
Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy

Final Report

**Housing Vision Consultancy
with
Gill Leng**



www.housingvision.co.uk

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Bromsgrove District: **Housing Market Assessment**

Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy: Final Report

By the Housing Vision Consultancy with Gill Leng

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EXECUTIVE SUMMARY

1. This project was commissioned by the Regional Housing Executive, working in partnership with Department of Health West Midlands and the Regional Health Partnership, to undertake research to identify the contribution that could be made to health outcomes by regional housing policy.
2. The research presents an understanding of the main housing and health issues, provides evidence of the positive impact housing can have on health, and identifies those factors that will influence the effectiveness of a response.
3. The focus for all in the public sector should be on achieving improved outcomes for people and their communities. These can only be enabled by bringing together the component parts of inputs, principally expenditure, and outputs such as services and homes more effectively. This requires new ways of thinking and working, but if it can be achieved, the gains could be very significant.
4. Any regional housing policy aiming to achieve better health and wellbeing outcomes has to make sense to those working in health, social care and housing and add to their capacity. It also has to be flexible in approach to reflect the diversity of health and wellbeing needs in the region.
5. Consideration could be given to how more can be made of housing in preventing ill health and promoting health
6. Regional housing policy could focus attention on delivering housing specific targets identified in health and wellbeing policy
7. Responding to the needs and aspirations of an increasing proportion of older people in the population is a challenge for health and social care. Regional housing policy could focus attention on this aspect, although further research is likely to be needed.
8. Consideration could be given to 'scaling up' existing, successful, housing initiatives that are felt to contribute to health and wellbeing outcomes.
9. Consideration should be given to support strategic housing authorities to align plans and policies at a local level, in partnership with social care, to achieve health and wellbeing outcomes.
10. In addition to, or instead of, targeting housing policy and plans towards health and wellbeing targets, consideration could be given to targeting policy and action towards achieving a combination of health, wellbeing and economic targets.

11. Local authorities and health are looking to achieve considerable efficiencies, with partnership working, increasing productivity and innovation all up for discussion. It will be important that housing is round the table with an 'offer' to the efficiency agenda
12. Consideration could be given at a regional level to how housing policy can contribute more to social exclusion.
13. Consideration should be given to the housing role in supporting a person-centred – personalised – approach.
14. For regional housing policy to support outcomes at a local level real consideration has to be given to how local engagement can inform the shape of policy and decision making, and how regional policy can be held to local account
15. A clearer relationship between 'what matters most' in health terms that housing can contribute to in partnership with others is needed in the regional health and wellbeing strategy
16. A resource is needed to support the Regional Health Partnership to interpret plans and policies in health and social care and to identify opportunities for alignment at all spatial levels.
17. A regional resource to support those working in housing to adopt a commissioning approach has the potential to enable more effective joint working with health and social care.
18. Regional support to develop the local strategic approach to housing to encompass a more effective approach to existing homes could have a significant impact on health and wellbeing.
19. Regional support could be provided to those working in housing to engage more effectively with the safeguarding agenda
20. There is a role for the Regional Improvement and Efficiency Partnership to support housing, health and social care to work together more effectively and efficiently
21. Regional lobbying will be needed in a number of areas where barriers to enabling a more effective housing contribution to health and wellbeing are felt to exist.
22. There is a need to establish a common perspective on the housing: health relationship to inform the development of integrated housing and health policies.

23. A useful contribution might be made to understanding the housing: health relationship and its policy implications by reviewing the overlap between the content and approaches of SHMAs and JSNAs.
24. If housing policy is to be led by confidence in the evidence informing the health impact of housing, then the first priority in the West Midlands is to eradicate harmful housing conditions, in particular damp and cold homes, and for the most vulnerable households, in particular older people.
25. Other housing-related health priorities include interventions to tackle noise; overcrowding; home safety and accidents; security and the effects of crime and the provision of public and open space.
26. Evidence of the health impact of new housing, in particular its preventive impact, is still being developed. However, there is a strong case for 'designing in health' to new or re-modelled housing environments, for example by giving consideration to the availability of green and open space, walkways and cycle routes etc., and for introducing a simple toolkit of criteria to be applied by planners and urban designers in the West Midlands.
27. Further measures required to embed health impact in housing policy include:
- undertaking in-depth health impact assessments of housing interventions to assess which investments have the greatest health gain, and reduce long term revenue health-related costs;
 - designing housing policy interventions so that their health effectiveness can be measured;
 - prioritising the effectiveness of interventions that target specific housing conditions that are known to affect health outcomes; and
 - planning for the impact of 'upstream' investment in housing on the 'downstream' health of residents.
28. There is a need to identify the extent to which SHMAs and JSNAs can be complementary within common boundaries.
29. To improve the integration and understanding of health and housing, it is recommended that:
- the many small-scale housing initiatives in place across the region that contribute to improved health and wellbeing are collated and evaluated;
 - shared health-related housing indicators are developed and agreed;
 - the overlap between the content and approaches of SHMAs and JSNAs is reviewed, best practice collated and guidance issued;
 - further broad based longitudinal studies to identify the most effective health-related housing interventions are undertaken, their cost effectiveness and long term impact determined

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- research is undertaken to understand who gets to live in new affordable homes and their health impact;
- the potential for 'designing in health' to new or re-modelled residential environments is evaluated, a toolkit developed and guidance provided to planners and urban designers in the West Midlands;
- a partnership run web based Local Information Systems to include mapping, small area data and housing/health datasets is developed;
- greater use is made of geographical information, including public health datasets not available to the public, and geo-demographic datasets
- a 'Housing: Health Neighbourhood Index' (HHNI) to inform the targeting of resources and/or interventions more effectively at small area level, and to measure change over time is developed.

1. INTRODUCTION

1.1 Background

The Housing Vision Consultancy, working with Gill Leng, was commissioned by the Regional Housing Executive, working in partnership with Department of Health West Midlands and the Regional Health Partnership to undertake research to identify the contribution that could be made to health outcomes by regional housing policy in the future.

The brief was for the research to present an understanding of the main housing and health issues, to provide evidence of the positive impact housing can have on health and vice versa, and to identify the factors that will influence the effectiveness of a response. This research should also result in the presentation of the available housing policy options.

Definitions

For the purposes of the research we assumed the following definitions:

- Regional housing policy is currently expressed by the Regional Housing Strategy and the housing elements of the Regional Spatial Strategy. However, the Local Democracy, Economic Development and Construction Bill proposes the development of a single regional strategy that will effectively replace existing regional strategies
- Outcomes are the longer term results of interventions, typically measured by a range of proxy indicators
- Housing refers to all activity that aims to meet housing need and aspirations. This can be capital investment in new supply, regeneration and improvement etc, or revenue investment in homelessness, housing support, housing options etc services. Regional policy will have varying levels of influence over this activity.

It is also worth highlighting that the research recognises that social care also aims to achieve positive health and wellbeing outcomes, and that health and social care are increasingly integrated to enable this. For this reason the policy review in particular considers the vision and expectations for delivery for both health and social care.

1.2 Our approach and the report structure

The research has been undertaken within the context of a commissioning framework. Commissioning is widely understood by those working in the health and social care sectors, and this approach was felt to provide the best evidence base from which housing, health and social care partners could work. The approach was also felt to be the best at enabling people to understand that research is only part of

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a process that will deliver better outcomes for people; further work will be needed to be undertaken against the other commissioning elements to achieve the desired outcomes. The research tasks addressed here are highlighted in yellow in Table 1.1.

Table 1.1: Project Commissioning Framework

Commissioning Framework
1. Vision and Direction
The vision and direction for health and housing clearly communicated?
This is informed by an understanding of: <ul style="list-style-type: none"> • The need for housing and health services • The strategic context - the vision and wider priorities for action, nationally, regionally and within the West Midlands • The inter-relationships between health and housing • How different responses can contribute to achieving health outcomes
Priorities for action – and targeted resources - reflect this understanding
2. Enabling the Delivery of Housing and Health Activity to Achieve Better Outcomes
It is clear how strategic action will be enabled, making best use of: <ul style="list-style-type: none"> • Plan and policy making, in partnership with others where appropriate • Legislative powers and available resources • The provider market, e.g., direction and support to housing and health providers, community and voluntary sector providers, private sector partners etc • Influence over, and procurement of, services to deliver outcomes
There is a robust delivery plan in place
3. Managing Performance and Improvement
There are robust mechanisms in place to <ul style="list-style-type: none"> • Monitor and assess delivery to ensure it contributes to the vision • Gain stakeholder feedback • Adjust plans and activity to improve value for money
There is evidence of positive outcomes from inputs and outputs

In summary the research was undertaken through:

- A review of existing and emerging health plans and policies at national and regional level and consultation with a small sample of key health stakeholders in the region to establish vision and direction. The outputs of this work are presented in Chapters 3 and 4.
- A review of evidence from Joint Strategic Needs Assessments, Strategic Housing Market Assessments (SHMAs) and from Urban Living's research output: a comprehensive and comparative review of literature and research findings concerning the housing: health interrelationship, an evaluation of the relevance

and potential of data sets (demographic, housing, neighbourhood etc) and collation of evidence of European, national and regional housing-related interventions to improve health. The outputs of this work are presented in Chapter 5 and supporting appendices.

The key output for the research is the identification of those regional housing policy areas that could be developed in order to support the delivery of better health outcomes, building on the priorities identified in the Health and Well Being Strategy. Suggestions and recommendations are provided in Chapter 2 alongside a brief supporting rationale drawn from the main body of the report. This chapter also suggests other practical regional interventions, such as support, lobbying etc, to deliver better health outcomes.

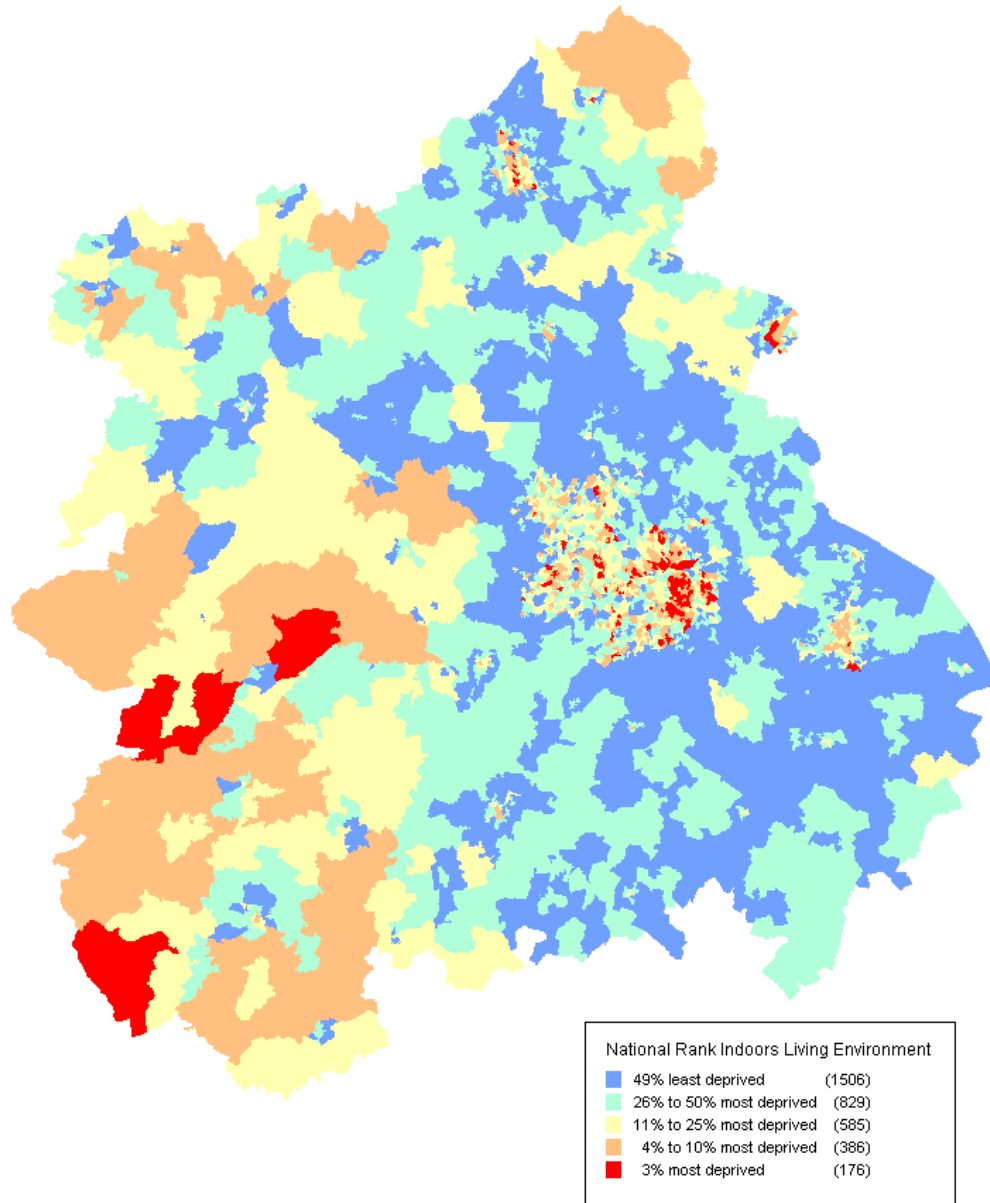
1.3 Acknowledgements

HVC and Gill Leng would like to thank stakeholders in the region for their time and input into this research so far and ultimately we hope this is reflected in the conclusions and recommendations we make. Please see Appendix B for a list of those who contributed.

1.4 The potential of this project

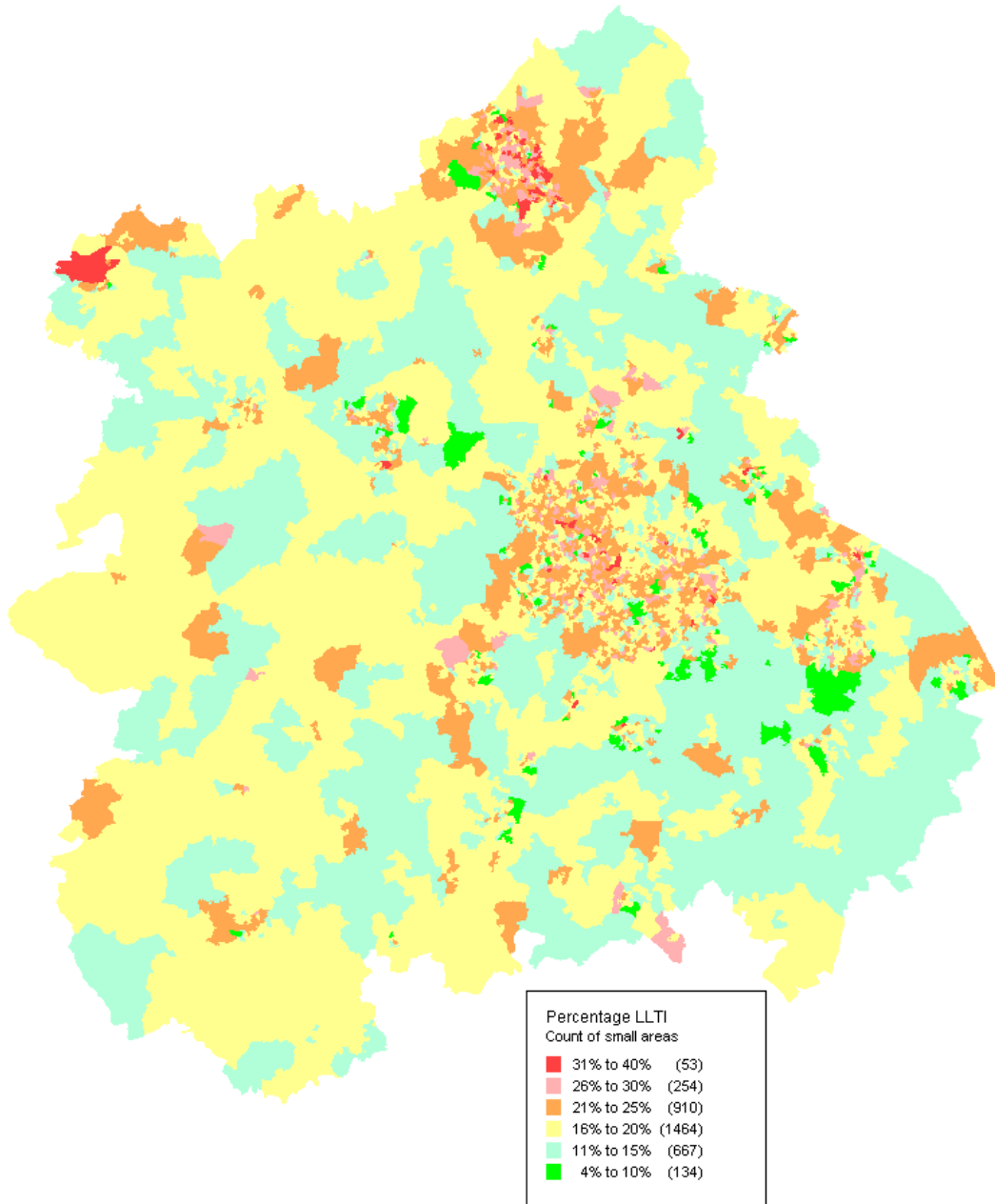
In terms of the potential for housing to have a positive impact on health, we have simply provided two maps. The first ranks Census Super Output Areas according to the Indoors Living Sub-Domain of the 2007 Index of Multiple Deprivation and is constructed from housing in poor condition, including without central heating. As such, it is a good indicator of housing quality. The second map ranks Census Super Output Areas according to the proportion of people with a Limiting Long Term Illness which is a good indicator of health. This report addresses the policy and practical relationships between the worlds of housing and health.

National Rank for the Indoors Living Environment Sub Domain, English Indices of Deprivation 2007 West Midlands Region



Source: English Indices of Deprivation 2007, CLG website www.communities.gov.uk
ONS, Super Output Area Boundaries. Crown copyright 2004. Crown copyright material
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Percentage of People with Limiting Long Term Illness within ONS Lower Super Output Areas in the West Midlands



Source: 2001 Census Data, Neighbourhood Statistics website, www.neighbourhood.statistics.gov.uk. ONS Super Output Area Boundaries. Crown copyright 2004. Crown copyright material is reproduced with the permission of the Controller of HMSO.

2. REGIONAL HOUSING POLICY AND PRACTICE INTERVENTIONS TO ACHIEVE BETTER HEALTH AND WELLBEING OUTCOMES

2.1 Introduction

This chapter presents the regional housing policy areas that could be developed, as part of a Regional Strategy framework, to direct and support the delivery of health and wellbeing outcomes. Suggestions are supported by a summary of supporting evidence, of which more detail can be found in the following chapters.

2.2 Recommendations in relation to the vision and direction for health and social care

The focus for all in the public sector should be on achieving improved outcomes for people and their communities. These can only be enabled by bringing together the component parts of inputs, principally expenditure, and outputs such as services and homes more effectively. This requires new ways of thinking and working, but if it can be achieved, the gains could be very significant.

2.2.1 Considerations for regional housing policy

Any regional housing policy aiming to achieve better health and wellbeing outcomes has to make sense to those working in health, social care and housing and add to their capacity. It also has to be flexible in approach to reflect the diversity of health and wellbeing needs in the region.

Despite national policy and regional plans the health and social care sectors are far more locally focussed than regional housing policy. There are broad national targets that health and social care should contribute to and meet (21 national indicators, and the top two tiers of Vital Signs – ‘must dos’ and national priorities), but many more targets are open to the strategic health authority, primary care trusts and local authorities to decide what is appropriate. There is more flexibility than in housing where there are only 7 housing related national indicators.

It is clear that capacity and understanding often prohibits local engagement between health and housing. However, this doesn’t mean to say a regional approach will be the most appropriate to adding capacity or providing direction – particularly given the different health challenges faced within the region.

Consideration could be given to how more can be made of housing in preventing ill health and promoting health

The government expects health and social care to move from a model of reactive, costly (to the organisation and individual), service provision to one of health promotion and the prevention of ill-health. This presented a challenge before the recession: organisations have to effectively run existing services whilst developing

new ones. In recession this is even harder – the resources don't exist and need for existing services increase.

Housing activity, particularly housing option services (including housing support, homelessness, allocations etc.), has had prevention at its core for some time and there is familiarity with the 'invest to save' approach. The same services are also likely to be facing increased demand from recession – but this presents an ideal opportunity for engagement with other preventative activities that will contribute to health and wellbeing outcomes eg, signposting to GPs.

Regional housing policy could focus attention on delivering housing specific targets identified in health and wellbeing policy

The government has identified a number of housing ambitions in relation to individuals facing exclusion and inequalities, ranging from the PSA target to provide settled accommodation for people with a mental health issue or learning disability, to enabling Lifetime Homes in all new-build homes, not just social housing.

Responding to the needs and aspirations of an increasing proportion of older people in the population is a challenge for health and social care. Regional housing policy could focus attention on this aspect, although further research is likely to be needed.

The government focus on the older population is evident from the weight of policy in this area which covers not just old age but related issues such as dementia and end-of-life care: regional stakeholders also all identify it as a challenge. Regionally, there is an opportunity for joint work with social care to:

- develop a better understanding of the lower levels of need from people as they get older;
- understand who lives where and what can be done to influence the balance of communities in the future at a local level for example, can more affluent older people be retained in the region instead of moving elsewhere? Developing an attractive offer for people as they get older - including the housing offer where new models of provision needed; and
- understand the impact on the housing market, and especially on the supply of family housing, of the move to providing health and social care services 'closer to home'.

Consideration could be given to 'scaling up' existing, successful, housing initiatives that are felt to contribute to health and wellbeing outcomes.

There are many small-scale initiatives in place across the region, of which some are also in existence in other regions. These are, more often than not, not the result of strategic planning – although there is evidence that this is changing, for example Birmingham City Council appears to be co-ordinating a number of initiatives.

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The Learning and Skills Council, as part of the region's Economic Inclusion Panel, is just beginning to consider the relationship between health, housing and the economy. There is interest from here in looking to scale up successful initiatives.

Consideration should be given to support strategic housing authorities to align plans and policies at a local level, in partnership with social care, to achieve health and wellbeing outcomes.

Regional housing policy is enabled and delivered by strategic housing authorities operating at the same spatial level as social care (in unitary authorities, not two tier areas). Health boundaries are not always the same, and there is the added complication of engaging with a different organisation resourced in a different way. There is perhaps a greater opportunity for a more effective housing contribution to health and wellbeing outcomes through joint work between housing and social care.

In addition to, or instead of, targeting housing policy and plans towards health and wellbeing targets, consideration could be given to targeting policy and action towards achieving a combination of health, wellbeing and economic targets.

Nationally *High Quality for All* commits the government and health in particular to supporting people to be healthy at work. Regionally the Learning and Skills Council has worked with health and housing employers (including housing associations) to identify how they can attract and support employees. Research has also been undertaken into the contribution housing associations make to tackling worklessness.

See also the recommendation to 'scale up' successful initiatives earlier.

Local authorities and health are looking to achieve considerable efficiencies, with partnership working, increasing productivity and innovation all up for discussion. It will be important that housing is round the table with an 'offer' to the efficiency agenda

The Department of Health has 'better value for all' as one of three strategic objectives. This was prior to the recession. Those working in the NHS have been tasked with responding to the QIPP agenda – quality, innovation, productivity and partnerships – by identifying what the priorities should be for the future given the likelihood of no growth in funding. Local government is facing greater cuts in resources – social care and housing will be affected.

See the later recommendation for the Regional Improvement and Efficiency Partnership.

Consideration could be given at a regional level to how housing policy can contribute more to social exclusion.

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Not only is there a specific PSA relating to accommodating and employing four 'groups' who face particular exclusion (PSA 16 – learning disabilities, mental health, care leavers and offenders), but health policy in particular (eg, High Quality for All) directs activity towards reducing exclusion for substance misusers (drug and alcohol) and those with mental health problems).

Some work is underway to scope the housing contribution in the region to PSA 16: this could be built upon and directed through regional housing policy.

Consideration should be given to the housing role in supporting a person-centred – personalised – approach.

Reform in health and local government aims to result in a person-centred approach – this is felt to be the best way in which independence, choice, dignity and control can be enabled. This approach presents real challenges for those who are commissioning (health and social care) or providing services (including the voluntary and community sector and housing organisations) – customers may not choose to use them so how do they plan for the future?

Work around personalisation, particularly the introduction of individual budgets, varies across the region. Despite a national target for 30% of clients to have an individual budget, local authorities have taken different approaches related to their priorities. However, there is a regional network of commissioners – recently involving health (the Darzi review signalled pilot personalised health budgets, and that everyone with a long term condition would have a personalised care plan) - that is looking at the agenda.

For regional housing policy to support outcomes at a local level real consideration has to be given to how local engagement can inform the shape of policy and decision making, and how regional policy can be held to local account

Citizen engagement and influence is at the heart of the government's for the public sector, with ambitions for local people to shape services and to hold decision makers to account. There are specific targets and plans in health and social care to enable this, for example by 2010 local authorities have to be 'user led organisations'.

Housing already engages with perhaps the most vulnerable and in need households in the region: there is an opportunity for joint engagement that will lead to holistic – housing, health, care and support – responses.

A clearer relationship between 'what matters most' in health terms that housing can contribute to in partnership with others is needed in the regional health and wellbeing strategy

There is room for improving how the health and wellbeing strategy communicates what is the most important issue to address. Housing priorities for action are in fact a

combination of targets and process and despite an evidence base within the strategy it's not clear which of these targets or processes will make the biggest difference. Consultation feedback and stakeholder feedback confirm the need to be clearer and more outcome focussed in future.

The evidence base developed by this research provides an opportunity to reconsider the five 'priorities' and refocus attention.

2.2.2 Recommendations for regional action

A resource is needed to support the Regional Health Partnership to interpret plans and policies in health and social care and to identify opportunities for alignment at all spatial levels.

It is not easy to understand the complexities of plans and policies that seek to direct health and social care activity to deliver health and wellbeing outcomes. At a local level the resources to undertake this task are unlikely to be in place, particularly in district authorities – this is where local strategic direction for housing comes from.

Whilst the national vision for health and wellbeing initially appears quite straightforward – reduced health inequalities, improved health, independence and choice for all – the way in which the government expects this to be delivered becomes extraordinarily complex even before strategic health authorities, primary care trusts and local authorities consider what their, more local, priorities for action are. Specific targets and plans to achieve this vision exist for a wide range of household groups who are felt to be more vulnerable.

At a more local level there is major transformation underway in health and social care, at a time where resources are likely to remain the same – or reduce – for some years to come and the population's needs and aspirations are changing.

A regional resource to support those working in housing to adopt a commissioning approach has the potential to enable more effective joint working with health and social care.

The Department of Health's *Commissioning Framework for Health and Wellbeing* aims to provide the health and social care sector with a framework within which national and local ambitions can be achieved. Capability within the sector has been supported to improve: within the NHS the Department of Health has introduced the world class commissioning programme. PCTs are assessed in a number of core competencies. Guidance has also been produced to support commissioners of housing support.

