children. In 2006 5.2 million people in the UK were receiving treatment for asthma: 1.1 million children (1 in 10) and 4.1 million adults (1 in 12). There were 1,381 deaths from asthma in the UK in 2004 (40 were children aged 14 years or under). On average, 4 people per day or 1 person every 6 hours dies from asthma.

A German study (*Dr Thomas Nicolai, of Munich University*), published in the journal *Thorax*, has found that dampness - long associated with wheezing and coughing - is a risk factor for asthma, partly because it helps the growth of the house dust mites which irritate asthmatics' airways. The research was extensive, involving 5,000 Munich school children over a three-year period. Teenage asthmatics living in damp homes were three times as likely to suffer night-time wheezing and other breathing problems as asthmatics whose homes were not damp.

As such exposure to persistent damp conditions in the home is a risk factor for a number of respiratory conditions, particularly asthma. The location of the dampness is relevant especially if found in a bedroom where exposure will tend to be more prolonged than for example a kitchen – especially for children. Whilst there is no specific dose-response relationship, remedying deficiencies that increase dampness or condensation with the potential for subsequent mould growth will have an impact on health, particularly if the occupant already has a predisposition to asthma.

Excess cold

Homes can be excessively cold if they are poorly insulated, lack adequate heating or the occupier can't afford to run the heating. Such homes have been shown to exacerbate existing illnesses such as asthma and chronic obstructive pulmonary disease and reduce resistance to respiratory illnesses like influenza, pneumonia and bronchitis. Cold homes also contribute to an increased risk of falls amongst the elderly and have been linked to social exclusion, low educational attainment and mental health problems.

The UK records 30,000-40,000 excess winter deaths (24,000 in England) each year, the highest number of avoidable deaths due to winter cold in Western Europe. Countries with much more severe winters than the UK, for example Sweden, Germany and Canada, experience comparatively low variation of mortality across the seasons, suggesting that the UK's poor housing standards and comparatively low incomes are the crucial factors. It has been suggested that for every 1°C that the winter temperature drops below the average there will be an associated increase of 8,000 excess winter deaths.

Fuel poverty

Fuel poverty is defined as having to spend more than 10% of your income on total energy needs i.e. heating, cooking, hot water etc The Yorkshire and Humber region is estimated to have the second highest level of fuel poverty in the UK. One in eight households in Yorkshire & Humber region suffers unnecessarily with fuel poverty.

Leeds has an estimated 22% of households in fuel poverty- equivalent to nearly 22,000 households living in cold, damp conditions, higher than the neighbouring authorities of Bradford with 18% and Wakefield at 16.4%. By way of comparison in North Yorkshire, the highest levels of fuel poverty are found in the coastal resorts of Scarborough (highest at 27%), Whitby and Bridlington (36% in one ward) plus inland urban areas around Goole, Selby and remote rural areas around the North Yorkshire Moors. Some 3,200 people in our region died in the winter of 2004/5, this is over and above the normal mortality rate.

Carbon Monoxide

Carbon monoxide (CO) is a colourless, odourless, poisonous gas that is produced by incomplete burning of carbon-based fuels, including fuel gas. When CO gets into the body, it prevents the blood from bringing oxygen to cells, tissues, and organs.

According to HSE figures every year approximately 20 people die from CO poisoning caused by gas appliances and flues that have not been properly installed or maintained. Many others also suffer ill health. Acute toxicity results from a single exposure but chronic carbon monoxide poisoning also needs to be recognised. The latter often results from a poorly serviced gas fire and the elderly are most at risk. Clinical features are non-specific e.g. headache, nausea, flu-like symptoms and so a high level of suspicion is required.

The HSE state that risk can be dramatically reduced by undertaking the following measures:

- *Ensure that any work carried out in relation to gas appliances in domestic or commercial premises is to be undertaken by a CORGI-registered installer, competent in that area of work.*
- *HSE strongly advises that gas appliances and/or flues are serviced regularly for safety by a CORGI-registered installer. If you live in tenanted accommodation, your landlord has a legal duty to carry out an annual gas safety check and maintain gas appliances. They must provide you with a copy of the completed gas safety check certificate.*
- *Always make sure there is enough fresh air in the room containing your gas appliance. If you have a chimney or a flue, ensure it is not blocked up and also ensure that vents are not covered.*

Having a yearly gas safety check undertaken by a CORGI registered plumber guarantees gas appliances are in safe working order.

Food safety

50% of food poisoning cases are thought to arise in the home. Some estimates have put this figure even higher at 86% for Salmonella and as much as 97% for Campylobacter. Food poisoning can cause death from infectious gastro-intestinal disease, or hospital admission because of severe diarrhoea, vomiting and dehydration. Those most susceptible are the young, especially infants, the elderly and pregnant women, and these groups may also suffer more severe outcomes.

Personal hygiene

Dysentery and rotavirus infections, a frequent cause of diarrhoea, are carried by the faecal-oral route. Even if the illness is contracted elsewhere up to 50% of family members may become infected if the hygiene levels are poor. In practice however there is little risk of cross-contamination of potable water by wastewater.

Falls on the stairs

Experiencing a fall can have a significant physical and emotional effect on people that experience them and the impact on family and friends can also be substantial. Every year over 1500 people aged over 65 years are killed by an accidental fall in the home (*Leeds PCT, 2006*). This equates to an older person dying every 5 hours as a result of a fall. Another serious consequence of falling is a lack in mobility and confidence and 42% of fallers have at least an 18% reduction in activity after a fall.