Regional support to develop the local strategic approach to housing to encompass a more effective approach to existing homes could have a significant impact on health and wellbeing.

Local Area Agreement (LAA) indicators in the West Midlands signal the focus on affordable housing provision, reflecting the national priority. However, whilst new supply is important it is not the only thing that local, strategic housing, authorities should be seeking to enable. A recent report by the Audit Commission, *Building Better Lives*, highlights that most local authority Chief Executives do not know that they have a broader housing role, for example to enable improvements in the condition of homes in all tenures.

Regional support could be provided to those working in housing to engage more effectively with the safeguarding agenda

National policy prescribes that health and social care services should enable people to feel and be safe yet some stakeholders suggested that, given the relationship housing providers have with vulnerable people, more could be done to ensure that housing is clearly engaged with the safeguarding agenda.

There is a role for the Regional Improvement and Efficiency Partnership to support housing, health and social care to work together more effectively and efficiently

The RIEP supports a number of the organisations working to support transformation in health and social care but support to local authorities on housing issues is not as evident. Local authorities face a challenge in meeting efficiency targets and housing is an area where value for money and efficiencies is less well-understood.

Regional lobbying will be needed in a number of areas where barriers to enabling a more effective housing contribution to health and wellbeing are felt to exist.

Stakeholders feel that new build housing does not address health inequalities or improve health unless it actually accommodates those facing inequalities, or those living in poor condition housing. There is no evidence that this is the case, regional decisions on investment are followed by local decisions on allocations i.e., there is no knowledge of who actually gets to live in new homes. This lack of knowledge also applies to new-build housing in regeneration areas.

What is felt with make a difference is investment in existing homes, in retro-fitting and improvements to warmth and energy efficiency. Lobbying would be needed to attract resources to this type of activity.

2.3 Recommendations Arising from Evidence of the Housing: Health Relationship

2.3.1 Introduction

The conclusions and recommendations presented here are drawn primarily from the evidence based research presented in Chapter 5.

Setting the agenda

Housing policy and health policy approach the relationship between housing and health from different starting points, i.e.:

- From a health perspective, the question is: what place does housing have in health?
- From a housing perspective, the question is: what place does health have in housing?

The outcome is that the connections between the two policy areas are unsystematic and, at times, random. There is a need to establish a common perspective on the housing: health relationship to inform the development of integrated housing and health policies.

A useful contribution might be made to understanding the housing: health relationship and its policy implications by reviewing the overlap between the content and approaches of SHMAs and JSNAs. The basis for this has been established in this project by providing detailed content reviews of each form of assessment.

2.3.2 Establishing health-related housing priorities

If housing policy is to be led by confidence in the evidence informing the health impact of housing, then the first priority in the West Midlands is to eradicate harmful housing conditions, in particular damp and cold homes, and for the most vulnerable households, in particular older people. This implies a prioritisation of housing investment either to improve or replace poor quality housing in older areas such as Stoke, Sandwell and in 'hot spots' throughout the West Midlands. Much of this housing will be urban terraced housing dating back to the late nineteenth and early twentieth centuries, but there are growing problems associated with unimproved market and former council housing from the period from the 1920s to the 1960s...

Other housing-related health priorities include interventions to tackle noise; overcrowding; home safety and accidents; security and the effects of crime and the provision of public and open space. Evidence of the health impact of new housing, in particular its preventive impact, is still being developed. However, there is a strong case for 'designing in health' to new or re-modelled housing environments, for example by giving consideration to the availability of green and open space, walkways and cycle routes etc., and for introducing a simple toolkit of criteria to be applied by planners and urban designers in the West Midlands.

2.3.3 Embedding the health impact of housing into policy

There is very limited evidence of health impact informing housing policy in the West Midlands. Further measures required to embed this in policy include:

- undertaking in-depth health impact assessments of housing interventions to assess which investments have the greatest health gain, and reduce long term revenue health-related costs;
- designing housing policy interventions so that their health effectiveness can be measured;
- prioritising the effectiveness of interventions that target specific housing conditions that are known to affect health outcomes; and
- planning for the impact of 'upstream' investment in housing on the 'downstream' health of residents.

NICE is currently developing guidance, due for circulation in December 2011, providing guidance for local authorities and PCTs, on the implications of spatial planning for health, see:

<http://www.nice.org.uk/Guidance/PHG/Wave20/55>

2.3.4 A shared approach to intelligence gathering

The most comprehensive geographically-based policy documents are SHMAs and JSNAs, and there is a need to identify the extent to which their content can be complementary within common boundaries. Future SHMAs could benefit from inclusion of a health/housing focus in the brief to ensure coverage of the most important issues.

2.4 Recommendations for Further Work

To improve the integration and understanding of health and housing, it is recommended that:

- the many small-scale housing initiatives in place across the region that contribute to improved health and wellbeing are collated and evaluated;
- shared health-related housing indicators are developed and agreed;
- the overlap between the content and approaches of SHMAs and JSNAs is reviewed, best practice collated and guidance issued;
- further broad based longitudinal studies to identify the most effective health-related housing interventions are undertaken, their cost effectiveness and long term impact determined

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- research is undertaken to understand who gets to live in new affordable homes and their health impact;
- the potential for 'designing in health' to new or re-modelled residential environments is evaluated, a toolkit developed and guidance provided to planners and urban designers in the West Midlands;
- a partnership run web based Local Information Systems to include mapping, small area data and housing/health datasets is developed;
- greater use is made of geographical information, including public health datasets not available to the public, and geo-demographic datasets
- a 'Housing: Health Neighbourhood Index' (HHNI) to inform the targeting of resources and/or interventions more effectively at small area level, and to measure change over time is developed.

3. ESTABLISHING VISION AND DIRECTION

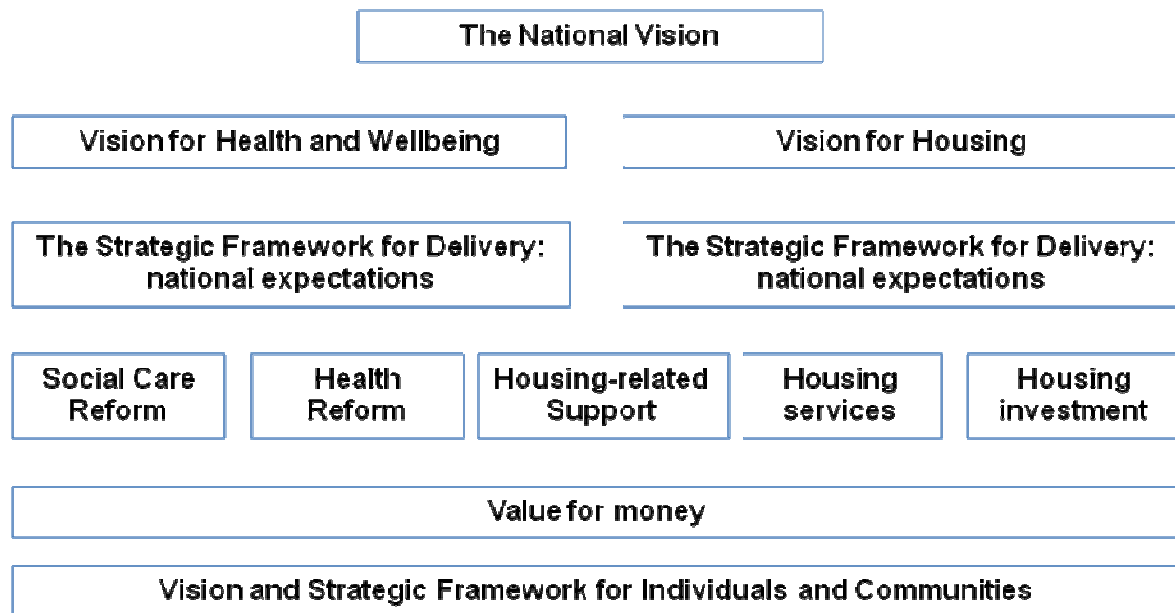
3.1 Introduction

In order to inform decisions about how regional housing policy can better contribute to improving health and wellbeing, we must understand the underlying strategic drivers – the vision and targets, how they are expected to be delivered (the strategic framework) and how they may change in the future.

It has been assumed that health and wellbeing outcomes cannot be achieved alone by those working in public health, NHS West Midlands or the 17 Primary Care Trusts (PCTs). Consideration has therefore been given to the role of local authority care and support for adults and children (referred to throughout as social care) in achieving health and wellbeing outcomes.

The following diagram depicts how this chapter seeks to make sense of the considerable number of plans and policies that exist to direct the delivery of the government’s vision for health, wellbeing and housing. Text is presented under each of the following headings.

Diagram 1: Making Sense of Plans and Policies Directing the Delivery of the Government’s Vision for Health, Wellbeing and Housing



The section begins with a summary of the government’s overall vision and priorities as described by the Government’s 2003 Sustainable Communities Plan and Public Service Agreements (PSA), followed by a description of how the government expects these to be delivered by those working in health, social care and housing: the strategic frameworks that aim to direct activity towards meeting the needs of specific individuals and communities. This chapter has been informed by a review of

a considerable number of plans and policies supplemented with conversations with stakeholders in the West Midlands.

3.2 The National Vision

Nationally, there are two ambitions that direct all activity - sustainable communities and economic stability and growth:

- The government's visionⁱ for 'prosperous and cohesive communities, offering a safe, healthy and sustainable environment for all' set the scene in 2003 for a raft of policy, guidance and legislation that enables local authorities and their partners – including health partners - to deliver this; and
- The government's ambition for stronger economic performance in England's regions, cities and localities is most clearly described in its 2008 response to a review of economic development and regeneration (referred to as the SNR)ⁱⁱ, followed by more recent guidance and the proposed Local Democracy and Public Involvement in Health Bill. These provide the basis for ongoing change to regional plan, policy and decision making to support economic growth and to tackle persistent pockets of deprivation, whilst the recession has highlighted the need to work together to manage the downturn and prepare for change.

Health and housing both have a contribution to make to these ambitions, with priorities for both described in Public Service Agreements published with the 2008 - 2011 Comprehensive Spending Review. These are described in the next two sections: the vision for health and wellbeing and the vision for housing.

Public sector reform (of which health and housing are part) has been necessary to deliver the government's vision, of which the main components are:

- devolving decision making and resources from the national level to local areas and their communities;
- better, targeted and evidence based, use of resources that will achieve greater efficienciesⁱⁱⁱ;
- stronger local leadership and accountability to direct new powers and ensure that the right decisions are taken;
- greater community engagement and empowerment in decision making and performance management; and
- considerable changes in regulation to support devolution.

Plans for Public sector reform are outlined by the government in [Strong and Prosperous Communities - The Local Government White Paper](#) and legislated for in the [Local Government and Public Involvement in Health Act 2007](#). It is seeking to

‘rebalance’ the relationship between central and local government and local people to enable the delivery of sustainable communities. This shift is most clearly seen in the transfer of resources and responsibilities from central to local government: we’ve shifted from local community plans that had no real resource attached to them to sustainable community strategies, Local Area Agreements (LAA) and Area Based Grant, the latter replacing a ring-fenced LAA grant and numerous pots of funding payable to different organisations of whom some operated at different spatial levels.

Increased local accountability and proportionate external regulation is fundamental to reform of the public sector, particularly to ensure that public finance and powers are used to best effect. This has been the basis for the introduction of Comprehensive Area Assessment, raised expectations that community and stakeholder engagement will shape services and investment and inform performance management, and for revising approaches to a number of public services such as health and social care. It is also the basis for proposals to change the role of local authority elected members locally, including revisions to the role of scrutiny. The role of regulation in relation to health, social care and housing is discussed in more detail under the section ‘Strategic Framework for Delivery’.

3.3 The Vision for Health and Wellbeing

The government’s ambitions for health and wellbeing can be summarised as:

- a reduction in health inequalities and social exclusion;
- improved health and wellbeing – quality of life - for everyone; and
- greater independence, dignity, choice and control.

Specific targets and priorities informing how these will be achieved are described by current Public Service Agreements (12, 16, 17, 18, and 25), strategies and guidance. The primary targets for health and wellbeing are found in PSA 18^{iv}, these are:

- by 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women; and
- by 2010, reduce health inequalities by 10% as measured by infant mortality and life expectancy at birth i.e.,
 - starting with Local Authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the "worst health and deprivation indicators" (spearhead areas – there are 10 in the West Midlands) and the population as a whole; and
 - starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the "routine and manual" socio-economic group and the population as a whole.

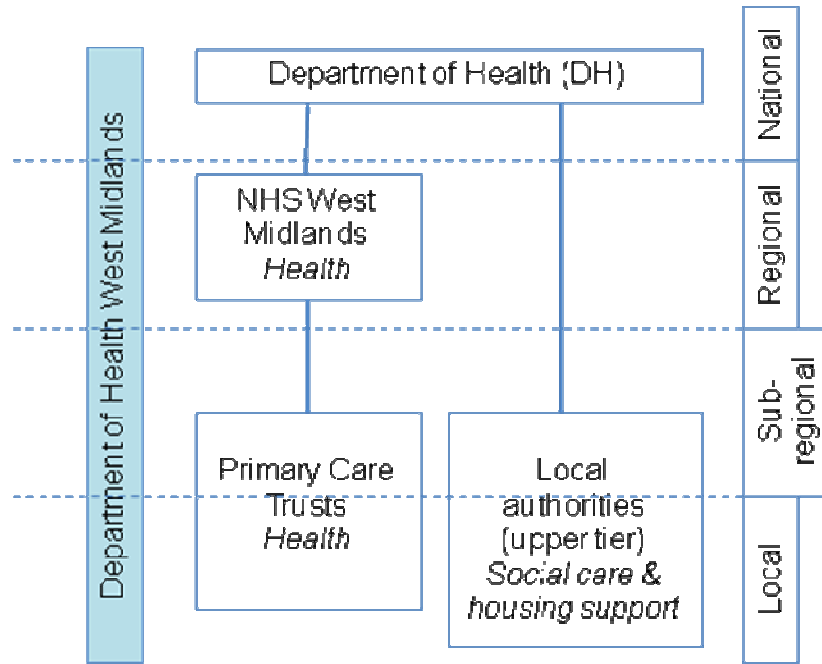
- increase the proportion of adults (18+) supported directly through social care community care assessment, to live at home.

The primary targets and measures relating to delivery can be found in PSA 19: Ensure Better Care for All and focus on reducing waiting times, increasing access and customer satisfaction. The Department of Health has responsibility for PSA 18 and 19. The work of the Department of Health centres around three strategic objectives:

- better health and wellbeing for all: helping people stay healthy and well; empowering people to live independently; and tackling health inequalities;
- better care for all: the best possible health and social care that offers safe and effective care, when and where people need it; and empowering people in their choices; and
- better value for all: delivering affordable, efficient and sustainable services; contributing to the wider economy and the nation. This is discussed later under value for money.

The following diagram seeks to provide some clarity about the organisations with responsibility for directing and delivering health and wellbeing targets at different spatial levels and relationships between these levels.

Diagram 2: Organisations with Responsibility for Directing and Delivering Health and Wellbeing Targets at Different Spatial Levels and their Interrelationship



3.4 The Vision for Housing

The government's ambitions for housing can be summarised as:

- supporting long term growth and economic prosperity
- a more environmentally sustainable world
- enabling fairness and opportunity for all

Specific targets and priorities informing how these will be achieved are described by current Public Service Agreements, the most relevant of which is PSA 20. Targets set by this are:

- to increase housing supply to at least 240,000 additional homes per year by 2016 and deliver 3 million additional homes in total by 2020; and
- to improve the energy performance and carbon footprint of new homes by 25 per cent by 2010 and 44 per cent by 2013 (compared with 2006 building regulations), moving to zero carbon by 2016.

PSA 16 is also important as it aims to increase the proportion of socially excluded adults in settled accommodation and in employment, education or training.

In addition to the targets established by the PSAs, there are a number of targets that local authorities are still measured against that were established by earlier housing policy, particularly by the 2005 Homes for All^v and Sustainable Communities: settled homes; changing lives^{vi} which established that by 2010 local authorities should:

- ensure that all social housing is decent (target set in 1997);
- ensure that at least 70% of vulnerable households in the private sector have homes that are decent;
- improve the average energy efficiency of all domestic homes by a fifth;
- ensure that all social housing should be accessed through a choice based lettings scheme;
- help over 80,000 people into home ownership who are currently renting privately or living with family;
- improve minimum energy standards for all new homes, reducing carbon emissions by around a further 25%;
- raise the average energy efficiency of the whole of the residential housing stock by 20% compared with 2000;
- deliver an extra 10 000 social rented homes per year by 2008; and
- ensure that over 60% of all new housing development should be built on brownfield land.

Sustainable Communities: settled homes; changing lives)¹ established that local authorities should:

- reduce the level of households in temporary accommodation by 50% (from December 2004 levels) by 2010;
- ensure rough sleeping remains below two-thirds of 1998 levels (new target anticipated);
- ensure that homeless families with children are not placed in bed and breakfast accommodation unless it is an emergency; and
- ensure that 16 and 17 year old homeless young people are not being accommodated in bed and breakfast by 2010 (November 2007 Youth Homelessness Initiative)

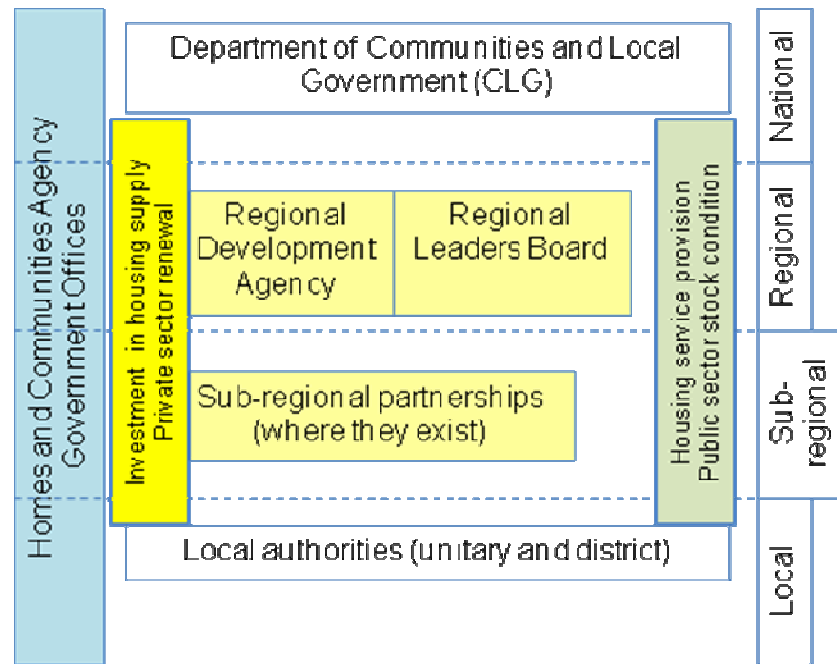
¹ Settled Homes; changing lives: <http://www.communities.gov.uk/publications/housing/sustainablecommunitiessettled2>

The Department of Communities and Local Government (CLG) has responsibility for PSA 20 and the settled accommodation measures of PSA16 (see Appendix C for measures). CLG's work centres around six strategic objectives, of which five are very relevant to housing and local authorities, they are:

- to support local government that empowers individuals and communities and delivers high quality services efficiently;
- to improve the supply, environmental performance and quality of housing that is more responsive to the needs of individuals, communities and the economy;
- to build prosperous communities by improving the economic performance of cities, sub-regions and local areas, promoting regeneration and tackling deprivation;
- to develop communities that are cohesive, active and resilient to extremism; and
- to provide a more efficient, effective and transparent planning system that supports and facilitates sustainable development, including the Government's objectives in relation to housing growth, infrastructure delivery, economic development and climate change.

The following diagram seeks to provide some clarity about the organisations with responsibility for directing and delivering housing targets at different spatial levels and relationships between these levels. Broadly speaking the delivery of housing supply targets and some housing condition targets is through regional decision making whilst the delivery of housing services and housing condition of social housing is the direct responsibility of local authorities (unitary and districts – not counties).

Diagram 3: Organisations with Responsibility for Directing and Delivering Housing Targets at Different Spatial Levels and their Interrelationship



3.5 The Strategic Framework for Delivery

To inform decisions about how housing policy can contribute to better health outcomes there must be a common understanding of how all partners working in health, social care and housing are expected to deliver the government's vision for these sectors described in the previous sections. To be effective, housing policy will have to support the alignment of housing, health and social care delivery.

3.5.1 National expectations of health and social care

In summary there is an expectation that improved health and wellbeing and reduced health inequalities will be delivered by:

- the establishment of *clear vision, outcomes and priorities*;
- *real partnership working*, within the health and social care sectors and beyond, particularly at a local level to deliver the vision for sustainable communities, to target resources effectively and to improve the quality and availability of services generally;
- *engaging the public* in understanding what is important to them and what can be improved, and what value means to them;

Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy

- the *promotion of health and wellbeing and prevention of ill-health*;
- understanding and responding to individual needs – *personalisation*;
- services that actively *safeguard vulnerable adults and children, and*
- *more effective and efficient investment* now to reduce future costs arising.

These expectations are being supported through a fundamental programme of reform, the main reference points of which are:

- In 2004 *Choosing Health: Making Healthy Choices Easier*^{vii} established ambitions for new thinking and action to tackle inequalities in health and engage people in looking after their own health.
- This was followed by *Our health, our care, our say: a new direction for community services*^{viii} in 2006, where a commitment was made to transform health and social care services.
- For the NHS the publication of Lord Darzi's *High Quality Care for All*^{ix} published in 2008 is key (also referred to as the final report of the *NHS Next Stage Review*), setting out a vision for quality health care for all that meets individual needs, is fair, effective and safe.
- The framework for the transformation of social care services is found in *Putting People First*, a Ministerial concordat published in 2007 and followed by government circulars to local authorities.
- The proposals of *Shaping the Future of Care Together*^x, the government's social care and support green paper published in 2009, suggest the next steps to the 2007 framework, proposing fundamental changes to ensure a focus on the needs of individuals, a fair and affordable system.

The 2008 *No Secrets*^{xi} consultation (government response not yet published) on guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse and the 2009 *Joint Chief Inspectors recommendations and the government's response on safeguarding in the delivery of all services to vulnerable people*. Regulation of health and social care has been aligned to the programme of reform: the government has introduced a new, single (replacing two organisations), independent regulator of health and social care in England. The Care Quality Commission (CQC) regulates services provided by the NHS, local authorities, private companies or voluntary organisations. CQC is also one of the inspectorates which contributes to Comprehensive Area Assessment.

3.5.2 National expectations of housing

There is an expectation that economic stability and growth, sustainable development and communities will be delivered by:

- the establishment of *clear vision, outcomes and priorities*;
- *real partnership working* at local, sub-regional and regional levels:
 - at a local level to deliver the vision for sustainable communities, to target resources effectively and to improve the quality and availability of services generally;
 - at a sub-regional level to understand the housing market and take action to balance markets, for example through large scale market renewal; and
 - at a regional level to target resources to balance housing markets and support economic growth
- *engaging the public* in understanding what is important to them and what can be improved, and what value means to them;
- understanding housing markets, needs and aspirations and the role that *housing has to play in the economy*;
- enabling fair access to housing and to support services that enable *opportunity and choice, support independent living and prevent crises eg, homelessness*; and
- *investment in new housing supply* to kick-start wider area development and the construction industry as part of plans to move out of the recession

These expectations are supported by a number of reforms, most notably to support an increase in the supply of housing:

- The government's 2007 housing green paper - *Homes for the future: more affordable, more sustainable*^{xii} sets out a large number of initiatives to support the delivery of new and greener homes, ranging from plans for infrastructure funding to partial reviews of the regional spatial strategy housing targets.
- The Green Paper also called on all local authorities to play a stronger role in addressing the housing needs of all residents, encouraging them to develop their strategic housing role by using the full range of housing and land use planning powers, working with partners to meet needs of residents and so on with a view to contributing to health, education, social care outcomes amongst others.
- The government's expectations around housing and economic growth are described in its 2008 *response to the sub-national review of economic development and regeneration*, and the May 2009 guidance which sets out how it intends to take this forward, including regional reform and the

introduction of the local economic assessment duty. The *Local Democracy, Economic Development and Construction Bill* will legislate for proposed changes when it is enacted (expected by the end of 2009).

- It is important to know that in 2008 the government announced plans for a housing reform Green Paper that did not come to fruition. The themes of the green paper were to be housing and young people, mobility, fairness, home ownership and the wider role of housing organisations, for example in relation to enabling tenants to gain access to work. The government has not explained why the green paper was not published.

Reflecting raised expectations the regulation of housing activity has also seen some major changes, particularly to reflect that local strategic partnerships and local authorities have a greater strategic role to play to ensure that housing contributes effectively to the local vision for the area, and in response to a review of social housing regulation which recommended a consistent and co-regulatory (involving a number of partners and customers) approach.

Comprehensive Area Assessment (CAA) asks ‘how well is housing need met?’ and has sought to identify if local and national priorities are being delivered. The organisational assessment element of CAA is applied at district council level – the strategic housing authority – and will seek to assess value for money, governance, resource and performance management: housing is part of this assessment. CAA will be informed by, and trigger, housing service inspections. This includes Audit Commission assessments of the strategic approach to housing (a new key line of enquiry has just been consulted on to reflect the much higher expectations), homelessness, housing options, housing support, private sector housing services, and Tenant Services Authority (this has replaced the Housing Corporation’s regulatory arm) assessments of social landlords.

3.6 The Direction for Delivery

3.6.1 Health reform

Reform in the NHS began in 2000 (the *NHS Plan*) and has been a three stage process, moving from investment and capacity to the third stage of transforming services to deliver high quality care and value for money, key developments are:

- In 2004, Sir Derek Wanless, in *Securing Good Health for the Whole Population*, described a vision for future of health and social care as one where citizens work with professionals to optimise good health and to avoid the avoidable^{xiii}.
- In the same year *Choosing Health: Making Healthy Choices Easier* established ambitions for new thinking and action to tackle inequalities in health and engage people in looking after their own health.

- In 2006, the Department of Health White Paper *Our health, our care, our say*: set out a new direction for improving the health and wellbeing of the population in order to achieve:
 - better prevention and early intervention for improved health, independence and wellbeing;
 - more choice and a stronger voice for individuals and communities;
 - tackling inequalities and improving access to services; and
 - more support for people with long term needs.
- In the same year the Local Government White Paper, *Strong and prosperous communities*, outlined a vision of responsive services and empowered communities, including a Community Call for Action across local public services.
- The 2008 publication of Lord Darzi's *High Quality Care for All*² (also referred to as the final report of the *NHS Next Stage Review*), sets out a vision for quality health care for all that meets individual needs, and is fair, effective and safe. Specifically it commits to (amongst other actions):
 - every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations. Efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health;
 - a Coalition for Better Health, with a set of new voluntary agreements between the Government, private and third sector organisations on actions to improve health outcomes;
 - support for people to stay healthy at work;
 - support GPs to help individuals and their families stay healthy; ensure everyone with a long-term condition has a personalised care plan; and
 - pilot personal health budgets to give individuals and families greater control over their own care, with clear safeguards.

3.7 Delivery through the NHS

3.7.1 Overview

Building on *High Quality Care for All* the NHS is expected to be:

- Fair - equally available to all regardless of circumstances – and making best use of resources.

² Darzi (2008) *High Quality Care for All*, Department of Health

- Personalised - personalised to the needs and wants of each individual, especially the most vulnerable; providing access to the health services most suited to every individual at the time and place of their choice; and with clinicians and individuals working closely together in partnership to improve health as well as treat illness.
- Effective - focused on delivering outcomes for patients that are among the best in the world – saving more lives and improving the quality of life.
- Safe - as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.
- Locally accountable – empowering staff locally to lead change and innovate, ensuring that change is based on the best clinical evidence and meets local needs; and where patients and the public are consulted to ensure they shape and champion their own local services.

In finalising the Darzi report the 10 Strategic Health Authorities were asked to present their regional visions for the NHS, and the West Midlands vision is presented in Chapter 4.

Priorities for the NHS are presented within *the NHS Operating Framework*³, for 2009-10 the framework sets out:

1. The health and service priorities: strengthening the focus on enabling local control and responsibility whilst maintaining the 5 national priorities and the Vital Signs agreed for the 3 year CSR period 2008/09 – 2010/11.
2. A system designed to deliver quality: making quality the organising principle of the NHS. The local visions set out in High Quality Care for All puts quality at the centre of all the NHS does, this focuses on the levers and incentives to further build on this, including staff engagement for the benefit of patients and the public.
3. The financial regime: Maintaining a framework that supports quality and innovative improvements in services within available resources. Key to this is asking the NHS to go further to ensure it makes the best use of taxpayers' money.
4. The business processes: Ensuring that planning is based on locally led decision making and maintaining the emphasis on genuine partnership working at a local level with local government and other partners.

National priorities for the framework are a combination of outcomes and the following service delivery priorities:

³ (2008) *The Operating Framework for the NHS in England and Wales 2009-10*, Department of Health

1. improving cleanliness and reducing health care associated infections;
2. improving access through achievement of the 18 week referral to treatment pledge, and improving access (including at evenings and weekends) to GP services;
3. keeping adults and children well, improving their health and reducing health inequalities;
4. improving patient experience, staff satisfaction and engagement; and
5. preparing to respond in a state of emergency, such as an outbreak of pandemic influenza.

The NHS Framework also highlights the health priorities where important national developments need to be considered by PCTs. For 2009/10, these included alcohol; dementia; end of life care; mental health; military personnel, their dependants and veterans; mixed-sex accommodation; people living in vulnerable circumstances; and people with learning disabilities.

Success in achieving the vision for health and priorities established by the NHS Framework is measured by Vital Signs which enable a distinction between national and local priorities. Performance indicators are split into three tiers:

- Tier 1 sets out a small number of 'must dos', which, because of the degree of importance which patients, staff and the public attach to them, apply to all PCTs. Tier 1 sets out national requirements about what needs to be achieved and by when, subject to performance management from the centre.
- Tier 2 sets out a small number of national priorities for local delivery where it is known that concerted effort and action is required across the board, but where it is recognised that local organisations would benefit from a greater degree of flexibility on how they deliver. Strongly performing organisations are allowed to get on and deliver these indicators without interference from the centre.
- Tier 3 provides a range of indicators available to PCTs which, following consultation with their local communities and partner organisations, they can choose to target at selected areas.

The 2009/10 Vital Signs are presented in Appendix C.

3.7.2 A framework for delivery in health

The Department of Health's *Commissioning Framework for Health and Wellbeing* aims to provide the health and social care sector with a framework within which ambitions can be achieved. Eight steps are identified to effective commissioning:

1. Putting people at the centre of commissioning – giving them greater choice and control and access to information and advice to support this.
2. Understanding the needs of populations and individuals through JSNAs, recognised assessment and care planning processes.
3. Sharing and using information more effectively.
4. Assuring high quality providers for all services – working in partnership, engaging them in understanding need and ensuring procurement is transparent.
5. Recognising the interdependence of work, health and wellbeing – collaborative approaches with businesses.
6. Developing incentives for commissioning for health and wellbeing – using the Local Area Agreement process to enable the delivery of shared outcomes, for example through pooling budgets and joint commissioning.
7. Making it happen: local accountability – supported by a single health and social care framework.
8. Making it happen: capability and leadership – supported by the Department of Health and other stakeholders.

Understanding local needs is required as part of commissioning, and there is a requirement^{xiv} for health, social care and other partners, including housing, to work together to produce a Joint Strategic Needs Assessment (JSNA). As a key element of establishing local strategic priorities and informing operational decisions, the findings of the Assessment are expected to inform Sustainable Community Strategies; Local Area Agreements and practice-based commissioning, and should be considered in the development of local housing strategies.

To enable effective commissioning capability within the sector has to improve. Within the NHS, the Department of Health has introduced the world class commissioning programme to achieve these improvements, with a focus on:

- establishing a clear vision and purpose for world class commissioning;
- identifying the key competencies that commissioning organisations will need in order to become world class;

- creating an assurance model to reward PCTs for delivering world class commissioning and to hold them to account; and
- putting in place a support and development framework to help PCTs attain world class commissioner status.

All PCTs are required to include health inequalities (as measured by the index of multiple deprivation) and life expectancy as part of the 10 World Class Commissioning outcomes. At a local level practice based commissioning (PBC) is expected to develop to cover non-acute services that have a strong preventative element including:

- social and practical support to isolated older people;
- self-monitoring equipment for people with long term conditions; and
- crisis avoidance and interventions – including aids and adaptations, tele-care and equipment.

3.8 Social Care Reform

3.8.1 Overview

A change in direction for social care was first signified in the 2005 social care green paper, *Independence, wellbeing and choice*⁴, followed by:

- The 2006 Department of Health White Paper (see earlier) *Our health, our care, our say*.
- The 2007 *Putting People First: a shared vision and commitment to the transformation of Adult Social Care*⁵ is a concordat between six central government departments and representatives of Local Government, NHS and care providers. The concordat describes how to work towards a single community-based support system focused on the health and wellbeing of the local population. Such a system includes health care services, public health, social care, housing, employment, benefits advice and education/training. The intention is to re-design services around the needs of citizens with the aim of maximising individual independence and economic/social participation.
- The 2008 Local Authority Circular '[Transforming Social Care](#)' confirmed the vision for personalised adult social care, with individuals empowered to shape their own lives and the services they receive. As part of this a Social Care

⁴ (2005) *Independence, wellbeing and choice*, Department of Health

⁵ (2007) *Putting People First: a shared vision and commitment to the transformation of Adult Social Care*, HM Government

Reform Grant has been set up to help local authorities and PCTs redesign and reshape their systems to ensure early intervention, prevention and re-enablement, aiming for everyone to have an individual budget for care.

- Finally, the *Shaping the Future of Care Together*⁶ Green Paper published in July 2009 proposes significant reform in care and support in response to greater expectations from customers and to the needs that will arise from an older population. It outlines plans to build the first National Care Service in England: a system that is fair, simple and affordable for everyone, underpinned by national rights and entitlements but personalised to individual needs.

Shaping the Future proposes a number of actions to achieve the vision for care and support:

- More joined-up working, for example better joined-up working between health, housing and social care services and between social care and the disability benefits system. Services will also be fully joined up between the NHS and the new National Care Service.
- A wider range of services in care and support to enable greater choice - local authorities are felt to be best placed to enable this. Housing support is highlighted time and again as a valuable service.
- Better quality and innovation, providing better value for money

The most contentious and fundamental changes proposed by the Green Paper relate to who should pay for care and support in the future: people who need care; their families; or everyone in society via the state? Currently people who have the highest needs and lowest means get some help through the social care system, and some people get help through disability benefits but many people, including some with high needs, get no help with paying for care at all. Three options are proposed: pay for yourself, partnership and insurance. To support the national vision a number of targets have been set that relate to the direction and delivery of social care, including:

- By 2011 30% of all service users will have individual budgets.
- By 2010 every local authority will have a user led organisation (see also the *Independent Living Strategy* later)

3.8.2 The delivery of social care

Upper tier local authorities are responsible for the strategic planning and provision of social care to achieve health and wellbeing outcomes. In many cases, the local

⁶ (2009) *Shaping the Future of Care Together*, HM Government

authority is also a provider of social care. In relation to their strategic role, the programme of improvement focussing on commissioning described under health applies. It is not uncommon for local authorities and PCTs jointly to fund commissioning posts and, with the introduction of the first ever joint health and social care regulator, the Care Quality Commission, it is possible that 'world class commissioning' will form the basis for future social care assessments.

As a local authority role, commissioning care and support forms part of local action to deliver the local vision for sustainable communities: the vision for health and wellbeing should be part of the sustainable community strategy with priorities for action in local area agreement and performance is assessed through national indicators. Of particular interest in housing terms is specific guidance for [Commissioning housing support for health and wellbeing](#)^{xv}.

Although the local authority has responsibility for social care there are a number of regional partnerships that bring authorities together. These are described in the later section on the West Midlands.

3.9 Housing-related Support

3.9.1 Overview

Housing-related support has been incorporated in this section as it clearly contributes to health and wellbeing outcomes and it is directed and enabled by local strategic partnerships between health and social care, housing and criminal justice partners.

Housing-related support has been funded by the **Supporting People** programme since April 2003. The main aim of the programme was to help end social exclusion by preventing crisis and more costly service intervention and enabling vulnerable people to live independently both in their own home and within their community through the provision of vital housing-related support services. Supporting People aimed to:

- 'offer vulnerable people the opportunity to improve their quality of life by providing stable environments which enable greater independence', by
- 'delivering high quality and strategically planned housing related services which are cost effective and reliable and complement existing care services'.

The government's strategy for Supporting People, *Independence and Opportunity*^{xvi} was based on four key themes:

1. Keeping people that need services at the heart of the programme.
2. Enhancing partnership with the Third Sector.

3. Delivering in the new local government landscape.

4. Increasing efficiency and reducing bureaucracy.

The Government has invested over £8.7bn since the programme began in 2003; and announced a further £4.9bn funding up to 31 March 2011. It is the biggest single source of Government revenue funding for the Third Sector - over £1 billion per year.

The Supporting People programme brought together seven funding streams from across Whitehall and is understood to be precursor to local area agreements, area based grants (or ABG) and strengthened strategic partnerships to lead, direct and enable delivery: the Supporting People programme required local authorities to form a Commissioning Body, 'a working partnership of local government, service-users and support agencies'. The programme, until April 2009, provided a ring-fenced grant that was payable only to eligible housing-related support services.

With the advent of ABG, and as part of plans to devolve resources further to local areas, in 2008 a number of local authorities piloted the removal of the ring fence i.e., they trialled using the funding for support services that local areas felt would deliver positive outcomes for vulnerable people despite falling outside the housing related support eligibility criteria. In 2009 the ring-fence was removed, although the grant is still referred to as Supporting People. From April 2010 the grant will be payable as part of ABG – it will no longer be named.

There has been national concern over the impact of the removal of the ring fence, in particular, there is a fear that resources that have been available to support the most excluded people who do not have access to any other form of support, including statutory services, will be used to prop up statutory services as public sector funding reduces. There have been two developments in response to this concern, firstly, the publication of revised research, *Research into the Financial Benefits of the Supporting People Programme*^{xvii} which demonstrates the cost savings (including to health) of housing support. Secondly, a Select Committee Inquiry (see http://www.parliament.uk/parliamentary_committees/clg/clgsphome.cfm) due to report this Autumn aimed to consider:

- the extent to which the Government has delivered on the commitments it made in Independence and Opportunity;
- the implications of the removal of the ring-fence, asking what needs to be done to ensure that the successes of the programme so far are not lost, or services cut, and
- what opportunities this change in the funding mechanism will offer for innovation and improvement in the delivery of housing-related support services.

Success in delivering housing-related support is primarily measured by two national performance indicators, percentage of vulnerable people achieving independent living (NI141), and the percentage of vulnerable people who are supported to maintain independent living (NI142). The national outcomes framework enables success to be measured in more detail under five headings:

- Enjoy and Achieve.
- Economic Wellbeing.
- Be Healthy.
- Stay Safe.
- Make a Positive Contribution.

3.9.2 Delivery of housing support

Upper tier local authorities are responsible for strategic planning the provision of housing-related support to achieve health and wellbeing outcomes, amongst others. As with social care, in many cases the local authority is also a provider of housing related support.

With the removal of the ring fence, local authorities and their partners can consider a wider range of activity to support people to live independently, although progress in practice is highly variable across the country i.e., some authorities have not made any plans for change yet.

To support local areas in their role as strategic commissioners of housing support guidance has been produced, *Needs Analysis, Commissioning and Procurement for Housing-Related Support: A resource for housing-related support, social care, and health commissioners^{xviii}*. More recently, a toolkit has been produced based on the research into financial benefits of Supporting People, to support local authorities and their partners in decision making – the tool, *Supporting People financial benefits model documentation and user guide^{xix}*, allows local areas to understand the financial benefits of services they procure.

As with social care, although the local authority has responsibility for housing related support there are regional partnerships that bring authorities and service providers together. These are described in the later section on the West Midlands.

3.10 Housing Policy: direction and delivery

3.10.1 Overview

Changes in the direction for housing, and the framework for delivery, are linked to public sector reform – particularly local government reform - to deliver sustainable

communities and to regional reform to deliver economic growth. In both instances the state of the economy plays a large part in targets and direction: the recession has led to significant changes in recent times. The direction and delivery of housing activity described in the housing green paper mentioned earlier is provided for by:

- The *Sustainable Communities Act 2007* and the accompanying 2008 *Statutory Guidance* support the housing green paper's plans for the local authority strategic role; local authorities and partners need to be more strategic i.e., plans for the area (including housing development) should be for 15 years-plus, be based on a robust understanding of the local issues and the wider context and must reflect a shared vision that can be measured in outcomes.
- The *2008 Housing and Regeneration Act* also legislated for commitments set out in the housing green paper, paving the way for the Homes and Communities Agency and the Tenant Services Authority (replacing the Housing Corporation's investment and regulatory functions respectively).
- The powers and duties of strategic housing authorities were summarised in *The Strategic Housing Role of Local Authorities: Powers and Duties, 2008^{xx}*. Overall responsibility for the strategic direction for housing lies with the strategic housing authority (unitary and district local authorities - upper tier authorities have no housing responsibility). This direction is typically communicated through a local housing strategy although it is not a statutory requirement to publish one. They also have a number of statutory duties, for example to accommodate homeless households. A recent report by the Audit Commission National Studies Team, *Building Better Lives*, reports that local authorities need to take action to improve their strategic approach to housing.
- In recent times the government has broadened responsibility for the strategic to the local strategic partnership, reflecting the role that housing is expected to play in contributing to the vision for the area expressed in the sustainable community strategy. This is most clearly spelled out in the 2008 *Creating Strong, Safe and Prosperous Communities: Statutory Guidance*: local strategic direction should be communicated first through the sustainable community strategy and local area agreement, supported by an appropriate framework ie, there may not be a local housing strategy.
- Whilst strategic housing authorities provide the overall strategic direction, the government has to ensure that its targets for new supply are met. To ensure this occurs two things are in place: the planning system and the Homes and Communities Agency. The former consists of the national *Planning Policy Statement 3 (2006)*, *regional spatial strategies and local development frameworks*. The HCA is the 'delivery agent' for the government: it is working with strategic housing authorities (often in partnership with other authorities) to translate spatial policy into reality through a process known as the 'single conversation' (the development of investment plans).

- Planning policy and regional housing allocations will be affected by regional reform described in the government's *response to the Sub-National Review of Economic Development and Regeneration*, with proposed legislative changes provided by the *Local Democracy, Economic Development and Construction Bill*. This will see joint responsibility for regional housing investment (capital) decisions being taken by the Regional Development Agency and Regional Leader's Board, as part of the proposed Regional Strategy – housing and planning decisions were previously taken by separate boards, albeit under the direction of regional assemblies (these will no longer exist from 2010). The HCA is expected to work with the new regional arrangements to inform their work with authorities.
- Whilst strategic housing authorities have statutory responsibilities relating to homelessness and housing need (directed by policy such as *Sustainable Communities: Settled Homes; Changing Lives* published in 2005 and the 2008 - [No One Left Out - Communities ending rough sleeping](#)), upper tier authorities have responsibilities for the direction of housing related support. Direction to this has been provided through the *Supporting People* programme described earlier.
- Sub-regional or cross-authority working is expected, particularly to enable housing supply and investment in failing housing markets. In recognition of the fact that housing markets don't adhere to administrative boundaries, and that there is a relationship between housing markets and the economy, there is an expectation that strategic housing authorities will work with each other understand their markets (by undertaking a strategic housing market assessment) and, where it makes sense, to deliver joint responses to the issues that exist. Examples of sub-regional working to tackle shared issues include the housing market renewal pathfinders that were established to tackle large areas of low demand, poor condition and obsolete housing eg, RENEW and the Birmingham/Sandwell pathfinder.

This complex picture presents a challenge to integrated service delivery, to delivering efficiencies and to regulation (CAA is at an upper tier level not strategic housing authority level).

3.10.2 The delivery of housing services

In addition to providing strategic direction to housing services the strategic housing authority often directly delivers a large number of housing services, ranging from housing advice and assistance, homelessness and temporary accommodation to assistance to those living in the private sector and choice based lettings systems for social housing. Local authorities also directly procure these services to other organisations, particularly to housing associations (they often deliver homelessness, housing option and allocation services on behalf of local authorities) and to voluntary and community sector organisations. Finally, a large number of housing services are

delivered by voluntary and community sector and private sector organisations with no income from the local authority. It is a challenge to the authority to influence the direction and standard of these services but this is the expectation from the government.

Resources for housing services are primarily from the local authority's general fund or from grants payable from CLG (for example homelessness prevention grant). These latter sources of funding are expected to be paid through the area based grant at some point in the future, although this will raise questions about the level of control for such funding as ABG is payable to upper-tier authorities which are not the same as strategic housing authorities.

3.10.3 Investment in housing supply

For some time the government has favoured housing associations as the main delivery mechanism for new affordable housing supply but in recent years private developers have also become preferred partners. Contributions to new affordable housing through planning obligations have also played a significant role in meeting targets, relying on a buoyant housing market to subsidise a large proportion of affordable housing (in some regions almost all affordable housing was developed through planning contributions). The recession has effectively brought an end to this. In response, and in an attempt to kickstart the economy, the government has recently announced the redirection of funding that was earmarked for investment to improve social housing conditions to new affordable housing supply.

3.10.4 Investment in improving housing conditions

Some strategic housing authorities still own and manage their own housing stock, or manage an arms length management organisation (ALMO) who undertakes this work this on their behalf. Where this is the case the authority has additional responsibilities, for example to ensure their housing is to the decent homes standard. Other local authorities have opted to transfer their housing stock to another organisation, for example a housing association (referred to large scale voluntary transfer or small scale) or have entered into long term private finance arrangements (PFI). The Homes and Communities Agency reports that by 2010, 95% of social housing will meet the 'decent homes' standard of being warm and weatherproof with reasonably modern facilities ie, the target for 100% established in 1997 will not have been achieved.

Investment in social housing decent homes is complex: there is a complicated subsidy system for those local authorities who continue to manage their stock, grant funding for ALMOs who successfully achieve a 'two star' rating from the Audit Commission and loans from the private sector for those organisations who manage transferred housing.

All social landlords, including local authority landlords, will be regulated by the Tenant Services Authority from April 2010.

In relation to all other housing stock in 2005, a target (to ensure 70% of non-decent housing occupied by vulnerable residents is improved by 2010) was established to improve housing conditions in the private sector. This target was the subject of a specific Public Service Agreement, PSA7. However, the target was not included in the 2007 PSAs (no explanation was provided by the government) and, beyond investment in housing market renewal pathfinders, there have been no additional resources available to local authorities to improve housing condition. The expectation has always been that local authorities will find the resources to improve conditions in the sector and, to support them the *Planning Act 2004* legislated for local authority powers to improve housing condition in the sector through a combination of incentives such as loans and enforcement action.

Strategic housing authorities do receive some government resources to enable the delivery of disabled facilities grants which local authorities ‘top up’ in order to meet the high – and increasing – level of need (CLG estimates this ‘top up’ equates to an additional £100m per annum). Legislated for in the 1985 Housing Act, DFGs are mandatory for essential adaptations to give people better freedom of movement into and around the home and to access essential facilities within it. The work to make improvements can be undertaken by any number of different organisations but increasingly this is done by home improvement agencies. In recognition of how essential DFGs are to maintaining the independence of disabled and older people the government introduced a package of changes were introduced in 2008, including changes in the way DFGs are resourced (there was a total funding increase of £45 million from 2008 to 2011) and accessed (for example applicants claiming Council Tax Benefit, Housing Benefit and Tax Credits for those on low incomes are no longer be required to provide any further financial information in addition to these benefits). Further changes are expected, including piloting the removal of the funding ring fence (nine local authorities are piloting this).

3.11 Value for Money and Efficiencies

3.11.1 Overview

Making best use of resources is a national priority and is clear in health and social care policy, initiatives and guidance. The 2007 Comprehensive Spending Review announced that all public services will be required to achieve 3% net cash-releasing ‘value for money’ gains per year, between 2008/09 and 2010/11. However, in response to recession the government has announced a target for 2010 of 4%.

The *National Improvement and Efficiency Strategy*⁷, supported by guidance, such as *Delivering Value for Money in Local Government*⁸, outlines how these gains should be achieved through partnership working, improved commissioning and procurement and service re-design.

⁷ (2008), *National Improvement and Efficiency Strategy*, Communities and Local Government

⁸ (2007) *Delivering Value for Money in Local Government*, Communities and Local Government

Support to health and social care partners in the West Midlands to deliver value for money and efficiencies is described in Chapter 4 but it is inevitable in the current financial climate that a greater integration of health and social care will be necessary to meet the challenges ahead. Initiatives such as *Total Place* will play an important part in unpicking what is spent where and how this expenditure can be used more effectively in the future. Birmingham City Council is a Total Place pilot. Durham is a Total Place pilot for housing and regeneration.

3.11.2 Health

The Department of Health has responsibility for a Departmental Service Objective established with the 2007 CSR: *Deliver Better Value: delivering affordable, efficient and sustainable services, contributing to the wider economy and nation*. The *Value for Money Delivery Agreement*⁹ produced by the Department of Health describes how this will be achieved and particularly the areas in which savings could be made – through improving performance – if all areas came closer to the best performers in the country. At a local level potential savings have been identified from:

- Reducing inappropriate hospital admissions and length of stay for
 - People with mental health problems; and
 - People with a long-term condition.
- Alcohol interventions.
- Drug treatment.
- Health and work.

The *NHS Operating Framework* leads on the expectation of efficiencies from the NHS and PCTs. Although the 2008/09 Framework was clear that the NHS is expected to identify and deliver 3 per cent cash-releasing efficiency savings for each of the three years of the current spending review period, ending 2010/11. In the current economic climate, it has been felt appropriate that the NHS goes further in making efficiencies to contribute to returning the economy to balance in the timescales identified in the Pre-Budget Report. The expectation is that PCTs and NHS trusts will be expected to explore the opportunities identified under the cross-Government Operational Efficiency Programme, where further efficiency savings can be secured from 2010/11.

Of current significance in relation to resources and their use is the government's *Quality, Innovation, Productivity and Prevention* initiative, announced by the NHS Chief Executive in August 2009. Those working in the NHS have been asked to consider how they can respond to the current financial challenge by:

⁹ (2007) *Value for money delivery agreement*, Department of Health

- Being clear about what needs to be done and at what level egg, team, local, regional or national, to remove inefficiencies from duplication and make best use of the limited resources.
- Getting the right leadership focus and behaviours to address this challenge at every level in the system.
- Engaging properly with staff, partners and the public.
- Being clear about what needs to change in the national policy framework to support action.

3.11.3 Health and social care

Within the West Midlands, a number of NHS West Midlands officers are working to develop the approach for the region and this is expected to be published in October 2009.

Social care, directed and often delivered, by local authorities is facing potentially a greater reduction in funding than health. Particular challenges exist in moving towards transformed (new) services whilst still delivering existing services) – there is a double running cost.

Support to health and social care to deliver value for money and efficiencies in the West Midlands is described later but it is inevitable that a greater integration of health and social care will be necessary to meet the challenges ahead.

The final point to note about health and social care is that, despite a common understanding about the need to work together within the sectors to achieve value for money, holistic and person-centred services, this will always be difficult. Health care is free to all – it can't be charged for - unless you choose to pay for private health services. Social care is not free to all and is unlikely to be in the future. Commissioners need to consider where funding comes from and what it can be used for on this basis ie, it isn't as straightforward as pooling budgets and paying for any type of service that will deliver the desired outcomes. Of interest here is that housing-related support – funded to date by Supporting People – is largely free and therefore can deliver health related services.

3.11.3 Housing services and supply

Value for money from investment in new housing supply has largely been the responsibility of the Housing Corporation and now Homes and Communities Agency, although guidance from the latter on local investment planning, expected in November 2009, makes it clear that consideration to value for money from development should form part of the planning process by the local authority and partners. The proposed key line of enquiry from the Audit Commission on the strategic approach to housing also reflects this expectation.

Value for money from housing services falls under the approach taken by the local authority, beginning with targets established in the medium term financial plan to deliver government expectations within the funding allocated to them. It is fair to say that most local authorities do not understand value for money in housing. Birmingham City Council is one of very few authorities who have taken this matter seriously.

External support to improve value for money in housing has not been forthcoming – nationally the Regional Improvement and Efficiency Partnerships have not offered support although there is scope for them to do this and CLG has actively encouraged this. In the absence of guidance HQN has developed guidance for local authorities and over 30 authorities have now undertaken an assessment of cost and outputs, but there remains work to be done.

Without an understanding of the value of housing, beginning with an understanding of the resources attached to housing activity, it will be difficult for those working in housing to work with partners in health and social care to explore how resources can come together to deliver improved value.

The vision and strategic framework relating to the health and wellbeing, and housing, of specific household groups or needs are presented in the next section.

3.12 Vision and Strategic Framework for Individuals and Communities

3.12.1 Overview

There are a number of national targets that relate to meeting the needs of household groups who are at particular risk of inequality or exclusion. These can be found in the current Public Service Agreements and are expanded upon in strategies and guidance, and in summary are:

- To improve the health and wellbeing of children and young people (PSA12^{xxi}).
- To increase the proportion of care leavers at age 19, offenders under probation supervision, adults receiving secondary mental health services and adults with learning disabilities known to councils in settled accommodation and employment, education or training (PSA 16).
- To improve healthy life expectancy at age 65 and to increase the extent to which people over 65 receive the support they need to live independently at home (PSA 17^{xxii}).
- To increase the number of drug users recorded as being in effective treatment and to reduce the rate of rate of alcohol-related hospital admissions (PSA 25^{xxiii}).

More detailed targets and priorities for vulnerable groups are provided next.