Electrical hazards

A study of 1985 data revealed that of the 39 fatalities that year, just 3 resulted from a fault in the wiring. The majority of the electric current fatalities resulted from faults in plugs, leads, and appliances. Injuries are primarily burns (53%) to the finger or thumb (58%). 84% of injuries are not serious – 38% of victims are sent home and 47% are referred to out-patients or a GP. Of those admitted to hospital, 71% stayed for less than 3 days. Males have more accidents (59%), and those under 40 have 80% of all

accidents. Boys between 5 and 14 are three times more likely to have accidents than girls of the same age.

Fire safety

Each year in England there are more than 40,000 accidental fires resulting in about 300 deaths & 9,000 injuries. Consequences of fires in HMO's are particularly serious causing about a third of fire related deaths.

The most common injury sustained was smoke inhalation, which accounted for 52% of those injuries recorded. Burns and scalds were also common, comprising 36% of those injured.

Table 1: Injuries caused by fire, 2004/05

Type of injury	%
Smoke inhalation	52
Burns/scalds	36
Other injuries	8
Bruises	6

These statistics fail to take into account the mental harm caused by a fire. The minimum outcome of which is usually a gutted room in which the person lives and contains all of their possessions. It can be argued this causes severe stress, a class 3 harm under the HH&SRS to the occupier.

The household characteristics with the highest prevalence rates of experiencing a domestic fire are typical of vulnerable groups:

- ACORN category multi-ethnic, low income areas (4.9%)
- The Households Reference Person (HRP) is economically inactive, i.e. permanently sick or disabled, students, looking after family (2.8%)
- Dissatisfied with current accommodation (2.8%)
- Lone parent with dependent children (2.8%)
- Dissatisfied with local area (2.7%)
- Gross annual household income is low, less than £5,000 (2.6%)

Summary:

Poor housing conditions and design contribute to major accidents, particularly in older people, and seemingly minor accidents, which may have grave consequences. Poor quality housing is associated with poor health in childhood, increased risk of asthma and inflammatory lung diseases. Damp homes in particular have been linked to respiratory symptoms. The improvement of housing conditions has been shown to have a number of positive impacts on health, including:

- Lower rates of mortality in those re-housed from socially isolated sub-standard housing;
- Reduced sense of isolation, fear of crime, and increased involvement in community affairs;
- Improved mental health including higher levels of psychological well being, reduced anxiety and depression;
- Lower rates of GP contact.

APPENDIX 3

QUESTIONNAIRE USED IN APPRAISAL

**ENVIRONMENTAL HEALTH SERVICES
Leeds City Council
&
PUBLIC HEALTH DIRECTORATE
Leeds Primary Care Trust**

**LEEDS LANDLORDS ACCREDITATION SCHEME
HEALTH IMPACT ASSESSMENT
QUESTIONNAIRE**

Your health and well-being is affected by the conditions of the house/flat etc in which you live.

The facilities provided by your landlord, the state of repair, how soon repairs are carried out and generally how you feel about the house are all important.

Some landlords in Leeds have signed up to the Leeds Landlords Accreditation Scheme. (LLAS)

We want to know if the LLAS has an impact on people's state of health.

We would be grateful therefore if you could help us by answering the following questions by putting a cross 'X' in the appropriate box

YOUR LANDLORD

1. Is your landlord part of the LLAS?

YES NO DON'T KNOW

YOUR HOME

2. Is where you live?

A terrace house semi-detached

Detached part of a house

Other

3. Please indicate what rooms are available for your own use.

Kitchen Bathroom Living room

Bedrooms No. of bedrooms

Do you share any of the above rooms with another household?

YES NO

If 'YES' please say which one(s)

4. Do you have satisfactory provision for the storage, preparation and cooking of food?

YES NO

5. Do you have suitable and sufficient provision for personal hygiene e.g. W.Cs, washbasin, hot and cold water?

YES NO

If 'NO' please give further details

6. Are smoke alarms fitted?

YES NO

7. Are you aware that annual checks are made with regards to the safety of..

Gas supplies/equipment YES NO

Electricity supplies YES NO

REPAIRS TO YOUR HOUSE

8. Please indicate how you feel about the state of repair of the external structure of your house.

1 Very good 2 Good 3 Satisfactory 4 Poor 5 Very Poor

9. Please indicate how you feel about the state of repair of the internal structure of your house.

1 Very good 2 Good 3 Satisfactory 4 Poor 5 Very Poor

10. Do you feel that your landlord responds quickly to complaints of disrepair?

YES

NO.

11. Approximately how long do you have to wait between asking for a repair and action being taken?

HEATING YOUR HOME

12. Please indicate how your house is heated.

Living room

Bedroom(s)

Central heating radiator	<input type="checkbox"/>	<input type="checkbox"/>
Underfloor heating	<input type="checkbox"/>	<input type="checkbox"/>
Electric fire	<input type="checkbox"/>	<input type="checkbox"/>
Gas fire	<input type="checkbox"/>	<input type="checkbox"/>
Paraffin/oil heater	<input type="checkbox"/>	<input type="checkbox"/>

Other – please describe

13. How much do you think you spend on heating your house each week?

Less than £10	<input type="checkbox"/>	£10-£20	<input type="checkbox"/>
£21-£30	<input type="checkbox"/>	£31-£40	<input type="checkbox"/>
£41-£50	<input type="checkbox"/>	more than £50	<input type="checkbox"/>

14. How do you feel about the heating of your house?

1. Very good	2 Good	3 Satisfactory	4 Poor	5 Very Poor
<input type="checkbox"/>				

YOUR HOUSEHOLD

15. How many people are in your household? Please put no. in box.

Males

Females

aged Over 19	<input type="checkbox"/>	<input type="checkbox"/>
aged 11- 19	<input type="checkbox"/>	<input type="checkbox"/>
aged 1 – 10	<input type="checkbox"/>	<input type="checkbox"/>