3.12.2 Older people

The Government's 2005 strategy for older people and an ageing society, *Opportunity Age – Meeting the challenges of ageing in the 21st century*^{xxiv}, described ambitions to:

- achieve higher employment rates overall and greater flexibility for over 50s in continuing careers, managing any health conditions and combining work with family (and other) commitments;
- enable older people to play a full and active role in society; and
- provide services that allow us all to keep independence and control over our lives as we grow older, even if we are constrained by the health problems which can occur in old age.

This strategy has largely been delivered and new ambitions are described in the more recent, 2009, *Building a society for all ages*^{xxv} (proposals are out for consultation until October 2009). This suggests ambitions to:

- promote everyone's wellbeing;
- help keep people healthy;
- create a stronger, richer sense of community; and
- boost the economy.

Specific proposals relating to health, social care and housing include:

- raising the profile of health prevention initiatives such as those that seek to reduce falls (resources have been made available from the Department of Health^{xxvi});
- providing funding to test new and innovative approaches to delivering services for older people;
- the new UK Advisory Forum on Ageing responsible for providing advice to ministers across Government on additional steps that Government and partners need to take to improve wellbeing and independence in later life;
- new approaches to addressing ill-health as a barrier to working longer;
- a 'one stop shop' for information and advice to inform decisions as people grow older – this will incorporate housing advice;

- the continuation of digital inclusion projects to enable access to new technology for people living in sheltered housing, with plans to build capacity and capability in the housing sector to offer this technology as an essential, communal residential service;
- close working with developers, architects, planners and other professionals to encourage them to adopt lifetime home standards in private sector housing; and
- an innovation panel of top architects and specialists to make sure homes of the future meet the needs of our ageing population

Living well with dementia: a national strategy^{xxvii} proposes steps to improve the quality of life for those with dementia and their carers, broadly covering three areas: developing a better understanding of dementia across the public sector, proper and early diagnosis and the development of services to meet needs. A specific housing objective is to consider the needs of people with dementia and their carers in developing housing options (for example housing support, extra-care housing etc), assistive technology and tele-care.

Finally, housing proposals are more specifically outlined in *Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing in an ageing society*^{xxviii}. Beyond the obvious connection of building houses to provide homes for life (all public sector housing will be built in accordance with Lifetime Homes standards by 2011) the strategy also seeks to reconnect housing with health and social care around the themes of prevention, personalisation, coordination and integration.

Preventative activity includes advice and information, adaptations and repairs, which prevent health and care crises for individuals. Recent and ongoing initiatives in this area are £33 million for new and enhanced handy person services from 2009 to 2011, £60 million in pilots called Partnerships for Older People Projects (POPP) and £80 million, in the form of grants, in the development of Telecare over the two years 2006 to 2008.

Actions from the strategy can be summarised under the following headings:

- the development of a new housing advice and information service;
- action to enable equity release;
- a new national rapid repairs and adaptations service and Warm Front;
- the implementation of a number of the Disabled Facilities Grant review recommendations;
- lifetime homes and Lifetime Neighbourhoods;

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- a planning response to the needs of an ageing population through better intelligence;
- join up housing and health and care services, improve crisis prevention and make housing more personalised; and
- improve specialised housing.

3.12.3 People with a disability – learning, physical or sensory

The Government's vision is to improve the life chances of people with a disability. For everyone with a disability the government committed to enabling equality and independent living for people with a disability in 2005 in *Improving the Life Chances of Disabled People*, followed by the Government's *Independent Living Strategy*^{xxix}. Targets include:

- By 2010, each locality will have a user-led organisation modelled on existing Centres for Independent Living (CILs).
- By 2011 the Lifetime Homes standard will be mandatory for all public sector funded housing by 2011.
- By 2013 disabled people have more choice and control over how their needs for support and/or equipment are met.
- By 2013, all new housing will be constructed to Lifetime Homes standard.
- By 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life, and will be respected and included as equal members of society.

Specific housing objectives included removing barriers to accessing housing, the development of partnerships between health and housing to support independent living and choice and the consideration of the needs, ensuring that capital investment in homes improves the housing opportunities for disabled people and that homes are built to the lifetime home standard.

The vision for people with a learning disability, their families and carers was first established in *A New Strategy for Learning Disability for the 21st Century: Valuing People*^{xxx}. Published in 2001 and developed on four principles of rights, independence, choice and inclusion, the Strategy proposed the following initiatives to enable access to opportunities and choice, tackle exclusion and improve quality of life:

- Health objectives aimed to respond to the greater health needs of many people with learning disabilities, enabling access to personalised services and the same access to mainstream health services.

- Housing objectives included enabling people with learning disabilities and their families to have greater choice and control over where and how they live. This paved the way for moves from long-stay hospitals to accommodation in the community.

Adults with a learning disability known to local authorities are a priority group for the government: the 2007 PSA (16) aims to increase the proportion in settled accommodation and employment.

More recently (2009) *Valuing People Now: a new three-year strategy for people with learning disabilities 'Making it happen for everyone'*^{xxxii} translates wider policy ambitions for health and social care (Putting People First and Lord Darzi's report in particular) for personalised services that enable people to live independently, stay healthy and have the best possible quality of life, irrespective of illness and disability.

Based on much research (for example recommendations made by *Healthcare for All: report of the independent inquiry into access to healthcare for people with learning disabilities*^{xxxiii}) and consultation, the vision is for all people with learning disabilities be supported to become empowered citizens and there is a particular emphasis on inclusivity, for example, people with more complex needs; people from black and minority ethnic groups and newly arrived communities; people on the autistic spectrum; and offenders in custody and the community.

There is a specific housing policy objective as part of achieving these ambitions, all people with learning disabilities and their families should have the opportunity to make an informed choice about where, and with whom, they live. A number of specific actions are suggested for regions and local authorities, including ensuring needs are understood, for example through JSNAs, and are reflected in housing strategies, and improving access to wider housing options such as home ownership.

Finally, in 2009 *Valuing Employment Now - real jobs for people with learning disabilities* set out the ambitious goal to increase radically the number of people with learning disabilities in employment by 2025. The strategy includes action to raise expectations throughout the system that all people with learning disabilities can and should have the chance to work: from birth and early years through education, among health and social care staff, local authorities, employment agencies, employers, and people with learning disabilities themselves and their families. Health and housing have a role to play: health to enable access to services from birth and housing to link to employment opportunities for example by including employment options in strategies to reduce use of residential care.

3.12.4 Mental health

There are a number of proposed ambitions relating to mental health, by 2020:

- most adults will understand the importance of mental wellbeing to their full and productive functioning in society, to their physical health, and to their ability to make healthy lifestyle choices;
- physical health and mental wellbeing will be seen as equal priorities, and the links between them recognised as key to maintaining physical and mental health;
- all individuals will be treated with respect in an inclusive society, whatever their age, background or circumstances;
- the stigma attached to mental health will have declined dramatically;
- services to treat and care for people with mental health problems, including personality disorder, will be accessible to all who need them; and
- people with mental health problems will no longer be at greater risk of physical ill health than the rest of the population.

These ambitions are described in the 2009 mental health strategy consultation (closing date 15 October) *New Horizons: Towards a shared vision for mental health*^{xxxiii}, and form part of plans to enable good mental health. This is in the context of understanding the impact of poor mental health on wellbeing and prosperity and it follows the ten year National Service Framework for Mental Health (1999) which led the transformation of mental health services in England.

As with policy relating to learning disabilities, New Horizons proposes change within the context of wider health and social care reform, for example the drive for higher quality and more personalised services, prevention and early intervention (with an emphasis on understanding the root causes of poor mental health), innovation and more effective partnership working. New Horizons also highlights, as does learning disability policy, that some people and communities face more exclusion from access to services and support, including some BME communities and those with complex needs.

Good quality housing and neighbourhoods (the physical environment), a better understanding of housing needs that informs access to appropriate accommodation, and housing based services are proposed as having a contribution to make to improved mental health. These proposals reflect the PSA 16 priority to increase the proportion of people in contact with secondary mental health services in settled accommodation and employment.

3.12.5 Drug misuse

The government's vision is to produce a long-term and sustainable reduction in the harms associated with drugs; helping to promote drug-free futures and drug-free streets for children, families and communities.

The 2008 drugs strategy *Drugs: Protecting Families and Communities*^{xxxiv} describes action that will contribute to a number of health related targets, such as increasing the number of drug users in effective treatment (PSA 25), recognising the correlation between drug misuse, ill-health, risk taking leading to accidents, the potential for physical and mental health problems and so on.

The positive role that housing and housing support services play in bringing stability to drug users' lives is recognised: they can provide a stable base from which to engage with treatment services as well as preventing homelessness. Proposals for action include cross-departmental work to support drug misusers' re-integration into society by:

- encouraging joint working between treatment agencies, Jobcentres and sources of housing advocacy and advice, to plan and manage clients' journeys through treatment and into work, helping them access the wider support they need to re-establish their lives;
- encouraging local authorities to work with partners to meet locally-identified need for housing and support for those affected by drug misuse;
- ensuring that all local partners are aware of the need to assess the wider needs of drug misusers and those in treatment; and
- exploring the potential, initially through pilot projects, of the use of pooled budgets, end-to-end case management and individual budgets linking treatment benefits, training and employment support, with a focus on achieving positive outcomes for clients.

3.12.6 Alcohol misuse

The long term goal is to minimise the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly.

In 2007 *Safe, Sensible, Social: The next steps in the National Alcohol Strategy* suggested that alcohol misuse leads to a £20 billion each year in ill health and crime and disorder, and recognises – as does drug misuse strategy – that misuse contributes to poor physical and mental health, risk of accident, and increased risk of disease. The strategy seeks to reduce chronic and acute ill health caused by alcohol, and in turn the rate of rate of alcohol-related hospital admissions (PSA 25).

Whilst ensuring that everyone is able to make informed choices about alcohol, the strategy responds to research that there should be a focus on those who place the greatest burden on services: young people under 18 who drink alcohol (in particular 11–15-year-olds), 18–24-year-old binge drinkers, a minority of which are responsible for the majority of alcohol-related crime and disorder in the night-time economy; and

the harmful drinkers, whose patterns of drinking damage their physical or mental health and who may be causing substantial harm to others.

The strategy does not suggest any specific housing-related action but there are some potential connections, for example, the relationship between alcohol use and areas of deprivation where the latter can be the focus of housing renewal and regeneration, and where alcohol misuse is a contributory factor to homelessness.

3.12.7 Children and young people

The government's vision is for England to be the best place for children to grow up by 2020, with ambitions to support children and young people to achieve the outcomes of being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic wellbeing. Specific targets relate to infant mortality and health inequalities and relate to the ambitions of PSA12: improve the health and wellbeing of children and young people. There are also clear links with ambitions around reducing child poverty and increasing the number of children and young people on the path to success.

The 2009 strategy *Healthy Lives, Brighter Futures – The strategy for children and young people's health*^{xxxv}, describes how the vision will be achieved, particularly to support families in securing world-class health and wellbeing outcomes for their children. It builds on a considerable policy framework:

- The 10 year programme, *The National Service Framework for Children, Young People and Maternity Services (2004)* to improve the quality of universal health services and promote health and wellbeing.
- The Every Child Matters programme, which set the Government's outcomes for every child, whatever their background or their circumstances, and focused on integrated design and delivery of services around the needs of children, young people and families to work together to deliver improved outcomes.
- *The Children's Plan* and *The Children's Plan One Year On* reflect the Government's overarching ambition for world-class public services. The former also provides guiding principles such as the 'government does not bring up children, parents do' (the focus is on supporting parents), prevention and shaping services to meet needs.
- The *NHS Next Stage Review* vision of high quality care for all.

There are few specific proposals within the strategy that directly relate to housing:

- Overcrowding has an impact on health inequalities (responded to in the *Implementation Plan for Reducing Health Inequalities in Infant Mortality*^{xxxvi} specifically through the government's overcrowding initiatives);

- Joint working^{xxxvii} between children's services, health professionals and their partners is necessary for effective transition planning for young people with complex health needs or a disability or those leaving care; and
- Children's Trust partners should consider the broad range of factors that impact on children's health such as housing, where evidence suggests that housing needs are sometimes considered in isolation from a child's health outcomes.
- The home and neighbourhood environment is very important to health. This is reflected in the subsequent Children's Environment and Health Strategy for the UK^{xxxviii}, part of the government's commitment to the Children's Environment and Health Action Plan for Europe in 2004. The strategy commits to delivering decent homes, improving access to healthier and safer heating, reducing overcrowding, supporting households to undertake radon tests and mitigate against it.
- All organisations with responsibility for child health and wellbeing should be fulfilling their statutory responsibilities for safeguarding children. Although housing organisations do not have a direct responsibility for child health and wellbeing they do have a role to play, particularly in relation to children of tenants and residents, to children living with their families in temporary or support accommodation and to vulnerable young tenants.

3.12.8 Homeless households

Whilst there are no specific health targets relating to the homeless, *Sustainable Communities: settled homes; changing lives* highlighted that people who are homeless or living in temporary or insecure accommodation are more likely to suffer from poorer physical, mental and emotional health than the rest of the population. These health problems can be both a contributory factor to, and a consequence of, homelessness. On this basis health related issues should be an integral part of strategic approaches to reducing and responding to homelessness.

In recent times, rough sleepers have been the focus of attention of housing policy. The 2008 rough sleeping strategy *No One Left Out: Communities Ending Rough Sleeping*^{xxxix} outlines the serious and complex health problems faced by people who sleep or have slept rough, they are more likely than the average citizen, to have mental health problems, misuse drug or alcohol and have very poor physical health. In response, the strategy proposes better partnership working, including with health and social care.

3.13 Factors Influencing Direction in the Future

3.13.1 Introduction

This final section highlights factors that are expected to influence the direction of health and social care in the future.

The Marmot review is expected to be published in December 2009 and follows the publication of the global [Commission on Social Determinants of Health](#), published by the [WHO](#). In summary it will:

- identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action;
- show how this evidence could be translated into practice;
- advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy; and
- publish a report of the review's work that will contribute to the development of a post-2010 health inequalities strategy

This review will be particularly relevant to decisions on housing policy. The first stage of the review identified a number of relationships, not least that health inequalities link to housing inequalities, but it also suggested the levels of intervention that may be appropriate, whether interventions should be universal or targeted.

The Social Exclusion Task Force at the Cabinet Office is working with the Department of Health on a *six month study examining primary health care for socially excluded groups*. This study will look at how well the primary health care needs of the socially excluded are being met and will identify recommendations and tools for improvements. As well as contributing new analysis about specific groups, the project will consider how we can improve access to, and quality of, primary health care for the most vulnerable in our society. It also aims to provide greater clarity about the contribution that primary health care services can make to social inclusion, and expose innovative ways of delivering NHS-funded care to those at risk. The key lines of enquiry include considering 'how well do services [health and non-health] meet the primary health care needs of socially excluded people' and 'what support is available and what approaches are taken?' The final short study report will be published in autumn 2009.

The Chartered Institute of Housing (CIH) has just published a policy and practice report, *Housing, Health and Care*^{xi} and will be following this with two workshops in early 2010 to encourage those working in each sector to come together.

4. THE WEST MIDLANDS STRATEGIC CONTEXT

4.1 Introduction

This section reviews the West Midlands regional response to the national vision and direction for health and wellbeing, and identifies the partners involved in enabling and delivering this. It highlights existing regional policy responses that relate to housing and the implications for future regional housing policy if it is to be effective in contributing to better health and wellbeing.

4.2 Regional Direction

The direction for health and wellbeing in the West Midlands is provided by two strategies: [*Investing for Health: A strategic framework for the West Midlands*](#) (direction for the NHS) and the *Regional Health and Wellbeing Strategy*. The West Midlands vision for the NHS, established in response to Lord Darzi's final report, *High Quality Care for All*, is also a useful reference point. These documents build on *Choosing Health in the West Midlands: Recommendations for Implementing Choosing Health and Achieving Health Equality*, a Report of the Regional Director of Public Health published in 2006.

4.3 Direction for NHS West Midlands, PCTs and Practice-Based Commissioners

[*Investing for Health: A strategic framework for the West Midlands*](#) describes plans for improving health and health services in the region to 2012. It identifies seven challenges and describes responses through five strategic themes and ten implementation projects. It was developed whilst the Darzi Review was ongoing, and an evaluation of *Investing for Health* is now underway. The seven key challenges relating to outcomes and service delivery are:

1. widening health inequalities (these are considered later);
2. insufficient investment in prevention, early detection and supporting self care;
3. variability in the quality and safety of services;
4. costs arising from "doing more of the same" will be unaffordable going forward;
5. lack of confidence in the NHS getting better;
6. buying services which offer little or no return on investment in terms of improved health; and
7. the need for services to be more "legible".

The five strategic themes are:

1. *Full Engagement*: supporting innovation and ensuring proven evidence-based actions are taken to achieve more patients engaged in their own health and a significant shift towards preventative and 'wellness' services. Engagement with local authorities in their housing role is highlighted as necessary to manage the impact of housing on health and health inequalities.
2. *Quality, safety and excellence of patient experience*: putting clinical quality, safety and patient experience at the centre of commissioning, training and service development.
3. *Care closer to home*: supporting the delivery of local plans to achieve a significant increase in the availability of services in the community. Enabling older people and those with a long-term condition to live independently, for example through the provision of extra care housing is highlighted.
4. *Sustainable services and sustainable local health systems*: managing the consequences of the shift in activity from hospital to community. Preventing excess winter deaths, for example through initiatives to address fuel poverty and prevent falls, is a role which housing can play.
5. *Organisations Fit for Purpose*: ensuring that health commissioning and providing organisations have the capability to use the freedoms and tools available and both can improve responsiveness, accessibility and quality of services. Support to PCTs and PCBs to develop commissioning models includes support to work in partnership with housing authorities.

The 10 implementation projects are:

- Project 1: Market Development for Lifestyle Risk Management Services (falls prevention forms part of this project).
- Project 2: Commissioner Collaboration on Upstream Interventions; Excess Winter Deaths focuses on early identification of people at risk and support to commission preventative action.
- Project 3: Towards Consumer Directed Care; which includes consideration to assistive technology and individual budgets.
- Project 4: Real Time Patient Experience Feedback.
- Project 5: Safest and Highest Quality Services in the Country.
- Project 6: Systematic Provision of Information on Quality of Primary Care Services.

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- Project 7: Development of Care Pathways.
- Project 8: A Clear Vision for Each Health Economy (How it will look in 2012).
- Project 9: Workforce Transformation.
- Project 10: Productivity Improvement Project, focusing on mental health and learning disability and PCT commissioning.

There is clearly a link to housing in some of these projects, for example there is a clear link between housing condition and excess winter deaths (Project 2), identified in the Regional Health and Wellbeing Strategy. Another example is PSA 16 makes it clear that settled accommodation has a significant role to play in contributing to reducing social exclusion faced by those with mental health issues or a learning disability – housing could contribute to increasing productivity (project 10). However, the scope of projects tends to focus on NHS commissioning activity ie, activity funded/controlled directly by the NHS. Delivery of the ten projects has been enabled through a specific *Investing for Health* programme board reporting to the NHS West Midlands Board.

NHS West Midlands built on *Investing for Health* in the submission of the regional vision required as part of the Darzi review. The NHS West Midlands aims to move from ‘reaction to prediction’ by:

- working with patients, staff, carers, partner organisations and the public to provide a service that ‘adds years to life and life to years’;
- aiming to achieve levels of care comparable to the best in the world by transforming services from reacting to patients to being driven by them; and
- delivering patient-centred care of the highest quality and also a step-change towards great management of population health and support for people to manage their own health.

In order to determine the actions required to deliver this vision, the West Midlands Framework for Excellence was established, setting out the challenges alongside their aims for different groups and identifying their ambitions for patients, for the NHS workforce, for the public, and for other organisations that work with NHS patients.

As part of developing the revised vision, 9 clinical pathway groups are considering how services can be made more effective. Although housing is only specifically identified as necessary to deliver improvements relating to mental health there is clearly a role within the other pathway groups as the overall aim is to enable access to services closer to home. The nine groups focus on: -

1. Staying healthy.

2. Maternity and newborn.
3. Children's services.
4. Mental health.
5. Planned care.
6. Acute care.
7. Long-term conditions.
8. Dementia.
9. End-of-life care.

In summary there are a number of projects and working groups where consideration to housing could identify a contribution to health and wellbeing outcomes. However, the focus on NHS commissioning alone suggests that opportunities may be missed.

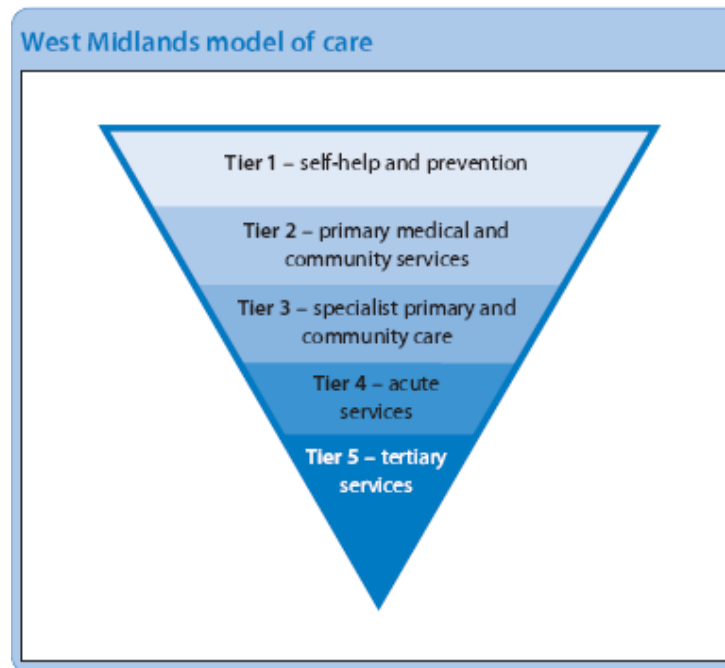
4.4 Delivering the NHS Vision

4.4.1 Overview

It is important to understand that whilst NHS West Midlands sets the overall strategy and framework for the future of health services in the region, it is the responsibility of local health service commissioners who 'buy' services from a range of organisations, including hospitals, to deliver plans to meet local needs. The national expectations of commissioners were described earlier in Chapter 2 (world class and practice based commissioning), whilst regionally there is an expectation that commissioners will develop local models of care that are evidence-based; clinically owned; clear about clinical and economical viability, and mapped on to local geography.

The model of care that has emerged is presented as a pyramid where the number and function of each tier vary according to local circumstances. Models have been developed for each local area for each of the nine clinical pathways and PCTs have been asked to identify 'neighbourhoods' or local areas within which services are clustered and interlinked.

Diagram 4: the West Midlands Model of Care



(Source: *Investing for Health*)

The model of care is important to understand as it is being used as the basis for decisions about models of other service provision in some local authorities in the country and there is no reason why it could not be applied to (or incorporate) housing service provision. Tier 1 services are also known as ‘universal’ services ie, those that are available to all: the middle tiers are ‘targeted’ ie, targeted to those who need something more than a universal service, whilst the top tier services are ‘specialist’ ie, used by those with very acute or specialist needs. There are variations on the theme (the model is also known as the ‘inverted triangle of care’ and is presented slightly differently in *Investing for Health*) but its use is for the same purpose – to remind people that there is a continuum of need and therefore services but the ideal position is one where more people use the preventative services than targeted and specialist – the latter are more costly.

4.4.2 Delivering action to address health inequalities

Within the West Midlands, 10 local authorities fall within the worst 20% of areas nationally in terms of “health and deprivation indicators”. These are referred to as ‘Spearhead Areas’, of which there are 70 local authority areas in the country.

Table 2: 'spearhead areas in the West Midlands, local authorities and PCTs

Local Authority	PCT
Birmingham City Council	Birmingham East and North South Birmingham Heart of Birmingham
Coventry City Council	Coventry
Dudley Metropolitan Borough Council	Dudley
Herefordshire Council	Hereford
Tamworth DC	Part of South Staffordshire PCT
Stoke-on-Trent City Council	Stoke
Walsall Metropolitan Borough Council	Walsall
Nuneaton and Bedworth BC	Part of Warwickshire PCT
Wolverhampton City Council	Wolverhampton
Sandwell Metropolitan Borough Council	Sandwell

Although the third report of the Parliamentary Health Committee in February 2009 identified that the 'Spearhead Areas' have not been an effective lever to galvanise people to action, the *National Support Team (NST) for Health Inequalities* set up by the Department of Health has visited the West Midlands 'Spearhead Areas' and suggested 10 broad areas for improvement to narrow the gap in health inequalities. In summary these are:

1. **Make the vision and strategy clear:** based on a clear understanding of the inequalities gap and the conditions responsible to develop the short (to 2010), medium and long-term actions.
2. **Extend leadership and engagement:** to support partnership working.
3. **Make partnership work:** at all levels, with agreed priorities and shared explicit responsibilities.
4. **Get system and scale right:** turn effective personal and community interventions to large scale population level interventions, modelling numbers where possible regarding impact.
5. **Adjust workforce:** to deliver programmes.
6. **Strengthen primary care:** to ensure that quality and quantity of primary care in disadvantaged areas, presenting challenge to poor practice and capitalising on strong performers.
7. **Find the missing thousands:** proactively seek out people who already have disease or are at high risk but are accessing services sub-optimally or not at all.

8. **Capitalise on community engagement:** support local authority partners in the development of community/neighbourhood infrastructures to engage with the ‘seldom seen, seldom heard’ in services and help motivate and support appropriate health- seeking behaviours.
9. **‘Raise the bar’ on target achievement:** to increase incentives to address patients with complex needs, who are not in touch with services and more in need.
10. **Utilise population health intelligence:** ensure adequate capacity and capability to generate population health information and intelligence in real time to drive programmes, such as linking public health, primary care, prescribing and commissioning data including with LSPs

Whilst these ‘areas for improvement’ could be applied to the process of achieving almost any ambition, they do highlight to those in housing where they can potentially make a contribution. For example health intelligence could and should be used in housing policy and decision making, whilst housing intelligence should be used by those working in health. Similarly, it is difficult at a local level to engage health in work with communities but the NST is advising that health need to do this if they want to reduce health inequalities.

4.4.3 Direction for all partners wanting to achieve health and wellbeing outcomes

The *West Midlands Health and Wellbeing Strategy*^{xli}, developed by the Regional Health Partnership, has a vision to “*maintain, enhance, improve and protect the health and wellbeing of people in the West Midlands Region and reduce health inequalities by 2020 within environmental limits, so as not to compromise healthy life for future generations*”.

The Strategy was developed to support partners in the West Midlands in tackling a range of challenges and to influence and support other regional strategies and plans, for example, NHS service delivery plans. Delivery of the Strategy is expected to be funded through largely existing resources.

The Strategy takes the challenges presented in *Choosing Health in the West Midlands* and presents proposals for action under a number of themes that represent the areas where there will be a greatest impact on health. These are:

- Planning, Transport and Health.
- Housing and Health.
- Environment and Health.
- Economy, Skills and Health.

- Culture, Leisure and Health.
- Safer and Stronger Communities.
- Children, Young People and Families.
- Later Life.

To reduce inequalities the strategy aims to:

- focus on the causes;
- improve the quality of life of all citizens as well as narrowing the gap in inequalities;
- promote a social model of health with emphasis on reducing inequalities that act as a barrier to wellbeing;
- promote both mental and physical wellbeing throughout people's lives
- ensure healthcare investment contributes to economic, social and environmental planning and regulation;
- identify and plan for the implications of the projected demographic changes for the West Midlands; and
- influence local strategies in particular, Local Area Agreements and Sustainable Communities Strategies.

Although the ambitions and intentions of the strategy are good there is lack of clarity about what matters the most ie, what are the one or two health issues in the region that matter above all else and therefore that is where the focus of resources across all sectors – including housing - should be. Clearly this is difficult – there are many challenges – but without a real focus (or drive) there is a danger that none of the ambitions will be achieved. This also applies to housing. The housing-specific theme of the Strategy aims *“to improve health through the delivery of improved housing conditions and sustainable communities”*, under which there are five priorities for action:

- support the provision of affordable Decent Homes built to the Lifetime Standard, as a minimum standard;
- promote health and wellbeing through sustainable design, energy efficiency, warmth, the reduction of risk of accidents in the home, green space and the provision of space for play;

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- reduce the number of excess winter deaths, and deaths through excess heat;
- promote affordable warmth and end fuel poverty;
- reduce homelessness and improve the health of homeless people; and
- promote the housing needs of diverse and additional needs groups and support people to remain in their own homes.

These priorities for action are in fact a combination of targets e.g., reduce excess winter deaths, reduce homelessness, and action e.g., promote affordable warmth. There is some work to do to improve the focus (this is supported by stakeholders spoken to in this research and from those who participated in consultation on the strategy initially – feedback suggests the need to embed housing in achieving other outcomes rather than singling it out) – thus increasing the changes of ambitions being realised – and this research project will contribute to this process. Future regional housing policy could begin with an understanding of which targets/actions will make the biggest difference to health and wellbeing across the region.

When the strategy was developed it considered the key themes emerging from Local Area Agreements (DAs), which at the time were:

- the need to meet the Decent Homes Standard;
- reducing fires in the home;
- the provision of affordable housing;
- reducing homelessness; and
- enabling people over the age of 65 to remain in their own home.

An analysis of current Local Area Agreement target indicators – those measures that (in theory) reflect national priorities that are important locally (see Appendix D) - suggests that local priorities have changed: the focus of local authorities is clearly on the provision of new build homes, reflecting the national priority in this area. Stakeholders contacted in this research feel that the LAA indicators do not in fact reflect local priorities at all and were chosen on the basis that they could be achieved or because they were 'leant on' to select them by government through regional offices. This is also the view of the recent Audit Commission report '*Building Better Lives*^{xliii} in relation to the affordable housing target, although this report also suggests that local authority chief executives also only think that 'strategic' housing means enabling affordable homes.

Finally, the future of the Regional Health Partnership– responsible for the Health and Wellbeing Strategy – in future regional arrangements is undecided. Stakeholders spoken to in this research are in full support of the Regional Health Partnership

having a role in the future, although there appears to be preference for the Partnership to retain its current independence, reflecting that it developed from a 'bottom up' commitment to partnership working to deliver better health and wellbeing outcomes. Wherever the Partnership sits in the future, it should have an important role in determining whether regional housing policy can or will be effective in contributing to its ambitions.

4.4.4 Delivering social care transformation

There is commitment in the region to delivering the national *Putting People First agenda*, and working collaboratively to do this in the most effective and efficient way. However, progress around the region in enabling social care transformation varies between local authorities and is related to local priorities and leadership, making it a challenge to come together on a common basis at regional level. Progress can be summarised as follows:

- A number of local authorities have progressed towards personalising services, achieving the **individual budget** (IB) target for social care and others have a resource allocation system in place (there is likely to be a national system at some point in the future). Different approaches exist in terms of how IBs are offered, with some focusing on particular client groups; to new customers or only to existing customers.
- Work is underway by local authorities (with health) to meet the 2010 '**user-led organisation**' target. Three authorities including Walsall and Staffordshire have been supported to date with further funding and support available for the remainder. Given the customer focus across all areas of the public sector, and with service user engagement central to housing related programmes such as Supporting People, there is potential for housing to be linked to social care through this work.
- **Prevention** is another area where work is progressing, with support from Department of Health (DH) West Midlands. Work includes developing responses to Valuing People (the strategic framework for people with a learning disability), the national dementia strategy, falls, and re-ablement.
- The future of **housing-related support** is being considered in different ways by local authorities, again reflecting local issues and priorities for action. There is clearly a relationship between housing support and the delivery of the government's social exclusion PSA (PSA 16), and work is underway to scope housing action to achieve this (led by GOWM).
- **Responding to the needs of an older population** is important across the region, where the focus to date in housing and health terms has primarily been on enabling extra care provision. However, there are three areas where housing, health and social care could come together:

- developing a better understanding of the lower levels of need from people as they get older;
- understanding who lives where and what can be done to influence the balance of communities in the future at a local level for example, can more affluent older people be retained in the region instead of moving elsewhere? Developing an attractive offer for people as they get older - including the housing offer where new models of provision needed; and
- understanding the impact on the housing market, and especially on the supply of family housing, of the move to providing health and social care services 'closer to home'.

As referred to in Chapter 2, value for money and efficiencies are areas of considerable challenge for local authorities. Social care directors have recently met to consider the extent to which more collaborative working could deliver savings, whilst some local authorities (for example Hereford) are considering how they can integrate further with health (most already jointly fund commissioner posts) for example in relation to back office functions, commissioning arrangements, making funding work differently (for example, through Total Place) and so on.

4.4.5 Health and wellbeing, housing and the economy

At a regional level, work has begun to bring housing, health and economic activity closer together, and has progressed from two directions:

1. at a more strategic level, the West Midlands Economic Strategy recognises the impact of poor health as a regional challenge and identifies the requirement to address poor health in regenerating our most deprived communities^{xliii}; and
2. at delivery level, following work to combine the Learning and Skills Council (LSC), with their focus on jobs and skills, with Job Centre Plus, with their focus on employment. Joint working has led to the development of an Integrated Employment and Skills System (IES) which provides a framework for everyone, regardless of their entry point, from exclusion from work to someone who is employed and wanted to progress, to gain skills and employment. IES has been trialed in the West Midlands since 2008 and will be introduced nationally from 2010.

The LSC contributes to the region's Economic Inclusion Panel (EIP), which has 3 objectives to:

1. work strategically and operationally with health sector to engage workless people to access opportunities in health;
2. establish working arrangements between various sectors to facilitate partnership working; and

3. explore contribution health providers make to worklessness.

As part of these objectives the LSC is leading on 'mapping and gapping' health and housing (this work is a very early stage and initial contact has been made with the WMRA). A small group (including a Homes and Communities Agency representative) will be considering which small programmes and initiatives can be scaled up, including through policy and strategy development. Some work has also been undertaken by the LSC in relation to health and housing with employers in the region:

- 10 months ago, housing associations were introduced to the IES model to see how it could be improved in relation to them as employers, and also to their work with tenants; and
- there is a Joint Investment Framework with NHS West Midlands over three years to provide progression opportunities for those entering employment from a worklessness background.

4.4.6 *Support for transformation*

The programme of transformation in health and social care is supported by a number of national and regional teams and networks. As one of the difficulties in aligning housing and health to achieve better outcomes is the capacity of people to work jointly across sectors, it is important that support to health, social care and housing sectors recognises and promotes these links. Support teams and networks include:

- ***The National Support Team for Health Inequalities*** is funded by the Department of Health and works across the country to support actions to reduce gaps in life expectancy and meet the 2010 PSA target. The team is drawn from NHS, local government and the third sector and has expertise in change management, public health and commissioning.
- ***The Department of Health regional team*** aims to support transformation in health and social care, focussing particularly on achieving national priorities, by working with NHS West Midlands and local authorities
- ***Deputy Regional Directors for Social Care and Partnerships*** are responsible, in relation to transforming adult social care, for working with councils and their partners to ensure delivery of *Putting People First*.
- ***The West Midlands Joint Improvement Partnership (JIP)*** is a partnership of organisations involved in improving services within social care. The JIP operates as a programme board on behalf of the Regional Improvement and Efficiency Partnership (RIEP). It has a business plan with the following priorities for 2008-11:

1. **Transformation:** providing support to enable local authorities to deliver the [Putting People First Agenda](#).
 2. **Personalisation:** development of effective resource allocation systems, improving information and advocacy systems, identifying best practice in internal and external brokerage models.
 3. **Early Intervention:** creating an evidence base; increasing the provision of tele-healthcare; measuring the impact of tele-healthcare on existing business processes.
 4. **Performance Improvement:** creating packages of support for local authorities in the West Midlands (currently Walsall and Herefordshire) that have only achieved a 'one star' performance rating following inspection by the national regulator (now the Care Quality Commission)
 5. **Workforce Development:** base lining the social care workforce in the West Midlands in partnership with the SHA; re-modelling core competencies to meet the transformation agenda; understanding future workforce requirements and influencing the national DH recruitment strategy.
 6. **Efficiency:** ensuring access to national Care Services Efficiency Delivery (CSED – see next page) tools alongside regional capacity; supporting initiatives that deliver cash releasing savings and/or improved productivity; supporting local authorities in meeting Comprehensive Spending Review (CSR) targets; rolling out the Care Funding Calculator tool which aims to support local authorities and Primary Care Trusts in managing the costs of residential care and supported living for adults with learning difficulties for example^{xliv}.
 7. **Delivery of LAA outcomes:** supporting local authorities to increase the number of people accessing a personalised budget plus improved health and wellbeing outcomes.
 8. **Developing Lead Member capacity:** creation of a Lead Member Network, including member feedback into delivery of regional support.
 9. **Dementia:** [Implementing the Dementia Strategy](#).
 10. **Carers:** improving the quality of advice, information and guidance available to Carers.
 11. **User Led Organisations (ULOs):** supporting the West Midlands in ensuring that each local authority has at least one User-Led Organisation by 2010.
- **The West Midlands Improvement and Efficiency Partnership (WMIEP)** and [Care Services Efficiency Delivery](#)^{xliv} (CSED) work in collaboration with the JIP and Deputy Regional Directors (DRD) to advise and support councils in implementing local efficiency projects.

CSED helps councils to identify and develop more efficient ways of delivering adult social care. It was first established in June 2004 by the Department of Health to support the implementation of the recommendations of *Releasing Resources to the Front Line - the Independent Review of Public Sector Efficiency*, better known as the Gershon Review.

Increasingly, the work of CSED is directed towards identifying efficiencies that will support the Sustainable Transformation of Adult Social Care, the policy direction set out in 'Putting People First'. CSED aims to help councils bring about the transformation of services in the most efficient way possible, so that users get the maximum benefit. There is a regional implementation manager.

The Department of Health is in the process of undertaking a review of the role of the regional improvement and efficiency partnerships to identify the support they have offered to improve health and wellbeing and whether more could be done.

- There is a **Personalisation Network** which meets bi-monthly and brings together social care personalisation leads from each local authority. Recently, health colleagues have joined the network to consider the integration of personal health budgets.
- The **West Midlands Regional Teaching Public Health Network** exists to increase the standard, range and availability of public health training in the West Midlands, in order to improve the health of the region's population. Established in 2006 it works with primary care trusts (PCTs) and West Midlands Strategic Health Authority (WMSHA), local authorities, universities and others in higher and further education, the voluntary sector and DH West Midlands
- **The Housing Learning Improvement Network** or LIN^{xlvi} is the national network for promoting new ideas and for supporting change in the delivery of housing, care and support services for older and vulnerable adults, including people with disabilities and long term conditions. The LIN has the lead for supporting the implementation and sharing the learning from the Department of Health's £227m Extra Care Housing Grant arrangements and related housing, care and support capital and revenue programmes.
- The **West Midlands Supported Housing Network** is a recent development. Four existing organisations, the Foyer Federation's Group; the NHF Care and Support Group; the Supporting People Provider Chair Forum and the Regional Action West Midlands (RAWM) housing group have come together, supported by SITRA (a national organisation that supports voluntary and community sector care and support providers) , the NHF etc, to hold a more strategic discussion about issues that affect all service providers, for example the potential impact of personalisation (particularly individual budgets) or reductions in public sector funding.

4.5 Implications

There is clearly a lot going on in the West Midlands to ensure that regional and local direction and delivery contributes to national priorities whilst meeting the diverse

needs of people and communities. This is a difficult balancing act and one that is being managed at a number of different spatial levels – the Regional Health and Wellbeing Partnership and NHS West Midlands (regional), the Primary Care Trusts (although boundaries have become more co-terminus with local authorities there are still examples of where more than one PCT covers a local authority area, for example housing market renewal areas), upper tier local authorities (social care and housing support, whilst districts have strategic housing responsibilities) and unitaries authorities (who have responsibility for social care, housing support and housing). Add to this 'pot' the considerable number of support teams and networks that are seeking to increase capability and capacity in health and social care and it becomes very difficult to see where consideration to housing's contribution to health and wellbeing would sit best.

For regional housing policy to contribute to health and wellbeing outcomes effectively it has to make sense to people, particularly those working in partnership sectors such as health or social care. A lot of time and energy could be put into trying to understand the multitude of projects and organisations working in health and social care - real thought has to be given to whether the outcomes will be worth the input, or whether the input could look different and be more effective.

5. HOUSING AND HEALTH: MAKING THE CONNECTIONS

5.1 Introduction

This extensive chapter reviews the housing: health relationship, especially the health impact of housing, by undertaking the following tasks:

1. A comparative research and literature review of the quality of evidence of the health impact of housing;
2. A review of relevant content from West Midlands Joint Strategic Needs Assessments;
3. A review of relevant content from West Midlands Strategic Housing Market Assessments and the output of Urban Living Housing Market renewal Pathfinder; and
4. An evaluation of the potential of current and available data sets, and their potential in developing a Neighbourhood Index.

5.2 Housing and health: research and literature review

5.2.1 Introduction

“To date, there is still no commonly agreed upon definition of ‘healthy housing’, and there are still major gaps in the knowledge of how housing conditions may affect health and which mitigation strategies may show the best results” (Bonney, 2007, p. 411).

“It is difficult to conclusively establish a link between poor housing and health, given that people who live in poor housing often suffer from multiple deprivations that can lead to ill health in their own right. However, research findings are generally consistent and a link between poor housing and ill health is widely accepted” (BMA, 2003).

These quotes perfectly capture the level of understanding of the relationship between housing and health, and they underpin the review presented below.

Under the combined effect of industrialisation and urbanisation, concern over the health impact of housing dates back to the nineteenth century and the emergence of the Public Health movement in the 1840s. It is important to emphasise that, until the advent over the past 30 years of the new Public Health movement with its re-focusing on prevention, concern over the health impact of housing has been led largely by developments in housing policy, in particular:

- The development of model and sanitary housing and the Garden City Movement in the late 19th and early 20th centuries;

- Early experience with slum clearance and the development of council housing, especially municipal flats, in the inter-war years of the 20th century;
- Mass slum clearance, and the building of high-rise flats in the 1950s and 1960s;
- Housing renewal in the 1960s and 1970s;
- Urban regeneration in the 1980s;
- The rationing of social housing in the 1990s and to date.

In this context, it is unsurprising that the primary focus has been on the home and on the impact on physical health of poor quality housing, and to which the role of the Environmental Health Officer stands testimony. Whilst moving towards a more holistic approach, such a mind set remains dominant.

5.2.2 Working definitions

This report attempts to avoid falling into the trap of excessive introspection over definitions and accepts the working definitions provided by Bonnefoy (2007, p.415) that:

- *“Health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity; and*
- *Housing is the conjunction of the dwelling, the home, the immediate environment and the community”.*

5.2.3 Methodological considerations

Analysis of the relationship between housing conditions and health has been dogged by methodological conflicts, especially those arising from the research models developed in the health and social sciences. Conflicts and controversy continue to centre around:

- working definitions of health and ill-health, especially where these stray into more subjective, psychological and especially quality of life measures;
- an over-concentration on physical health: the impact of inadequate housing conditions on mental health has developed only recently
- studies tend to be sectoral: they focus on separate issues such as noise or indoor air quality or they examine a single health effect rather than assessing combined housing risks (the ‘cocktail effect’);

- explanatory relationships of ‘association’ and ‘causation’. Associations are easily established between housing profiles in distinct geographic areas and patterns of health and ill-health, but this does not mean that the former cause the latter. There are likely to be a wide range of other factors which have an influence, from behaviour to health history, and separating out the relative influence and impact of these factors is a major challenge;
- the use of subjective ‘self-reporting’ versus objective ‘clinical’ data in assessing health and ill-health. It is hardly surprising that people’s views are sought in determining their health, but there is a risk that the attitude of people living in poor housing may be more negative and may therefore skew their opinions towards their health;
- the lack of cohort and longitudinal studies. Many studies of the housing: health interrelationship are effectively ‘snapshots’ in time, and fail either to pursue cohorts of people through housing-related changes over a period of time, for example, before, during and after a housing improvement programme;
- insufficient repeat studies to ensure comparison and consistency of findings. The criticism here is that, in the absence of longitudinal studies, studies are not repeated to confirm the validity of findings; and
- the absence of any rating system to assess the validity of research examining the health impact of different aspects of housing, and therefore an inability to develop a robust intelligence-based prioritisation of housing-related health interventions.

5.2.4 Principal research sources

There are now available a series of reviews of literature and research, the findings of which have been consulted for this project, in particular:

- Literature arising from the World Health Organisation’s (WHO) housing and health programme, such as Bonnefoy et al, 2004.
- The British Medical Association’s (BMA’s) (2003) report *Housing and Health: Building for the Future* which provides an examination of the “evidence in relation to health and housing”.
- *The Final Report of The Built Environment and Health Task Group* (2009) completed in connection with the Strategic Review of Health Inequalities in England post-2010, (the Marmot Review).
- The Evidence Briefing completed by the National Institute of Clinical Excellence (NICE) in December 2005 into *Housing and Public Health: a*

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review of reviews of interventions for improving health and focusing on the question:

“What housing interventions are effective at improving health outcomes?” (p.3)

This is the only paper to apply a robust “critical appraisal process to its “review of reviews”, as a result of which only 15 papers were selected and summarised.

- The Chartered Institute of Environmental Health officers (CIEH) with the University of Greenwich is in the process of establishing an evidence base concerning which health-related housing interventions work, how and why, incorporating research and good practice, case studies and currently unpublished literature.
- Finally, the European Network for Housing Research (ENHR) operates a working group on the theme of ‘The Residential Context of Health’ which provides both a forum for research and publications in relation to:
 - the role of behavioural, social and cultural factors in shaping relations between housing and physical and mental health;
 - ways in which housing policy can be co-ordinated with other social welfare policies to pursue more effectively health objectives; and
 - emerging initiatives for the delivery of health care services in the home.

Further information can be found at:

<http://www.enhr.ibf.uu.se/wg/health.html>

5.2.5 Principal research projects

LARES (Large Analysis and Review of European housing and health Status)

On the basis that the relationship between housing and health was insufficiently understood, the WHO’s Housing and Health programme initiated a large scale European housing and health survey in 2002, which residents’ perceptions of housing quality is a key component (Bonney et al, 2003a; Braubach, 2007). The approach is based on four dimensions of housing:

1. the home as a refuge and safe haven;
2. the building as the physical shelter;
3. the neighbourhood/community as the social climate surrounding the residential place; and

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4. the immediate housing and residential environment as the physical infrastructure of the residential place.

The objectives of the study are:

- to oversee and assess the quality of the housing stock in an holistic way;
- to identify avenues that would allow to set priorities among the individual problem areas of housing and health;
- to design a tool that would allow local authorities to assess the prevailing housing and health conditions within their cities or regions;
- To produce a more comprehensive evidence database;
- And to develop guidelines and recommendations for policy-making.

The LARES data base contains data relating to:

- 8,519 residents;
- in 3,373 households; and
- in 8 countries Italy, Germany, Lithuania, Switzerland, France, Slovakia, Portugal and Hungary.

The UK is not included in this data base, but health and built environment practitioners and researchers are actively involved in the research programme.

Further information can be found at:

http://www.euro.who.int/Housing/lares/20080403_1

The 'Putting Health Back Into Clearance' Working Group

The CIEH's Commission on Housing Renewal and Public Health recommended a greater focus on health impact:

"It should be recognised by all levels of government that urban and housing renewal policies require a greater public health focus and should not be based solely on supporting, or seeking to counter the workings of, the housing market. The impact on health should be a major component in the decision-making process on housing renewal".

The aim of the 'Putting Health Back Into Clearance' working group is to produce a report on the health impacts (both positive and negative) of housing clearance. The working group is chaired by Andrew Griffiths, Principal Policy Officer, Chartered

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Institute of Environmental Health, and is evenly divided between academics with an interest in the field of inquiry and experienced practitioners, including some from the West Midlands.

5.2.6 Housing and Health: established agenda

A number of studies have already established agenda for examining the relationship between housing and health as follows.

The WHO's housing and health programme of the Regional Office for Europe

As a starting point, and based on recent literature reviews and expert consultations (Bonney, 2007), the current priorities of the WHO's housing and health programme of the Regional Office for Europe are:

- thermal comfort, energy and fuel poverty;
- quality of sleep;
- housing and mental health;
- the challenge of ageing populations;
- home safety and accidents;
- construction and home materials; and
- indoor air quality and indoor comfort.

The Final (2009) Report of 'The Built Environment and Health Task Group' completed in connection with the Strategic Review of Health Inequalities in England post-2010, (the Marmot Review)

At national level, this Report identified a range of specific housing-related factors known to adversely affect health as follows:

- 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 usability of housing), 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 (i.e. lack of availability and accessibility of health services, parks,

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stores selling healthy foods at affordable prices), neighbourhood safety, and social cohesion; and

- factors that relate to the broader macro-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.

Chartered Institute of Environmental Health' (2008) Good Housing leads to Good Health. A toolkit for environmental health practitioners, BRE

Finally, and closely related to the Housing, Health and Rating System, this toolkit identified that the most significant housing hazards associated with health effects are:

- poor air quality (particles and fibres that can cause death among the very ill);
- poor hygro-thermal conditions (excess heat, cold or humidity);
- radon;
- slips, trips and falls;
- noise;
- house dust mites;
- ambient tobacco smoke; and
- fires.

Comment

A common agenda of health-related housing conditions emerges from these sources, as follows:

- hygro-thermal conditions, cold and damp;
- indoor air quality;
- noise;
- home safety and accidents, especially fire, and especially affecting children and the elderly; and
- the wider residential environment.

The following sections review the evidence base of the relationship between housing and health, and especially the health impact of housing.

5.2.7 Research themes

Introduction

There has been a steady evolution of research interest from a narrow focus on the physiological impact of poor housing conditions through a growing interest in the psychological and sociological impact of housing design towards attempts to assess the health effects of intervention and change and create healthier living environments. At the same time, the focus has widened from the internal environment of the home to the immediate residential environment, to the neighbourhood and wider urban area.

This progression is reflected in the typology presented in Table 1 which allocates literature and research activity to four main themes which reflect the organisation of the source literature. It is fully recognised that these categories are not mutually exclusive, a cold house located in a high crime area is likely to have multiple and cross-cutting health impacts, but the literature still tends to remain within the following discreet areas:

- *The home: impact on physical health*

This theme includes the health impact of such conditions as cold and dampness; indoor air quality; space and light and accidents in the home.

- *The home: impact on mental impact*

This theme includes the health impact of such conditions as mortgage insecurity and overcrowding.

- *The residential environment: impact physical and mental health*

Compared with that examining the health impact of housing, research examining the health impact of the residential environment has been more holistic in approach, both in terms of causal factors and definitions of health. This theme includes the health impact of, for example, access to services, traffic pollution and access to open space, feelings of safety, security and a sense of community.

- *Vulnerable groups*

In addition to these four areas, there are separate strands of literature and research activity relating to vulnerable social groups principally the elderly and the homeless.

- *The health consequences of housing improvement and change.*

Finally, there is the expanding but still limited literature relating to changes in people's housing conditions and circumstances, from home improvements to accessing a different property.

The following review summarises the literature and research base relating to each main theme, and the sub-themes associated with them. The focus has been placed on research undertaken within the past decade and includes evidence from Europe and North America. For each theme, specific methodological issues are also highlighted. Table 5.1 provides a summary of the outcome of the review.

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Table 5.1: the Home, the Residential Environment and Health - Research and Literature Review

Housing Condition: main category	Housing Condition: sub-category	Health Impact	Potential Response	Policy	Policy Tools
The home: impact on physical health	Temperature: cold	Excess winter deaths/respiratory infections/ischemic heart disease, myocardial infarction and strokes/broncho-spasm/hypothermia	Investment Maintenance Home improvement Neighbourhood renewal	&	Housing Health & Safety Rating System (HHSR) Decent Homes Reducing fuel poverty Improving heating systems Energy efficiency
	Humidity: dampness, condensation, fungal/mould growth	Asthma, rhinitis and alveolitis/respiratory problems/asthma/chronic bronchitis/eczema/tuberculosis, diarrhoea	Investment Maintenance Home improvement Neighbourhood renewal	&	HHSR Decent Homes Home improvement Improving ventilation
	Indoor air quality: Environmental Tobacco Smoke (ETS)/house dust mites	Allergies/asthma/respiratory problems/lung cancer			HHSR Decent Homes Allergy & asthma prevention Smoking cessation
	Sanitation	Water born infections	Investment Maintenance Home improvement Neighbourhood renewal	&	HHSR Decent Homes
	Lead	Lead poisoning/neurological and intellectual development	Investment Maintenance	&	HHSR Decent Homes

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Housing Condition: main category	Housing Condition: sub-category	Health Impact	Potential Response	Policy	Policy Tools
			Home improvement Neighbourhood renewal		
	Radon gas	Lung cancer	Investment Maintenance Home improvement Neighbourhood renewal	&	HHSR Decent Homes
	Noise, space (including overcrowding) and light	Increased risk of infectious or respiratory disease/reduced stature	Investment Maintenance Home improvement Neighbourhood renewal	&	HHSR Decent Homes
	Safety at home, including carbon monoxide	Accidents, including fire and poisoning			HHSR Decent Homes Home improvement Neighbourhood renewal Accidental injury/fire prevention
The home: impact on mental health	Public safety, security and the effects of crime	Anxiety, shock and depression	Investment Maintenance Home improvement Neighbourhood renewal	&	HHSR Decent Homes Neighbourhood management/wardens/local policing
	Overcrowding	Anxiety and depression/developmental	Housing supply and		Increase housing supply/re-model/re-

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Housing Condition: main category	Housing Condition: sub-category	Health Impact	Potential Response	Policy	Policy Tools
		delay	options services e.g., support		provide Housing options services
	High-rise flats	Anxiety and depression, especially among women			HHSR Decent Homes Home improvement Neighbourhood renewal
	Mortgage insecurity	Anxiety and depression	Impact of Recession Housing supply and options services e.g., support		Increase housing supply/re-model/re-provide Mortgage rescue packages Housing options services
	Housing instability	Anxiety and depression Vulnerability to HIV/AIDS	Impact of Recession Housing supply and options services e.g., support		Increase housing supply/re-model/re-provide Housing options services
The residential environment: Impact on physical health	Access to services: including health care	Inadequate health care	Neighbourhoods for health Place making. Regeneration		CABE 'Building for Life' Enabling planning/planning as problem solving/public health in planning
	Open, green and play space	Obesity	Neighbourhoods for health Place making. Regeneration		CABE 'Building for Life' Walkable neighbourhoods Green infrastructure Cycle routes
	Traffic: levels, noise & air pollution	Accidents	Neighbourhoods for health Place making. Regeneration		CABE 'Building for Life' Traffic calming Speed restrictions Home Zones Cycle routes School routes
	Air pollution	Asthma/respiratory problems	Neighbourhoods for health Place making.		CABE 'Building for Life'

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Housing Condition: main category	Housing Condition: sub-category	Health Impact	Potential Policy Response	Policy Tools
	Noise pollution	Depression	Regeneration Neighbourhoods for health Place making. Regeneration	CABE 'Building for Life'
The residential environment: impact on mental health	Safety, security & anti-social behaviour	Anxiety, shock & depression	Sustainable communities and crime Regeneration Design	CABE 'Building for Life' Neighbourhood management/wardens/local policing
	Sense of community	Wellbeing	Community cohesion	CABE

(Source: HVC Review)

5.2.7a The home: impact on physical health

Overview

The impact of the home on physical health, and especially of hygro-thermal conditions, especially cold and damp, remain at the heart of analysis of the health impact of housing, with research and literature focused on a range of associated sub-themes.

The relationship between these housing conditions and health are most widely accepted, although studies involving consultation with adults and children, for example in relation to the impact of dampness on health (Packer et al 1994), have been criticised for their reliance on self-reporting or 'subjective' measures of illness.

Air temperature

Health issue

The causal relationship between cold and ill-health, especially among the elderly, is one of the most strongly established with cardio-vascular and respiratory conditions resulting in 'excess winter deaths', though hypothermia is estimated to constitute no more than 1% of the total. The generally accepted measure is that for every degree Celsius by which a winter is colder than average, there are 8,000 excess winter deaths in Britain, principally amongst those of retirement age (Aylin et al, 2001). Cold weather has been estimated to result in 40-50,000 more deaths between the beginning of December and the end of March, a trend which varies between socio-economic groups (Donaldson and Keatinge 2003, Lawlor et al, 2000, Shah and Peacock, 1999) and which is much greater for than for comparable countries including those with more severe winters (Healy, 2003).

Cold houses are especially linked to:

- Respiratory illness, people living in poor homes are estimated to be twice as likely to have poor chest health;
- Cardiovascular problems; and
- Increased risk of injury.

The LARES study has reported that the following factors were statistically significant:

- respiratory health is affected by dissatisfaction with the heating system, persistent damp and condensation, and is also higher in areas with high relative humidity (after compensating for age, height, socio-economic status (SES) and smoking);

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- cardio-vascular problems are affected by the number of temperature related complaints in winter, persistent mould and fuel poverty (after compensating for age, height, weight and gender);
- arthritic problems appear linked to temperature complaints and the annual mean outdoor temperature (after compensating for age, gender, weight and smoking);
- the most frequent temperature complaints were about thermal insulation, ill-fitting windows and poor heating systems.
- homes with mould problems are more likely to have a high number of occupants (creating generating moisture). The building related factors, in order of effect, are homes that:
 - report dissatisfaction with thermal insulation;
 - dissatisfaction with heating systems; and
 - those with draught problems;
 - all of which are more likely to have mould (after compensating for climate).
- Building-related risk factors for those people believing that their home was affecting their health (poor sleep, low interest in activities, low self-esteem, decreased appetite), were in order, after compensating for high number of inhabitants, low SES, gender, height and smoking:
 - dissatisfaction with insulation
 - persistent damp
 - dissatisfaction with heating system.

Housing implication

Both indoor and outdoor temperature have an approximately equal effect in excess winter mortality but there is strong evidence that the quality of British homes, especially their thermal efficiency and therefore the difficulty of heating them are a contributory factor, especially for vulnerable households.

Wilkinson et al (2004) found five major determinants of cold indoor temperatures in UK properties:

- the age of dwelling (the older, the colder);
- the absence of/dissatisfaction with the heating system;
- the cost of heating the dwelling (highest is colder);
- low household income (less is colder); and

- household size (smaller is colder).

The principal temperature-related housing issue is therefore people living in older, badly heated and hard to heat homes who are:

- suffering from or vulnerable to ill-health living in cold homes;
- older people; and/or
- other low income households living.

Clearly, a combination of these factors will increase the level of risk to health.

Indoor air quality

It is estimated that people spend in the region of 80% of their lives indoors and therefore, the quality of internal air is crucial to health. The literature tends to focus on dampness and associated health problems, and on conditions associated with home lifestyle, principally Environmental Tobacco Smoke (ETS) also referred to as 'second-hand smoking', and house dust mites (HDM). Consequently, each has been dealt with separately below

Indoor air quality 1: humidity, dampness, condensation and fungal/mould growth

Health issue

The research literature tends to treat dampness, condensation and mould growth collectively and, despite methodological concerns over 'self-reporting' and the difficulty of controlling for such factors as poverty and smoking, the causal relationship between them and ill-health is widely accepted, especially where they are associated with cold indoor temperatures and in relation to children.

Dampness-related health effects identified include throat and eye irritations, allergies (such as allergic rhinitis), respiratory symptoms (dry or productive cough, wheeze) and asthma, as well as increased incidence of respiratory infections (Peat, Dickerson and Li, 1998). Some studies show a relation between dampness and mould and objective measures of lung function (Chapman et al, 2003). Many moulds are allergenic and provide a food supply for house dust mites which are in turn allergens. It has been estimated that in the region of 13% of childhood asthma may be attributable to dampness in the home (Burr et al, 1988).

The research literature identifies the effects on adults and the particular vulnerability of children to the effects of dampness and condensation resulting in higher symptom rates for respiratory problems, headaches and fever (see for example, Strachan, 1987).

LARES survey findings reinforce those from the research literature that mouldy homes are associated with allergic and respiratory symptoms, cerebral stroke, heart attack and hypertension, diarrhoeal disease, fatigue, headache, chronic anxiety and depression.

Housing implication

Home humidity of 70% is considered to provide the ideal environment for mould growth with condensation encouraging mould, fungi and micro-organisms to grow. Condensation is caused by poor construction quality and inadequate heating, including lack of central heating, insulation and ventilation.

Indoor air quality 2: Environmental Tobacco Smoke (ETS) and house dust mites (HDM)

Health issue

Damp housing provides the perfect environment for HDMs, and as mentioned above, they can trigger allergic reactions, most significantly, asthma and especially for infants.

The medical literature on the health risks of ETS or 'second hand smoke' is increasing, with widely quoted figures of the risk of lung cancer increasing by 24-30% when living among smokers (BMA, 2003) and a quarter of all lung cancers occurring in non-smokers, in the region of 400 deaths per annum in the UK.

According to a recent study, each year passive smoking at home might account for approximately 2,700 deaths in persons aged 20–64 years in the UK, and 8,000 deaths among people aged 65 or above (Jamrozik, 2005).

ETS is also a factor in eye, nose and throat irritation, myocardial infarction and adult asthma (Dejmek et al, 2002)

Housing implication

The growth of house dust mites depends on a combination of temperature and humidity - a minimum of 50% and 17-25 degrees centigrade to thrive - and the age, use and cleanliness of soft furnishings (Gotsche et al, 2004).

Cleaning is the main preventative measure as HDMs feed on human skin and high levels are found in mattresses and other soft furnishings.

ETS is a use rather than a house condition issue, with ventilation and air cleaning the main preventative measures.

Radon gas

Health issue

Radon is a radioactive gas producing lead and bismuth emitted by uranium in soil and rock. Once produced, may be “captured” and concentrated in indoor air, and when inhaled, it irradiates tissue in the body, especially in the lungs, a process exacerbated by smoking. The established health effect of radon gas is lung cancer, resulting in up to 2,500 UK deaths annually (Darby et al, 2005; Field et al. 2000).

Housing implication

This is not a generalised problem as exposure to radon gas is dependent on geographical location with problems especially concentrated in the south west of England.

Lead

Health issue

Vehicle exhaust fumes, paint - especially on imported children’s toys - and water piping are the main sources of lead intake. Research has established the impact of lead on children’s neurological and intellectual development, even with low level exposure, as measured by IQ (Brown, 2002, Pocock et al, 1994).

Housing implication

Older homes with lead water piping and those located adjacent to high concentrations of exhaust fumes are most likely to be affected (WHO 1995). Water companies will replace lead pipes leading into a property, the householder is responsible for those inside it.

Safety at home

Health issue

This is a huge health-related housing area. Accidents are major causes of injury and death in the home, especially to children and young people, but they also increase with age. It is estimated that injury at home results in over 4,000 deaths in the UK annually, and 6 million people attend Accident and Emergency Departments or visit general practitioners as a result of them (Centre for Reviews and Dissemination (1996a and b).

More serious categories of accidents at home include:

- Falls among the elderly;

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- Nitrogen dioxide and carbon monoxide emitted from faulty cooking and heating equipment, especially where associated with poor ventilation, and associated with respiratory problems; and
- Domestic fires, which are more prevalent in lower income areas, with cigarette smoking the second highest cause of house fire injury causing as many as one third of all fatalities (Watson et al, 2000).

Housing implication

This is an issue where it is difficult to separate house conditions, especially design and maintenance, from other variables including behaviour, care, supervision and general state of health. However, one study has estimated that design features in the home contribute to as many as 10% of injuries to children (BMA, 2003).

The LARES survey results suggest that the likelihood of any accident is increased where:

- there is dissatisfaction with the dwelling size and/or layout;
- bedrooms are shared;
- the home is considered too warm or too cold;
- there is poor natural lighting or glare;
- there is dissatisfaction with the kitchen or insufficient workspace; and
- there are problems of sleep disturbance.

Accessibility is essential in enhancing older and/or disabled people's possibilities to live independently in society (Steinfeld, 1999).

Smoke alarms allow fires to be discovered more quickly and reduce risk and all new homes and all those in the public sector must now have mains wired alarms.

Noise, space (including overcrowding) and light

Health issue

Domestic noise is the main source of complaint to Environmental Health Officers and its effects include impaired concentration, irritability and sleep deprivation (Lercher et al, 2002, and Rosenlund et al., 2001). Noise acts as a stressor by disturbing sleep at night and strong annoyance during the day which may impair cardiovascular and mental health.

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It has been estimated that over 10% of adults in Europe suffer from chronic sleep disturbance which requires treatment, and another 10% suffer from occasional sleep disturbance (Stansfield et al, 2000 and 2003).

Overcrowding is more prevalent among lower income households, and is associated with respiratory infections, including tuberculosis (TB) and enteric diseases, including diarrhoea (ODPM, 2004).

Housing implication

This is also an issue where the ability to separate house conditions from other variables including poverty and poor diet is difficult to achieve.

5.2.7b The home: impact on mental health

Overview

This theme evolved over concern, arising in the inter-war years, of the impact of overcrowding in older industrial housing and of families living in new municipal flats, especially on upper floors.

LARES has established that people are significantly more depressed and anxious when they live in a home that does not:

- offer sufficient protection against external aggressions: noise, vibrations, dampness, moulds, draughts, cold in winter;
- provide personal space through overcrowding or poor architectural design, or to feel free in one's home;
- provide sufficient light and/or does not offer a good window view of the outside environment;
- facilitate socialization (through an absence or parks and gardens);
- and is prone to vandalism.

It is also accepted that stressful housing conditions can aggravate pre-existing psychiatric pathologies (Evans, 2003).

Overcrowding

Health issue

Several studies, particularly in the field of social and environmental psychology, have demonstrated the influence of environmental factors such as pollution, level of noise and overcrowding on mental health (Gomez-Jacinto/Hombrados-Mendieta 2002).

Controlling for such factors as socio-economic group, unemployment and the presence of children, studies have identified a relationship between overcrowding and psychological symptoms.

Housing implication

The main concern here is the supply of family housing for lower income households, especially in high demand, high value areas.

Public safety, security and the effects of crime

Health issue

The concept of public safety encompasses the overlapping subjective conditions of a general perception of safety and a specific fear of crime (Austin et al. 2002). The 2002/2003 British Crime Survey estimated that fear of crime impacts significantly on the quality of life of 7% of the population and has a lesser impact on a further third of people.

There is a growing understanding of the extent to which physical or environmental cues such as the presence of graffiti and fly tipping, strangers and groups of young people 'hanging around' are associated with feelings of insecurity (Halpern 1995, Mozingo 1995).

Within the home, there is a wide range of identified risks from domestic violence to physical injury from an intruder to associated feelings of shock and depression. Fear of crime is a recurrent problem, especially for the elderly, the poor and for women.

LARES has established that:

- heightened anxiety is a symptom of some illnesses; and
- people in poor general health tend to be more anxious.

Housing implication

In view of the scale of house crime and domestic violence, these are two major areas of housing-related health problems. Improvements in home security and housing design can have a major impact on the incidence of house crime and fear of crime.

Living in high-rise flats

Health issue

This is another issue where the ability to separate house conditions from other variables, such as poverty, illness and social problems, is a challenge. It can also be difficult to disentangle urban myth from housing reality where the ‘problem’ of living in public sector flats disappears when the focus is placed on private sector apartments. Research (for example, Bonnefoy et al, 2003b and Green et al, 2002)) has centred on the impact on families of living in high-rise flats, especially:

- illness among children;
- restricted development in children; and
- depression among mothers.

Housing implication

Since the 1980s, the general view has been that the upper floors of public sector high-rise flats are unsuitable for families, especially with young children, but faced with shortages of social housing, such policies have been reversed or abandoned by providers.

Housing instability and mortgage insecurity

Health issue

These issues were identified during the previous economic recession of the late 1980s and have reappeared during the current economic situation. They mainly concern feelings of anxiety, hopelessness and depression among those who fear, risk or experience the loss of their mortgaged or privately rented home (Nettleton and Burrow, 1998).

Housing implication

The fundamental issue is one of housing supply and cost, mortgage rescue packages and other flexible responses to mortgage debt.

5.2.7c The residential environment: impact on physical and mental health

Overview

“There is increasing acceptance of evidence that area of residence may influence health either by adding to or interacting with the individual characteristics of residents” (BMA, 2003, p.41).

Whilst this may be so, the extent of acceptance will depend on the quality of evidence, and in complex situations of interaction and causality, this is even more difficult to achieve than for the health impact of conditions within the home.

Spatial variations in health are easily demonstrable, but there is a major issue concerning whether these effects are 'compositional' - resulting from concentrations of certain types of people by location, or 'contextual' - resulting from the characteristics of the neighbourhood - or both! Methodological approaches developed include:

- Comparing the health of groups of residents in contrasting locations at the same time;
- Comparing the health of groups of residents in comparable locations at the same time, and assessing the impact of improvement or other change in one area; and
- Comparing the health of groups of the same residents in the same location over time, and assessing the impact of improvement or other change.

Strong associations have been established between mental health and the built environment, and the development of this theme has accompanied attempts to assess the impact of urban regeneration and neighbourhood renewal, including 'quality of life' measures (Diener and Eunkook, 1997).

Impacts on physical and mental health

The literature has developed in two directions:

1. Considering the direct health effects of the quality of the residential environment, such as the incidence of crime and fear of crime, and of improvements to areas; and
2. Considering the indirect health effects of the quality of the residential environment, such as access to services, including health provision, and of improvements to areas.

Over the past decade, research (Cattell, 2001; Dunn, 2002; Ellaway and Macintyre, 2000; Ellaway et al, 2005; Evans, 2003; Handy et al, 2002; Latkin and Curry, 2003 and Stafford and Marmot, 2003) have provided evidence that the health status of residents is affected by the quality of the residential environment. This influence is based on two mechanisms, firstly, that improved residential quality and reduced residential stressors directly lead to lower exposure to pathogenic factors, and secondly, that improved neighbourhood quality increase resident satisfaction and quality of life.

Despite the diversity of areas and uniqueness of local problems, there are five general features of local areas that appear to have a direct or indirect influence on health (Macintyre and Ellaway, 2000):

- physical characteristics of the shared environment;

- healthy environments in general, referring to the conditions at, and the functionality of, home, work, school or recreational settings;
- services provided to support the daily life of residents;
- socio-cultural features of neighbourhoods; and
- the reputation of the neighbourhood.

These five points indicate that residential neighbourhood quality covers a wide range of aspects, including physical and social characteristics as well as subjective dimensions.

Evidence quoted by the 2009 Built Environment report of the Marmot Review identified the following health potential of the built environment:

- physical activity through the presence of green space not only reduces the risk of heart disease (by up to 50%), but also has a positive impact on stress, obesity and a general sense of well being. It also cuts the risk of premature death (by 20-30%);
- green infrastructure, including green spaces and 'walkable 'neighbourhoods'', has a significant impact on health, mental health in particular, and wellbeing in general;
- child and elderly friendly environments have a beneficial impact on health, including community facilities and meeting points, engagement in decisions and local services and sociability, neighbourliness and sense of security; and
- growing things, community gardens, allotments, trees etc are all positive in health terms.

One of the most important objectives of LARES has been to attempt to identify and quantify the impact of environmental aspects such as green space, safety, amenities and noise, and perceived environmental quality (air, light, view etc.) on resident satisfaction and quality of life. Preliminary findings are that:

- there are a variety of associations between general environmental quality, and residential satisfaction or quality of life indicators;
- associations are found between residential satisfaction and quality of life indicators, showing that increased satisfaction with the living conditions supports a better quality of life and wellbeing;
- satisfaction with the dwelling is significantly related to the perception of air quality, and the visual appearance of the neighbourhood;

- satisfaction with the residential area is associated with level of noise exposure, perceived annoyance due to environmental problems, and the presence and quality of greenery and vegetation; and
- quality of life is most strongly linked to the overall satisfaction with the residential environment, air quality, and dampness.

Research has focused on the following specific aspects of the residential environment:

Noise exposure

Noise exposure and its effects including sleep disturbance, emotional and hormonal effects and increased risk of cardiovascular problems have been examined by Lercher et al., 2002; Sharp, 2002; Stansfeld and Matheson, 2003; Stansfeld et al., 2000.

Traffic

The location and structure of neighbourhoods in relation to traffic flows, both as originator of noise and as a cause of air pollution have been examined by Nakahara et al., 2004 and Thomson et al., 2003.

Outlook from the home

The positive effects of a view of natural scenery have been examined by Kaplan, 1995 and Ulrich, 1991.

Public, open and green space

Research examining the meaning and importance of public and social places includes Thompson, 2002, and of green and open spaces, and vegetation in urban settings, Attwell, 2000; Botkin and Beveridge, 1997.

Physical activity reduces the risk of obesity, cardiovascular disease, diabetes and stress and the availability and quality of green open spaces as places for physical exercise have been examined by de Bourdeaudhuij et al., 2003; Emery et al., 2003; Giles-Corti and Donovan, 2003 and Hume et al., 2005.

Crime and insecurity

The impact of neighbourhood insecurity has been examined by Chandola, 2001; Green et al., 2002 and Latkin and Curry, 2003.

Resident satisfaction

The significance of residents' assessments of the quality of their residential environment have been examined by Anderson and Weidemann, 1997 and Türkoglu, 1997

The health impact of housing change

This is a key area for the purposes of this review, but systematic analysis of the health consequences of housing change, including improvements to housing or residential environments, is recent and limited (see for example Atkinson, 2004 and Evans, M. 2002; Stewart and Rhoden, 2003; Thomson et al, 2001, 2002 and 2003). One of the reasons for this is the methodological difficulty - in complex and multi-factorial situations - of identifying the separate causal impact of housing conditions. In their systematic review of such studies, NICE identified only 18 papers which used robust experimental approaches on the basis of which the following conclusions were drawn:

In relation to refurbishment and renovation

There is review-level evidence that:

- housing interventions involving improvements to energy efficiency measures, such as installation of new windows, can positively affect health outcomes;
- home hazard modification interventions that seek to remove and repair safety hazards are effective in reducing falls in older people. This effect was strongest for people with a history of falling prior to intervention and men aged over 75 years;
- home visits to people in lower socio-economic areas plus provision of advice on home hazards, combined with health education and media campaigns, are effective in encouraging parents to make physical changes to the home environment to ensure their homes are safer;
- the provision of free or discounted home safety equipment and/or educational campaigns may lead to behavioural and environmental change.
- community-based interventions that provide free smoke alarms (with or without installation) may reduce fire-related injuries; and
- the use of cleaning and/or chemical measures may lead to a reduction in allergen load for those with house dust mite-provoked respiratory disease when combined with maintenance drug treatments.

There is a lack of review-level evidence of:

- the effectiveness of interventions involving general refurbishment initiatives in improving health outcomes;

- the effectiveness of provision of home safety equipment and/or educational campaigns in reducing physical injuries in children and young adults through modification of the home environment;
- the effectiveness of interventions in reducing the risk of injurious falls in older people through modification of the home environment compared with control measures; and
- The effectiveness of air filtration systems in improving health outcomes in people with asthma or of interventions that aim to reduce exposure to house dust mite allergen in the home in improving health outcomes in people with mite-sensitive asthma.

There is conflicting review-level evidence on:

- The effectiveness of interventions comprising healthcare counselling or education, provision of safety information or free thermometers in encouraging people to use safe hot water temperatures.
- effectiveness of education-based interventions combined with provision of discounted smoke detectors in increasing the proportion of people that install smoke detectors.

In relation to re-housing and neighbourhood regeneration

There is review-level evidence that:

- anxiety and depression scores are reduced in people who are re-housed on the basis of medical need; and
- re-housing people from slum areas can improve self-reported physical and mental health outcomes in the longer term (18 months) but can adversely affect self-reported health outcomes in the short term (9 months).

There is a lack of review-level evidence:

- of the effectiveness of re-housing from a socially isolated area or substandard housing in improving health; and
- of the effectiveness of interventions involving re-housing or housing improvement combined with neighbourhood regeneration initiatives in improving health outcomes;
- the effectiveness of interventions involving mixed-income housing developments in improving health outcomes.

The Marmot's Built Environment group summarised evidence of interventions that work as follows:

- many government interventions to improve and equalise poor areas don't reduce health gap but do improve the basic conditions that may, in the long run, improve health;
- neighbourhood management and neighbourhood wardens have improved area conditions, increased involvement, led to more local delivery and therefore shown measurable improvements in quality of life and wellbeing. They have also closed the gap on crime, education, jobs etc
- many experiments in local policing have shown a steep fall in crime and some reductions in fear of crime;
- many NGOs show beneficial links between safe cycle routes, cycle/walk to school and children's health (Sustrans); benefits of cared for outdoor spaces (Groundwork); the link between community; involvement of itself and a sense of wellbeing (City Survivors; Empowering Communities, Trafford Hall, co-operatives and credit unions) inner city farms and allotments. There are many other examples. These bodies focus on trying to benefit lower income groups;
- New Deal for Communities: like most large scale regeneration schemes has proved slow and rather cumbersome. But unlike earlier programmes it had a high element of community involvement and supported many local projects. The measurable outcomes have shown a closure of key gaps (education, crime, jobs, poverty, and environments) and much greater satisfaction with areas.
- planning vision versus planning control - Planning as local enabler and problem solver; and
- overall action to target specific area-based problems and disadvantages through local action and involvement has shown some significant gains and closing the gap-at least in the sense of wellbeing, belonging, and overall conditions. It seems reasonable to assume that if sustained, it should feed through into better health. Indeed, whole primary preventive health (e.g. health visitors) initiative, through local delivery in poor areas, has shown improved health outcomes and the gap is closing.

5.2.8 Research in the West Midlands

This sub-section reviews the limited number of studies undertaken with reference to the West Midlands as follows:

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CURS, University of Birmingham (2000) Spatial Variations in Housing and health Inequalities in the West Midlands, Housing Corporation

This paper reviews quantitative evidence of the spatial distribution of housing conditions and health and their relationship across the region. The report identified:

- Concentrations of deprivation;
- Intra-rural and intra-urban differences in health;
- Complex relations between tenure and health;
- Concentrations of hospital admissions and asthma admissions in inner urban areas;
- The limited predictive value of deprivation in relation to hospital admission rates; and
- a “tension between ‘common-sense’ public perceptions of the relationship between housing and health and the ‘evidence-based’ approach of public health and bio-medical research models”.

GHK with the University of Birmingham (2009) The South Birmingham Young Homeless Project: Evaluation Report.

The report provides an independent evaluation of the South Birmingham Young Homeless Project (SBYHP), which provides support to homeless young people and those at risk of homelessness, aged 16-25 years. The evaluation was commissioned with support from the South Birmingham Primary Care Trust (SBPCT), it aimed to establish and explore the outcomes that SBYHP achieves and to place these in the context of the PCT’s priorities for promoting improved health and wellbeing.

The evaluation established that SBYHP provides a high quality service that meets the needs of vulnerable young people in Birmingham and achieves health and wellbeing outcomes. By supporting parents, SBYHP are also promoting the health and wellbeing of children.

O’Mahony, J and Fitch, H. (2009), Housing and Health in Herefordshire. Setting the Agenda: how partnership working between the private sector housing team and the primary care Trust can help to improve the health of the residents of Herefordshire. The Herefordshire Council

The report uses Excess Cold/Fuel Poverty and Fall hazards as examples of how the Private Sector Housing Team at Herefordshire Council contributes to improving the health of Herefordshire residents and how, with partnership working with the PCT, preventative benefits can be improved by strategically positioning resources and services in the future. The HHSRS calculator in the Environmental Health toolkit is

used to show the cost benefit to the NHS of allocating funding to Private Sector Housing to reduce hazards with the potential to save the NHS in Herefordshire millions of pounds.

Smith, R. and Fowajuh, G (2009) *Excess Winter Deaths in the West Midlands, 2009. NHS West Midlands, West Midlands Public Health Observatory, Sandwell PCT*

The 'key messages' from this report are:

- The West Midlands Excess Winter Deaths Index (proportion of excess winter deaths to non winter deaths) is very similar to that of England.
- The West Midlands Excess Winter Deaths Index is no longer the highest of all regions.
- The 85+ age group within the West Midlands was confirmed as those most at risk of Excess Winter Deaths.
- There is wide range variation of the number of Excess Winter Deaths and Index values across Local Authorities and health economies within the West Midlands.
- Similar to other studies, circulatory and respiratory disease groups contribute the most to Excess Winter Deaths in the West Midlands.
- Evidence suggests that the "Fuel Poverty Indicator" can be useful to target interventions across Local Authorities and health economies within the West Midlands.
- There appears to be a relationship between levels of Excess Winter Deaths and the amount of non-decent housing within the West Midlands.

We have also been advised, through stakeholder consultation, of the following research initiatives, though no output is currently available:

- Birmingham City Council has undertaken some research into the provision of services to people as they get older, including planning for retirement to understand motivations for work; approaches to retirement planning etc. Findings so far include the potential to link people to undertaking public/community focused activities as it is more likely that people involved in this kind of activity will remain living in the area once they retire. There is also a likelihood that this activity will impact on productivity at work.
- GOWM has procured a scoping exercise from MWB Consultancy in relation to PSA 16 to identify action in relation to housing.

Given that the profile of tenants in the social housing sector, Midland Heart is undertaking a number of research projects concerned with the impact of ageing, contacts are Chris Mundy, Director of Care and Support and Neil Tryner, Head of Performance.

5.2.9 Conclusions

“Housing and health are crucial components of our daily lives. Although the relations between housing and health have been recognized for centuries, there still is little consensus about the nature of these relations” (Lawrence, 2004).

The fundamental problem behind a lack of consensus over the relationship between housing and health is the adequacy of evidence which is capable of dealing with multi-dimensional conditions. There is a spectrum of evidence ranging from the health impact of physical housing conditions, over which there is general agreement, through to those associated with the impact of the wider residential environment, where the multi-dimensionality of the situation is such that causal relationships are difficult to determine.

Returning to the initial agenda, this has been extended to include the wider residential environment, and the following table summarises the level of confidence in evidence of an impact on physical and/or mental health. It must be emphasised that this is a judgment-based assessment and given the constraints on resources available, it is based on:

- the volume and currency of research studies completed by topic; and
- the conclusions of other reviewers.

The table demonstrates that confidence in the evidence of the impact of the Home Environment on physical health is highest in relation to:

- cold;
- humidity, dampness, condensations and fungal/mould growth;
- Radon gas; and
- home safety and accidents

Then in relation to:

- Environmental Tobacco Smoke and house dust mites
- overcrowding

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- noise; and
- home security and the effects of crime

Confidence in the evidence of the impact of the Home Environment on mental health is highest in relation to:

- noise; and
- public safety, security and the effects of crime.

Confidence in the evidence of the impact of the Wider Residential Environment on physical health is highest in relation to:

- noise.

Confidence in the evidence of the impact of the wider Residential Environment on mental health is highest in relation to:

- noise;
- public and open space; and
- public safety, security and the effects of crime.

There is a medium level of confidence in the health benefits of housing and neighbourhood improvement, but only low confidence in the health benefits of new housing.

Overall, the greatest health impact is likely to be achieved when the following conditions are tackled:

- cold;
- internal air quality, ranging from dampness to Environmental Tobacco Smoke;
- noise;
- overcrowding;
- home safety and accidents;
- security and the effects of crime; and
- public and open space.

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Table 5.2: evidence of a housing impact on health: confidence levels

General Condition	Specific condition	Confidence in evidence of a housing impact on physical health			Confidence in evidence of a housing impact on mental health		
		High	Medium	Low	High	Medium	Low
The Home Environment							
Air temperature	Cold	✓					
Indoor air quality	Humidity, dampness, condensation & fungal/mould growth	✓					
	Environmental Tobacco Smoke & house dust mites		✓				
	Radon gas	✓					
Lead		✓					
Noise, space and light	Overcrowding		✓				✓
	Noise		✓			✓	
Home safety and accidents		✓					
Home security & the effects of crime			✓			✓	
Living in high-rise/multi-storey flats							✓
Housing instability and mortgage insecurity							✓
The Residential Environment							
Physical	Appearance						✓
	Noise		✓			✓	
	Traffic			✓			✓
	Outlook						✓
	Public and open space			✓		✓	
	Services provided						✓
Social/psychological	Reputation						✓

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General Condition	Specific condition	Confidence in evidence of a housing impact on physical health			Confidence in evidence of a housing impact on mental health		
		High	Medium	Low	High	Medium	Low
	Public safety, security & the effects of crime		✓			✓	
	Social contact						✓
	Resident satisfaction						✓
The Health Benefits of Changes to the Home and/or Residential Environment							
Home Improvement			✓			✓	
Improvement to the Residential Environment			✓			✓	
New Market Housing				✓			✓
New Social Housing				✓			✓

(Source: HVC Review)

5.3 Housing and Health: review of evidence from Joint Strategic Needs Assessments

5.3.1 Introduction

This sub-section reviews the approach of each of the West Midlands Joint Strategic Needs Assessments (JSNAs) and the extent to which they incorporate housing/health themes, and provides best practice recommendations concerning the analysis of housing and health. A detailed review of relevant content is provided at Appendix E.

5.3.2 Review

Overview

The full list of JSNAs, date of completion and inclusion in the reviews is as follows:

- Birmingham Baseline Profile 2008/09 (not available)
- Coventry Initial Strategic Assessment 2007
- Dudley 2007
- Herefordshire 2008
- Sandwell v6 2008
- Shropshire 2008
- Solihull (no date)
- Staffordshire 2007
- Stoke-on-Trent (Summary no date)
- Telford and Wrekin (Not Available)
- Walsall 2009
- Warwickshire 2009
- Wolverhampton 2008
- Worcestershire 2008/09

A clear process informs the production and use of JSNAs. The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier local authorities and PCTs to undertake Joint Strategic Needs Assessment (JSNA). JSNA is a process intended to identify the current and future health and well being needs of a defined local population, inform the priorities and targets set by Local Area Agreements and lead to agreed commissioning priorities that will improve outcomes and reduce health inequalities. (Source: *DH Guidance on JSNAs 2007*).

JSNAs require contributions from a range of stakeholders, including statutory partners in the Local Strategic Partnership, providers from the public, private and third sectors and members of the local community. JSNA is a continuous process, all contributors should engage with each other throughout and refine their analyses as part of this ongoing process.

The statutory guidance emphasises that, as part of a strengthened commitment to local priorities, JSNAs should be taken into account by the local authority and its partners in preparing the Sustainable Community Strategy. The issues identified by a JSNA should inform the priorities and targets set by the Local Area Agreement, the delivery agreement for the Sustainable Community Strategy (Source: Local Government and Public Involvement in Health Act 2007, P 4 DH Guidance on JSNAs 2007).

JSNAs should contain a range of information to inform a number of other local authority and PCT strategies and plans. Ensuring linkage of these plans is intended to encourage joined-up commissioning across health and social care, and will have a positive impact on locally provided services. The following are examples of Strategies/Plans which are commonly linked to JSNAs:

- PCT and Local Authority commissioning strategies
- PCT Local Delivery Plans
- Children and Young People's Plans
- PBC commissioning plans
- Local development plans
- Community regeneration strategies
- PCT Pharmaceutical Needs Assessments
- Supporting People strategies
- Housing strategies
- Community safety strategies
- Carers strategies
- Workforce planning strategies

Community engagement can be a resource intensive process and PCTs and local authorities should work together, respecting the time and efforts of local people. Many PCTs and local authorities already have wider engagement and consultation strategies in place, and should build on the duties to consult and involve and optimise available listening opportunities such as LINKs and Citizens Panels.

JSNA relies on good quality data. The core dataset (Annex B) is a resource that signposts users to a range of existing data sources that can assist the JSNA process. The dataset is being developed to inform the set of indicators which support the Department of Health's key outcomes and the Local Government National Indicator Set for local authorities, either working alone or in partnership. Local areas will be expected to supplement the core dataset with additional, locally relevant information to add depth and insight into the needs of their populations, having locally agreed standards on data quality for inclusion.

As set out in the draft statutory guidance *Creating Strong, Safe and Prosperous Communities*, the *Sustainable Community Strategy* must be based on sound evidence. JSNA should identify the health and well being needs of local areas, contributing to this evidence base. JSNA should provide a framework for examining

all the factors that impact on the health and well being of local communities, including employment, education, the environment and, of course, housing. Local authorities and PCTs should therefore build on the core dataset, using clearly defined criteria to select additional, high quality and locally relevant information that provides a clear picture of their area.

Evaluation

Whilst the JSNA process has the same aim for all the West Midlands PCTs and local authorities, and the JSNA Guidance allows for some flexibility in approaches so they can be tailored to the community, many different approaches have been taken.

All JSNAs should be evidence based; however, some JSNAs choose to include analysis of the data in the main document and others keep the data analyses separate either in another document or in the form of an electronic database held elsewhere. Some JSNAs keep their evidence base in a Local Information system on a website including small area mapping.

The JSNA should be linked to and feed back into the Local Area Agreement, Sustainable Community Strategy and other relevant strategies/plans. Some JSNAs refer to some strategies and others refer to many strategies/plans. Some JSNAs include the relevant parts of strategies/plans in such a way that it is clear how they are related. Some JSNAs include housing strategies or other housing related strategies/plans and others do not.

Some JSNAs have included geographical analyses of smaller areas such as Wards or ONS Lower Super Output Areas or Priority neighbourhoods. Other JSNAs have presented data at local authority or county level. Some JSNAs have carried out geographical analyses within a Local Information system elsewhere on a website enabling them to target local need.

Some JSNAs have used geo-demographic datasets to enable them to target resources at the areas most in need, and also to predict future needs. Some have only mentioned these datasets but not made full use of its capability and most do not include this type of data. The 2008 DH Core Dataset includes the ONS Classification (free dataset) or other social marketing datasets such as MOSAIC, ACORN, Places and People could be used if available.

Some JSNAs provide analyses of general housing data such as tenure, overcrowding, affordability etc. and others provide little or no housing data. Some JSNAs also present analyses of housing and health data in a linked way, such as data on social housing and higher emergency admissions to hospital, or lower life expectancy in priority neighbourhoods.

The quantity and quality of housing/health data analyses is very variable in the West Midlands JSNAs. This may be a reflection of how important these issues are within different geographical areas or it may be due to how closely the JSNAs are based on

the recommended Core Dataset from the DH Guidance and how much they have added to this. The original Core Dataset in the 2007 Guidance included some data on Living Arrangements under the theme of Social and Environmental Context. It included tenure and overcrowding for everybody, and central heating plus living alone for older persons. The more recent 2008 Core Dataset also contains National Indicators on settled accommodation for people with learning disabilities (NI 145) and mental health problems (NI148).

5.3.3 Joint Strategic Needs Assessments: examples of good practice

Below are examples of good practice identified from a review of West Midlands JSNAs both in relation to the derivation and use of data followed by a table providing examples of good practice coverage in relation to housing and health. A further subsection provides a good practice model of these two aspects.

Birmingham JSNA

- Includes a section specifically on Housing
- Detailed list of all relevant strategies, Evidence Base and Needs Assessment, Local Area Agreement Targets, Services and any other local intelligence used to compile JSNA
- Includes some geographical ward based analyses
- Homelessness covered in relation to health

Coventry JSNA

- Comprehensive use of Strategies and Plans including main relevant points
- Detailed analysis of Priority Neighbourhoods
- Analysis of BME communities

Dudley JSNA

- Some Ward based analyses for health data
- Good detail on needs of older people particularly independent living and ways in which that can be better achieved but also assessment of sheltered housing and need for extra care for frail elderly

Herefordshire JSNA

- Particular focus on the disadvantaged
- Extends to all factors affecting quality of life and life chances reflected in a gap analysis and prioritised programme to fill most important gaps
- Includes some smaller area geographical analysis

Sandwell JSNA

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- Recognition of need to look at plans in place and needs of population in addition to analysis of socio economic data
- Good identification of information gaps
- Recognises need to involve stakeholders in identifying needs and acting on them
- Inclusion of maps and graphs to enhance output
- Some geographical analyses of Wards

Shropshire JSNA

- Will be live document on website with hyperlinks to ongoing needs assessments
- Information from qualitative surveys to include communities experience of existing services and thoughts on future design can be integrated into commissioning decisions
- Includes some maps to enhance analysis
- Some geographical analyses of smaller areas.

Solihull JSNA

- Use of geo-demographic datasets (Acorn, Places and People by Beacon & Dodsworth) to look at health patterns and predict future health concerns
- Inclusion of maps and graphs to enhance output
- Inclusion of some smaller area geographical analyses
- Inclusion of trends and comparative data

Staffordshire JSNA

- Demographic and social economic analysis,
- Analysis of health status, service user/carer perspectives (including community views where available)
- Involvement of both health and local government organisations
- Consideration of health inequalities/areas of greatest need
- Priorities of investment/service redesign to inform commissioning decisions

A separate Children's JSNA to support the Children and Young Peoples Plan
Includes maps, charts and tree maps to enhance analyses

Stoke on Trent JSNA (Summary only)

- Focus on Life Expectancy as key measure of health and identifies major areas where action needed to reduce inequalities in health outcomes
- Identifies need for data systems to be developed to capture needs of local people with physical and sensory disabilities, mental health needs and learning disabilities

Walsall JSNA

- JSNA is linked to Walsall's Health Inequalities Strategy
- Includes suggestions for improvement including more housing and other data, and a more detailed geographical analysis for parts of the borough
- Includes qualitative data on peoples needs in addition to quantitative data
- Identifies health and well being priorities emerging
- Identifies both short and longer term actions needed to reduce health inequalities and achieve better health and well being outcomes

Housing and Health

Walsall NHS set up a working group to look at areas of housing and health-related interventions with the aim of reducing the detrimental impact of housing on health and wellbeing in the borough. Walsall's working group identified several streams of work funding related specifically to mental health, the elderly and social housing regeneration.

Warwickshire JSNA

- Partnership mechanisms including Local Area Agreement, Sustainable Communities Strategy, Joint Commissioning Strategies and Housing and Homelessness strategies underpin JSNA
- Informed by Foundation report containing numerical and modelled data, and information from consultation exercises to capture view of stakeholders, patients, service users and carers.
- Includes some maps and tables to enhance analyses
- Includes some geographical analyses
- Includes wide range of vulnerable people

Wolverhampton JSNA

- Good use of geo-demographic data (MOSAIC) for targeting services to areas where groups in need are located and to assist with future projections
- Analysis of priority wards
- Identification of need for databank run by partners from which to draw on in the form of database linked to mapping tools, and investment in skills of staff responsible for data analysis

Worcestershire JSNA

- Separate JSNA for Children with interactive mapping available on a website to help identify local needs and plan service delivery at a local level.
- Data from the JSNA Core Datasets is available on a website including mapping.

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- Considers eight priorities identified by Worcester Commissioning Group and priorities from both the existing and new Local Area Agreement
- Includes some geographical analyses
- Includes wide range of vulnerable groups

The following table summarises examples of good practice in the coverage of housing and health issues.

Table 5.3: Housing and Health in Joint Strategic Needs Assessments: examples of good practice

Example	South	West	North	C1	C2	C3
Accessibility and adaptability of housing for those with long term needs						✓
Accidents in the Home				✓		✓
Adaptations to housing for those with physical and sensory disabilities	✓					
Alcohol misuse and problems with housing/homelessness	✓					
Ambulatory, community and home based services to increase						✓
BME groups and decent homes				✓		
Costs of accommodation people with dementia			✓	✓		✓
Decent homes essential for independent living						✓
Development of telemedicine to support users in home through care package						✓
Digital technology and social inclusion/quality of life						✓
Earlier preventative interventions and care at home						✓
End of Life Care	✓	✓			✓	
Excess winter deaths among vulnerable people	✓				✓	
Extra-care housing	✓				✓	
Fires risks in the home		✓				
Future health concerns and geo-demographic groups						✓
Fuel poverty, causes, estimates of numbers of households, older people and under occupancy						✓
Gap in housing provision/stable housing for drug users				✓		✓
Geographical concentrations of families with no central heating				✓		
Geographical variations in major health risk factors recognised						✓
Hard to reach groups for healthcare	✓				✓	
Gypsies and travellers and homeless people: health needs	✓				✓	
Helping people with mental health problems to live at home	✓	✓				
High density housing and quality of life					✓	
Home environment and effects on health						✓

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Example	South	West	North	C1	C2	C3
Homelessness: addressing results in health and social benefits						✓
Homelessness affects health and social inclusion				✓		
Houses in Multiple Occupation and Safety Risks				✓		
Housing asylum seekers and refugees	✓				✓	
Housing aspirations and quality of life in neighbourhoods					✓	
Housing construction and climate change link to dampness and respiratory disease					✓	
Housing for vulnerable groups e.g. people with mental health problems, learning disabilities					✓	
Housing needs of victims of domestic violence				✓		
Housing and support needs of children and young people	✓					
Housing and support needs of older people		✓			✓	
Identification of local needs in relation to social care, housing and health			✓			
Inadequate housing and health including hazardous and injurious conditions such as damp				✓		
Increased choice and control of people normally admitted to care homes	✓				✓	
Independent living and lifetime homes standards plus mobility needs		✓			✓	
Indirect link between housing and health – healthy homes provides confidence and opportunity				✓		
Initiatives to tackle deprivation including housing			✓			
Lack of central heating and poor health in the elderly	✓					
Links between BME communities and poor health indicators such as lower life expectancy					✓	
Links between decent housing and health well being				✓		
Links between homelessness and psychological health				✓		
Links between geo-demographic groups and higher limiting long term illness						✓
Links between illness, deprivation and housing quality						✓
Links between keeping homes warm, respiratory disease and life expectancy				✓		
Links between mental and physical health, domestic abuse and good quality housing in a sustainable environment	✓					
Links between older people and tenure (social housing) with high care needs/highest service users						✓
Link between poor housing and substance misuse	✓					
Links between Priority Neighbourhoods and poor health indicators such as low life expectancy, higher infant mortality						
Links between tenure (social housing) and health outcomes, unhealthy lifestyles, access to leisure						✓

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Example	South	West	North	C1	C2	C3
services, hospital admissions						
Living away from home for people with learning disabilities		✓				
Long term conditions and self care/more flexible care in home/assistive technology	✓	✓			✓	
Low income households and health problems for children	✓					
Older persons and assistive technology		✓				
Overcrowding, inadequate amenities and poor health						✓
Poor housing conditions in private sector and high heating costs plus carbon footprint					✓	
Poor housing conditions makes it difficult to maintain health and well being e.g. damp, uneven floors, lack of support rails etc.						✓
Poor housing condition of migrant workforce		✓				
Pregnant teenagers and need for supported housing						✓
Primary health care needs homeless and offender unmet	✓				✓	
Quality of life and independence for vulnerable adults		✓				
Referrals for abuse and neglect low from Housing sector	✓				✓	
Renewable energy systems and climate change					✓	
Residential care and nursing homes for older people		✓				
Role of housing in deterring offenders	✓					
Support services and adaptations to keep older people in their homes						✓
Supporting people with learning disabilities to live at home	✓	✓				
Targeting of services for substance misuse to geographical hotspots	✓					
Tele-care to support independent living						✓
Tenure (home ownership) and links to independence, health and social inclusion for older people						✓
Vulnerable households and non decent homes				✓		
Working group to look at areas of housing and health related interventions with overall aim to reduce detrimental impact of housing on health and well being within borough (Walsall)						✓
Working group on housing and health identified streams of work funding related to mental health, elderly and social housing regeneration						✓

(Source: HVC Review)

5.3.4 Joint Strategic Needs Assessments: a good practice model for addressing housing and health

A model Joint Strategic Needs Assessment which effectively addresses the health and housing would include analysis of:

- housing and health factors, e.g. life expectancy and social housing, and especially in relation to priority neighbourhoods;
- poor housing conditions, damp, decent homes, Housing Health and Safety Rating System, Accidents in the home, Energy efficiency, Fuel poverty, Excess Winter Deaths Index and Heating;
- other housing issues that affect health inequalities and quality of life such as affordability, tenure, overcrowding, housing design, neighbourhood design and housing choice;
- deprivation and its effect on housing/health related issues particularly in smaller areas;
- the housing and support needs of vulnerable groups including homeless people, gypsies and travellers, drug users, alcoholics, offenders, pregnant teenagers and others with high housing and health support needs;
- older people, independent living, care in the home, lifetime homes, sustainable housing, fuel poverty, heating, access to services especially in rural areas, housing choice, under-occupation, adaptations, assistive technology, telemedicine, preventative measures in the home, home and quality of life, end of life care;
- climate change and how to deal with this in terms of housing design/renewable energy systems to avoid future health problems; and
- ensure that the JSNA housing/health analysis links and feeds back; and into the Supporting People Strategy, Housing Strategy, Homelessness Strategy, Older Peoples Strategy, Strategic Housing Market Assessments and other relevant strategies plans

Good practice in data derivation should include:

- establishing a web based partnership-run Local Information System to develop the evidence base. This could be hosted by a PCT, local authority or Local Strategic Partnership website and would need to include mapping facilities and be updated regularly by trained/skilled staff. The Local Information System may be used for other purposes other than the JSNA;
- undertaking detailed geographical, comparative and trend analyses involving the use of datasets at different geographical levels such as the Public Health

Mortality files and Hospital In Patient Records and ONS Output Area Classifications;

- the development of a Neighbourhood Index to identify Priority Neighbourhoods using housing and neighbourhood data in the Core Data set 2008;
- the regular involvement of stakeholders, partners, service users, carers and residents of the area in the development of both the Local Information System and priorities for actions; and
- creating a live downloadable document held on the Local Information System website, which is continually updated as new datasets are produced or new strategies/plans are fed into it. It could be updated by the trained/skilled staff who keep the Local Information System up to date.

5.4 Housing and Health: a review of West Midlands Strategic Housing Market Assessments (SHMA) and Urban Living research output

5.4.1 SHMA: review of housing and health content

Introduction

Strategic Housing Market Assessments (SHMA) were introduced in 2007 as the successor to Housing Needs Assessments which were typically undertaken through sample survey within the boundaries of a single housing authority area^{xlvii}. They were introduced to encourage a cross-boundary perspective shaped by the dynamics of sub-regional housing markets and to include all tenures and forms of housing. More precisely, they were intended to assist in policy development, decision-making and resource-allocation processes by:

- enabling regional bodies to develop long-term strategic views of housing need and demand to inform regional spatial strategies and regional housing strategies;
- enabling local authorities to think spatially about the nature and influence of the housing markets in respect to their local area;
- providing robust evidence to inform policies aimed at providing the right mix of housing across the whole housing market – both market and affordable housing;
- providing evidence to inform policies about the level of affordable housing required, including the need for different sizes of affordable housing;
- supporting authorities to develop a strategic approach to housing through consideration of housing need and demand in all housing sectors – owner

occupied, private rented and affordable – and assessment of the key drivers and relationships within the housing market;

- drawing together the bulk of the evidence required for local authorities to appraise strategic housing options including social housing allocation priorities, the role of intermediate housing products, stock renewal, conversion, demolition and transfer; and
- ensuring the most appropriate and cost-effective use of public funds.

This sub-section reviews the housing and health-related themes incorporated in the six West Midlands Strategic Housing Market Assessments which constitute the first generation of such studies, i.e.:

- Central 1: Birmingham, Lichfield, Tamworth and Solihull
- Central 2: North Warwickshire, Coventry, Rugby and Nuneaton and Bedworth
- Central 3: Telford & Wrekin, South Staffordshire, Cannock Chase, Wolverhampton, Sandwell, Dudley and Walsall
- South: Worcester, Wychavon, Wyre Forest, Stratford-on-Avon, Warwick, Redditch, Malvern Hills and Bromsgrove.
- West: Bridgnorth, Herefordshire, North Shropshire, Oswestry, Shrewsbury and Atcham and South Shropshire
- North: East Staffordshire, Newcastle, Stafford, Staffordshire Moorlands and Stoke-on-Trent

Searches were undertaken against the following themes:

- health;
- social care;
- housing support; and
- housing-related support.

Two tables are provided, Table 5.4 provides a review of the frequency of mention of specific health-related themes, and a second table provides extracts from each Assessment which are illustrative of the approaches taken to incorporating a focus on health, and is included at Appendix F.

Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy

Table 5.4: Housing and Health Related Themes included in Strategic Housing Market Assessments

Themes	South	West	North	C1	C2	C3
Damp	0	✓	✓	✓	✓	0
Decent Homes: general	✓	✓	✓	✓	✓	0
Decent Homes: vulnerable households	0	✓	✓	✓	✓	0
Non Decent Homes: thermal comfort/warmth	0	✓	0	✓	✓	0
Poor quality housing	0	✓	✓	✓	✓	✓
Unfitness & healthy water	0	✓	0	0	0	0
Energy Efficiency	0	✓	✓	✓	✓	✓
Fuel poverty	0	0	0	0	0	✓
Gypsies & Travellers: accommodation needs/reference to other studies	✓	✓	✓	✓	✓	✓
Health	0	✓	✓	✓	✓	✓
Health facilities in town centres	0	✓	0	0	0	0
Homelessness – general	✓	✓	✓	✓	✓	✓
Homelessness need for partnership working probation, health & social services/prevention/reduction	0	✓	✓	✓	0	0
Homelessness - vulnerable groups	0	✓	0	✓	0	0
Homeless with mental health issues support needs	0	✓	0	✓	0	0
Homeless - young/care leavers	0	✓	0	0	0	0
Homeless women	0	✓	0	0	0	0
Homeless - fleeing domestic violence	0	✓	0	0	0	0
Homeless vulnerable owner occupiers	0	✓	0	0	0	0
Homeless – rural	0	✓	0	0	0	0
Homeless Extra Care	0	0	0	✓	0	0
Houses in Multiple Occupation – poor standards heating/fire safety	0	✓	✓	0	0	✓
Housing-related Support	0	✓	✓	✓	✓	0
Housing Health & Safety Rating System (HHSRS)	0	✓	✓	✓	✓	0
HHSRS link to potential injury/mortality	0	✓	✓	✓	✓	0
Minority Groups - Supported housing needs	✓	0	✓	✓	0	0
Older People - under-occupation/downsizing	✓	✓	✓	✓	✓	✓
Older People - housing design not fit for purpose	0	0	✓	0	0	0
Older People - housing design need for more lifetime homes	0	0	✓	0	0	✓
Older People – heating	0	✓	✓	✓	✓	0
Older People – Adaptations	0	✓	✓	✓	✓	✓
Older People – Assistive Technology	0	✓	✓	✓	✓	0
Older People – Maintenance of own homes/Resources	0	✓	✓	✓	✓	✓

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Themes	South	West	North	C1	C2	C3
Older People – distribution between urban and rural areas needs to inform housing and support services/high numbers in rural areas	0	✓	✓	0	0	0
Older People – social isolation	0	✓	✓	0	✓	0
Older People – rural isolation	0	✓	✓	0	✓	0
Older People – rural access to services	0	✓	✓	0	0	0
Older People – access to services	0	✓	0	0	0	0
Older People – Accessible services in wider area	0	✓	✓	✓	✓	0
Older People – Independent Living	✓	✓	✓	✓	✓	✓
Older People – Low level support/Floating support	✓	✓	✓	✓	✓	✓
Older People – levels of support	✓	✓	✓	✓	✓	✓
Older People – increasing population/needs for support/living longer	✓	✓	✓	✓	✓	✓
Older People – needs health & social care increasing with ageing/different needs	0	✓	✓	✓	✓	✓
Older People – resources/finance	0	✓	✓	✓	✓	✓
Older People – unmet need for accommodation/meeting needs	✓	✓	✓	✓	0	✓
Older People – Shared Ownership/Shared Equity/Leasehold Schemes for Elderly/retirement villages	✓	0	✓	0	✓	✓
Older People – housing choices/choices to move on/different needs demands aspirations within group	✓	✓	✓	✓	✓	✓
Older People – Need for specialised accommodation	0	✓	✓	✓	✓	✓
Older People – Extra Care	✓	✓	✓	✓	✓	✓
Older People – Sheltered Housing	✓		✓	✓	✓	✓
Older People – ‘hard to let’ schemes/low demand	✓	0	✓	0	0	0
Older People – tenure	0	✓	✓	✓	✓	✓
Older People – staying healthy	0	✓	✓	✓	0	0
Older People – preventative measures, reducing health inequalities	0	✓	0	✓	0	0
Older People – homes affect quality of life	0	✓	✓	✓	✓	0
Older People need for Partnership working	0	✓	✓	✓	✓	0
Overcrowding	✓	✓	✓	✓	✓	✓
People with Disabilities – Accommodation needs	✓	✓	✓	✓	✓	0
People with Learning Disabilities/Difficulties	✓	✓	0	✓	✓	0
People with Mental Health problems housing with support	0	✓	0	✓	✓	0
People: single person households – small	✓	✓	✓	✓	✓	✓

Themes	South	West	North	C1	C2	C3
units/ sustainability and quality of housing/increase especially older people						
Rural access to services	0	✓	✓	0	0	0
Social Care	✓	✓	✓	✓	✓	0
Supporting People need for partnership working	0	✓	✓	✓	0	0
Vulnerable households	✓	✓	✓	✓	✓	0
Vulnerable groups – Accommodation needs/unmet needs/special needs/development supported housing	✓	✓	✓	✓	0	0
Vulnerable groups - Floating support	0	✓	0	✓	✓	0

(Source: HVC Review)

Findings

A number of conclusions can be drawn from this review:

- The most extensive coverage of housing/health related themes in the SHMAs was older people. This generally included both housing and support needs of older people, and examples are independent living; increasing and varied support needs; housing choice; downsizing; sheltered housing; extra care; owner occupied schemes for older people; sustainability and quality of homes; finance; rural access to services and social/rural isolation.
- Decent Homes was mentioned in most of the SHMAs in general terms but not all covered Decent Homes in relation to vulnerable households.
- The Housing Health and Safety Rating System (HHSRS) was included in four of the SHMAs, including links to injury/mortality.
- Energy efficiency was mentioned in most of the SHMAs but not covered in depth. Some mentioned non-Decent Homes and thermal warmth and/or heating for the elderly.
- Fuel poverty was mentioned in only one of the SHMAs.
- Overcrowding and under-occupation were mentioned in all the SHMAs;
- Housing support or housing-related support was mentioned in some of the SHMAs and all included some reference to providing support for older people living at home.
- Some of the SHMAs mentioned the accommodation and/or support needs of people with disabilities, mental health problems or learning difficulties.

- Most of the SHMAs mentioned vulnerable households, but sometimes only in relation to Decent Homes. Some mentioned vulnerable or minority groups either in detail or generally in relation to accommodation or support needs.
- Homelessness was mentioned by all SHMAs, but mainly in general terms and not in relation to health or support needs. Some SHMAs did give coverage to homelessness in relation to vulnerable groups and other issues such as rural homelessness.
- One SHMA did not include the word 'health' at all, others included it in relation to the HHSRS, and some mentioned it in relation to older people staying healthy, preventative health or having health and social care needs.
- Gypsies and Travellers were mentioned in the SHMAs but usually only in terms of referring to other studies or work that has been or is being carried out.

5.4.2 Urban Living: review of housing and health output

Introduction

The Birmingham Sandwell Housing Market Renewal (or Urban Living) Area has produced two Baseline Reports on Housing Health Related Indicators in 2004 and 2005. These are intended to establish a baseline for monitoring change. A separate project was undertaken to attempt to establish causal links between the investment in the Urban Living Area and health outcomes. This was called the HMRA Health Assessment Project (Smith and Maher).

This is a summary of the two baseline reports including their findings and conclusions. The two reports include a level of detail about the methodology, tables and charts. These are not included in this summary.

Baseline Housing Health Related Indicators for the Birmingham Sandwell Housing Market Renewal Area Report 2004 (Mike Maher)

The Baseline Housing Health Related Indicators for the Birmingham Sandwell Housing Market Renewal Area Report 2004 provides health indicators as an evidence base. It establishes the principal that it is important to monitor health in housing interventions and to set up longitudinal research that can measure changes to the individual and are capable of a high practical level of causal attribution. It reviews evidence of housing interventions and health and finds that it is supportive rather than conclusive.

The 2004 Report establishes a baseline for monitoring change irrespective of causal attribution using aggregated rates of morbidity and mortality.

Indicators, and uses the following 6 measures:

- Excess Winter Mortality

- All Causes Mortality
- All Circulatory Diseases – Mortality
- Diseases of the Respiratory System – Mortality
- Fractured Neck of Femur for over 65s – Morbidity
- Serious Home Accidents – Morbidity

The health of the HMRA population at ‘baseline’ is relatively poor on a number of important measures of mortality. For certain other Area Framework sub regions, particularly Smethwick, the morbidity and excess winter mortality indicators are poorer than the rest of Birmingham-Sandwell. These findings will help focus and shape core HMRA housing interventions and wider collaboration efforts to improve health.

The HMRA as a whole has not had significantly greater excess winter mortality index rates than local, regional and national comparators between 1995 and 2003. However, for those dying aged 75 and over, the variation between the Area Frameworks is large.

When comparing the Urban Living HMRA, as a whole, with non-HMRA Birmingham-Sandwell, the Urban Living area had higher all causes mortality. This higher all causes mortality is partly underpinned by higher mortality due to circulatory diseases and diseases of the respiratory system. The rates of death due to these causes are likely to be reduced by better housing conditions. In contrast the excess winter deaths index and morbidity due to fractured neck of femur and serious home accidents are not significantly different from the rest of Birmingham-Sandwell.

However certain of the Area Frameworks (smaller areas within the HMRA) had higher morbidity rates than the HMRA taken as a whole.

The HMRA as a whole has not had significantly greater excess winter mortality index rates than local, regional and national comparators between 1995 and 2003. However, for those dying aged 75 and over, the variation between the Area Frameworks is large.

The low EWDI for those dying aged 75 and over in Aston/Newtown/Lozells is worth further scrutiny. There is some suggestion that the larger numbers of flats in this AF has provided better protection from cold in winter than other property types occupied by older people. In order to test this hypothesis, and further explore these findings, the Public Health Mortality Files will need to be linked to a lookup list of property types by individual address, if this exists for the HMRA area.

Housing-Related Health Indicators for the Urban Living Housing Market Baseline Update 2005

This report updates the six indicators in the 2004 Report and reports on the findings. This is a continuation of the monitoring process set up in the Baseline 2004 Report and reports back on trends.

The HMRA as a whole has not had significantly greater excess winter mortality index rates than local, regional and national comparators between 1995 and 2004. As previously reported, for those dying aged 75 and over, the variation between the Area Frameworks is large, with Aston/Newtown/Lozells showing a trend to lower EWDI.

On the other hand, for the 75+ group West Bromwich/Greets Green had the highest levels in 2003/4, and has shown very high levels previously. These trends continued when data for the update period is analysed. The Aston/Newtown/Lozells EWDI increased slightly but was still the lowest amongst the AFs. West Bromwich/Greets Green still remains the highest index. Sandwell, again, has shown a consistently higher EWDI (for those dying aged 75 and over) than Birmingham, the West Midlands and England.

In the update reporting period of April 2000 to March 2004, all causes mortality for persons has reduced for the HMRA and AFs (but this reduction is not statistically significant). This reduction over time is consistent with falling rates for the West Midlands and nationally. However the HMRA still has considerably higher rates than the non-HMRA Birmingham-Sandwell area.

This higher all causes mortality is partly underpinned by higher mortality due to circulatory diseases and diseases of the respiratory system. The rates of death due to these causes are likely to be reduced by better housing conditions. In contrast the morbidity due to fractured neck of femur (admissions) is lower in the HMRA when compared to the rest of the non-HMRA Birmingham-Sandwell area.

HMRA serious home accidents remain not significantly different from the rest of Birmingham-Sandwell. But it is worth noting that for both serious home accidents and fractured neck of femur, rates between the two reporting periods showed a non-statistically significant trend to increase for Sandwell, but decrease for Birmingham.

Considering the AF mortality, Smethwick still has by far the highest all causes mortality, when the updated figures are considered. It is still the only AF significantly higher than non-HMRA Birmingham-Sandwell for diseases of the respiratory system. The updated data still shows Smethwick, along with Soho/Handsworth, as having raised levels of circulatory disease mortality. All individual AFs have higher circulatory disease mortality and all causes mortality compared to the non-HMRA region.

When morbidity is considered, certain of the Area Frameworks have higher rates than the HMRA taken as a whole. Smethwick and West Bromwich/Greets Green have higher rates of fractured neck of femur; with Smethwick again having a higher

rate of serious home accidents than non-HMRA Birmingham-Sandwell. The health of the HMRA population at baseline was relatively poor on a number of important measures of mortality. For certain other Area Framework sub regions, particularly Smethwick, the morbidity and excess winter mortality indicators are poorer than the rest of Birmingham-Sandwell. This update report has confirmed this situation, despite many rates falling over time in line with national trends. These findings will help focus and shape core HMRA housing interventions and wider collaboration efforts to improve health.

Conclusions

The health of the HMRA population at baseline was relatively poor on a number of important measures of mortality. For certain other Area Framework sub regions, particularly Smethwick, the morbidity and excess winter mortality indicators are poorer than the rest of Birmingham-Sandwell. This update report has confirmed this situation, despite many rates falling over time in line with national trends.

5.5 Housing and Health: evaluation of the relevance and potential of available data sets

5.5.1 Overview

We have undertaken a comprehensive review of relevant data sets which are summarised at Appendix G. In the following sub-section, their potential for creating a Housing: Health Neighbourhood Index is examined. For each data set, we have provided detail concerning:

- The data source
- The title of the data set
- The client group(s) to which it applies
- A summary of content
- Its location in the form of a weblink
- The geographic level at which the data is available.

We have further organised the data and data sets which enables the construction of the following profiles:

- housing profile;
 - In view of its significance, data relating to housing conditions have been separately identified;

- area profile (the residential environment);
- social profile;
- health profile; and
- cross-cutting profile.

5.5.2 The potential of data sets for developing a Housing: Health Neighbourhood Index

Introduction

A Neighbourhood Index is one means of developing a small area database which can inform the targeting of resources and/or interventions more effectively, and measure changes over time. An Index may consist of a number of datasets that are useful on their right, and can provide a methodology for combining datasets. Indicators need to be chosen to construct the Index and enable monitoring.

Geography

A fundamental question is the appropriate spatial scale at which to develop an index, and the geography recommended is the Office of National Statistics (ONS) Lower Super Output Area (LSOA). These were developed to make it possible to compare areas of a similar population size. Lower Super Output Areas are comprised of smaller 2001 Census Output Areas (typically 5); the minimum population of a Lower Super Output Area is 1,500.

Methodology

One method for creating an Index is to take the z-score of each relevant variable in order to normalise the ranges, and then represent these as an index around the global average. An overall Index would be produced by a sum of the squares based on the range of Z-scores of the different variables. (Z-scores can be created in SPSS or Excel software). The current can then be compared to the previous index to show change in an area over time. Analysis of the reasons for changes may be complex and will depend upon the variables chosen. It is possible that one-off occurrences may skew the data so trends need to be monitored over time.

Another methodology is the one used by the Newcastle Neighbourhood Information Service (NNIS) Vitality Index. This combines various indicators at a neighbourhood level using a similar methodology to that developed by Oxford University for the Multiple Index of Deprivation. This methodology is based on factor analysis, and a detailed technical report on the website explains how it works, see:

<http://www.newcastle.gov.uk/core.nsf/a/nnissnapshot>

This methodology will not establish causal relationships between housing interventions and health, but it can provide a baseline against which to measure change over time.

Relevant datasets

There are an increasing number of publicly available datasets supplied at the ONS LSOA level. Some of these datasets are included in the JSNA Core Dataset 2008 produced by the Department of Health and the Association of Public Health Observatories. These publicly available datasets could be combined with other datasets which are less easy to obtain or must be paid for to enhance the information.

The Urban Living Research used data from Public Health Mortality files and Inpatient Hospital Records to attempt to measure change in non-standard geographical areas over time, and these datasets might be useful in creating a Neighbourhood Index.

An example of a supplementary dataset that is expensive but useful is MOSAIC data from Experian. MOSAIC data is updated annually whereas many free datasets are updated less frequently. Some local authorities in the West Midlands already have MOSAIC data and some PCTs may also have this dataset and be familiar with its uses for the social marketing of health interventions.

When populated, the National Register of Health and Social Housing (NROSH) will contain a wealth of housing data, including information on Supported Housing and client groups. It is currently only available to Registered Social Landlords (RSLs) and Local Authorities (LAs). This data contains a National Land and Property Gazetteer unique reference code, and therefore it should be possible to look at the data for any geographical area. This dataset is regularly updated.

The table below lists potential datasets relevant to constructing a Housing/Health related Neighbourhood Index. GIS skills will be required to process this data. In addition to these datasets the PCTs may be able to supply more data at lower levels.

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Table 5.5: constructing a Housing: Health Neighbourhood Index: potential datasets

Variable	Source	Availability	Reason	JSNA Core Dataset
Sub Domain Wider Barriers, English Indices of Deprivation	CLG website	Public	Overcrowding, homelessness acceptances and access to owner occupation	Yes
Sub Domain Indoors Living Environment, English Indices of Deprivation	CLG website	Public	Social and private housing in poor condition, Houses without central heating	Yes
Geographical Barriers sub domain, English Indices of Deprivation	CLG website	Public	Access to services (road distance to GP, supermarket or general store, post office, primary school)	Yes
Health and Disability	CLG website	Public	Years of Potential Life lost, Comparative Illness & Disability Ratio, acute morbidity from HES, and proportion adults under 60 suffering anxiety disorders based on prescribing)	Yes
% of homes failing decent homes standard - RSLs and LAs	NROSH	RSLs and LAs only	Condition of Housing	No
% of RSL/LA homes without central heating	NROSH	RSLs and LAs only	Thermal comfort	No
% of homes without loft/cavity wall insulation	NROSH	RSLs and LAs only	Thermal comfort	No
SAP Ratings RSLs and LAs	NROSH	RSLs and LAs only	Energy Efficiency	No
% in fuel poverty	West Midlands Regional Observatory	Public	Fuel Poverty and links to poor health	No
Numbers of Social Housing properties in area	NROSH	RSLs and LAs only	Links between tenure and health	No
ONS Output Area	NESS website		Geo-demographic classifications similar	Yes

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Variable	Source	Availability	Reason	JSNA Core Dataset
Classification			census characteristics to identify homogeneous sub areas to target & housing profile	
% likelihood teenage conceptions	MOSAIC household data, Experian	Cost	Target resources teenage conceptions and health indicator	Yes Mosaic data mentioned but not precise indicator
% likelihood heavy smokers	MOSAIC household data, Experian	Cost	Target resources pharmacies offering anti smoking measures and health indicator	Yes Mosaic data mentioned but not precise indicator
% with limiting long term illness	Census data, NESS website	Public	Health indicator	No
% health not good	Census data, NESS website	Public	Health indicator	No
% tenure types	Census data, NESS website	Public	Housing indicator	No
% no central heating older people	T06, NOMIS website, NESS website	Public	Thermal comfort	Yes
% living alone older people	T06, NOMIS website, NESS website	Public	Higher support services required for single people	Yes
% overcrowding	T06, NOMIS website, NESS website	Public	Links between overcrowding and poor health	Yes
Hospital Accessibility	Core Accessibility Indicators, DFT website	Public	Access to services	Yes
GP Accessibility	Core Accessibility Indicators, DFT website	Public	Access to services	Yes
Indicators on Mortality and Morbidity used in Urban Living Research	Public Health Mortality Files & Hospital Inpatient Records	Not publicly available	Suitable for measuring change over time and already used in Urban Living area	No

(Source: HVC Review)

6. HOUSING AND HEALTH: POLICY AND PRACTICE RESPONSES

6.1 Introduction

This chapter reviews housing-related policy and practice responses to improve health, and two sections are provided below:

- Examples of national housing policy and practice responses of relevance to the West Midlands; and
- Examples of West Midlands policy responses have already been reviewed in Chapter 3.

Chapter 2, within the policy areas that focus on specific communities or individuals, also describes some housing policy responses.

NICE is currently developing guidance, due for circulation in December 2011, providing guidance for local authorities and PCTs, on the implications of spatial planning for health, see:

<http://www.nice.org.uk/Guidance/PHG/Wave20/55>

6.2 National Policy and Practice Responses of Relevance to the West Midlands

The Housing, Health and Rating System (HHSRS)

The main policy tool available to determine health-related housing conditions is the Housing, Health and Rating System (HHSRS). Using robust evidence, this system was developed by Warwick University' Law School to identify and evaluate the potential risks to health and safety from deficiencies in dwellings, and to provide an accurate basis for calculating the likelihood of a hazard causing harm and the range of harms that might be expected.

There are 29 hazards but many are comparatively rare, for example, lead poisoning. The more common hazards, as seen regularly by environmental health officers working in private sector housing, are:

- damp and mould growth;
- excess cold;
- crowding and space;
- entry by intruders;
- falling on level surfaces;

- falling on stairs; and
- fire.

Health Impact Assessment (HIA)

The World Health Organisation 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”.

[European Centre for Health Policy, WHO Regional Office for Europe, Gothenburg Consensus Paper \(1999\)](#)

and describes it as

“a practical approach used to judge the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. Recommendations are produced for decision-makers and stakeholders, with the aim of maximising the proposal's positive health effects and minimising its negative health effects”.

For further detail, see:

<http://www.who.int/hia/en/>

There is an immense range of potential applications in housing, from housing improvement and renewal to neighbourhood regeneration, new settlements and the provision of new market and/or social housing. A good practice example is provided below and an example of guidance is available at Douglas, M. and Thomson, H. (2003).

The Health Impact Assessment of a Decent Homes programme: good practice example

The single most significant research UK study attempting to assess the health impact of housing improvement is the Health Impact Assessment (HIA) of Sheffield's £700 million Decent Homes Programme completed in 2006. This was commissioned by Sheffield City Council and Sheffield's Primary Care Trusts to jointly commission this Health Impact Assessment of the Decent Homes Programme. The national Housing Health and Safety Rating System was first used to produce conservative estimates of the health impact of Sheffield's Decent Homes Programme and the outcome measured in practice. The key findings are that:

- despite Sheffield Council's dwellings now having energy efficiency levels better than the English average, there is scope for the Decent Homes Programme to raise energy efficiency levels further and reduce heart disease and excess winter deaths to Scandinavian levels;

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- raised temperatures, coupled with improved ventilation planned for nearly every dwelling in the Decent Homes Programme, will help reduce levels of condensation, damp and mould and the likelihood of respiratory disease;
- as a major element of the Decent Homes Programme, improved kitchens and bathrooms will reduce falls, trips, scolds and burns, with substantial savings to the NHS;
- new windows and external doors will improve security, promote feelings of safety and have a major impact on mental health and wellbeing, with cost savings to the NHS.

The Health Impact Assessment of a Housing Strategy: good practice example

A Health Impact Assessment of Liverpool's City Council Housing Strategy was undertaken in 2003 which made recommendations under 4 headings as follows:

- Human Capital

For example, community consultation and involvement in stock clearance and redevelopment.

- Natural Resources

For example, the proposed PSA for private sector housing requires a proactive policy to inform households of the health impact of lead piping.

- Environmental Protection

For example, the City Council should complete its work on the development of a Travel Plan.

- Social Capital

For example, commission more substantial research to identify the most appropriate ways to access hard to reach groups living in HMOs.

6.3 Examples of West Midlands practice interventions,

Policy responses have already been reviewed in Chapter 3.

6.3.1 Introduction

It's clear from talking to stakeholders in the region that there are numerous examples of housing-led initiatives and services – and joint working with health and social care – that are felt to contribute to health and wellbeing outcomes. However, it also apparent that the way in which these come into being varies greatly: more often than

not it appears individual interest and commitment, innovative use of resources and the willingness to take a risk combine ie, initiatives and services are not often the result of strategic planning.

There are many sources of good practice, and guidance, available nationally – these have not been replicated here but include: -

- The Housing Learning and Improvement Network briefings and tools include a local assessment tool on health risks and health inequalities in housing, and briefings, for example their briefing on the prevention of homelessness and the role of health and social care
- The 2008 '*Commissioning housing support for health and wellbeing*' led by the Integrated Care Network highlights a number of examples of how housing support contributes to health, including how support can reduce health costs,
- *Regional Action West Midlands* has sought to identify and publicise examples of how the voluntary and community sector – including organisations who deliver housing related services (it runs a Housing Network) - contributes to health and wellbeing outcomes. Examples of resident-led initiatives that have sought to improve neighbourhoods – and health – are provided in the Autumn 2008 newsletter.

The examples provided here are by no means exhaustive but have been chosen to reflect the scope of activity in the region. It is worth noting that stakeholders in the region who have been contacted as part of this research are interested in looking at whether small-scale activity, which has been proven to be effective, could be scaled up through support from regional housing policy or other assistance.

6.3.2 Planning for housing to contribute to health and wellbeing

The Regional Homelessness Strategy Implementation Group has procured a scoping exercise from MWB Consultancy in relation to PSA 16. It is identifying what people are doing around housing and will be pulling a report together in late 2009.

The Regional Homelessness Strategy Implementation Group has just started work to assess the impact of recession on more vulnerable groups, particularly young people. This work is felt to have direct links to health – as it gets harder for people to get on the housing ladder their choice of quality accommodation diminishes.

There are two projects of interest in housing, health and wellbeing terms in the RENEW pathfinder/Stoke-on-Trent area. In partnership with North Staffordshire and Stoke PCTs, Health Impact Assessments are being undertaken in relation to four different regeneration projects. These include: transport and a new bus route; a regeneration masterplan; masterplanning for a market town centre and a private sector new-build site. Consideration is also being given to jointly funding a health post. Stoke is part of European Healthy Cities, and the local authority and partners

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(including RENEW) have been considering how Healthy Cities and regeneration can be brought together.

Birmingham City Council has undertaken some initial research work with people who provide services to people as they get older, including planning for retirement eg, solicitors and bankers to understand motivations for work, barriers to productivity, approaches to retirement planning and so on. Findings so far include the potential to link people to undertaking public/community focused activities as its more likely that people involved in this kind of activity will remain living in the area once they retire. There is also a likelihood that this activity will impact on productivity at work.

Sandwell PCT is undertaking work to assess the long term health impact evaluation of housing market renewal.

Revolving Doors has conducted research into the housing needs of vulnerable people in contact with the criminal justice system, and the systemic challenges encountered in establishing multi-agency protocols to promote personal wellbeing and community safety. We have also researched the specific issues encountered by women with mental health needs who are in prison.

Given that the profile of social housing tenants is ageing, Midland Heart is undertaking a number of research, including research into end of life issues. Contacts are: Chris Mundy, director of care and support and Neil Tryner, head of performance.

6.3.3 Investment in housing

Beyond the obvious investment in homes to bring them to the decency standard there are other examples of investment that are felt to have contributed to health and wellbeing.

Family Housing has invested heavily in green technology in existing homes (the Summerfield Triangle)

Mercian Housing Association was cited as supporting older home owners in Castle Vale by providing loans to improve homes (Kickstart for homeowners) , with a consequent impact on health, where a large proportion of older people have purchased their homes through the Right to Buy but are unable to afford to improve them.

6.3.4 Investment in people and communities

Housing organisations are felt to be best placed to gain access to some of the most vulnerable and excluded people, including those who may not be tenants but who live in neighbourhoods that are predominantly owned and managed by social housing providers.

Housing associations working with people and communities to tackle worklessness are cited as having a positive contribution to health and wellbeing, particularly in relation to self-esteem, confidence and mental health. The 2009 publication by Advantage West Midlands, the National Housing Federation and DTZ *Housing Associations Help Tenants Open their Doors to Jobs and Skills*, provides a baseline study of 170 housing associations. It describes the role of associations, highlighting how older people, people with long term ill-health and mental health issues are supported, and the correlation between ill-health and unemployment.

Local examples of the housing contribution to worklessness and health include the Birmingham City Council City Housing Partnership worklessness group (which includes housing associations).

The PSA 16 scoping exercise has already identified some good examples of housing contributing to health and wellbeing for example, Stoke and Brighter Futures are looking at whole range of housing-related issues and have identified a range of health outcomes that can be contributed to by partnerships between housing, health and social care, Shropshire has developed a single referral point that co-ordinates access to services and

There are numerous schemes that aim to support people at risk of, or actually, homeless, that are felt to contribute to health and wellbeing outcomes. These range from St. Basils and their work with young people, Revolving Doors *and their* services for people with mental health problems in contact with criminal justice system (this has led to the development of supported housing services for women with mental health and multiple needs leaving HMP Brockhill), the Social Inclusion Charity that engages with rough sleepers and enables access to accommodation and health care, health promotion work with homeless young people by Telford and Wrekin PCT and Bromsgrove District Housing Trust's work to enable Health Visitors to support vulnerable families with young children in hostel accommodation.

Work to achieve the regional target to reduce the excess number of winter deaths and end fuel poverty is being supported by NHS West Midlands and joint work with the PCTs and local authorities.

APPENDICES

APPENDIX A: BIBLIOGRAPHY

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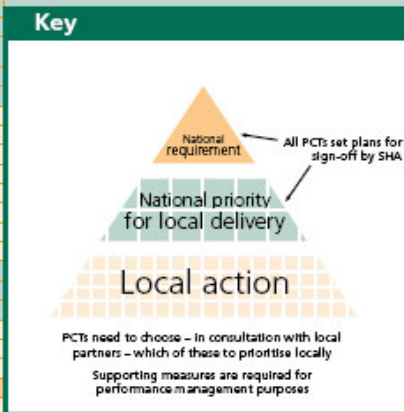
APPENDIX B: CONTACTS CONSULTED/APPROACHED

Contact	Role	Organisation
Contacts Consulted		
Chris Eade	PSA 16 lead	GOWM
Ms Kate O'Hara	Mental health lead	NHS West Midlands Regional Development Centre
Alistair Mctintyre	Associate Director	NHS West Midlands Regional Development Centre
Sherman Wong	Head of Local Government Policy	WMRA
Marie Greer	Director of Sustainable Communities,	AWM
Mrs Janet Baker	Deputy Regional Director of Public Health	DH West Midlands
Sharon Palmer	Chief Exec,	RAWM
Paul Muir	Director – scoping PSA 16 actions for GOWM	MWB consultancy
Helen Wilkes		HCA
Michael Kilduff	Lead of links between employment/training, housing and health	LSC
Tamsin Hartley	RENEW	
Marcia Richard	Transformation lead	DH West Midlands
Karen Murphy	Performance and Improvement	DH West Midlands
Peter Hay	Secretary (also Strategic Director Adults and Communities, Birmingham City Council)	ADASS
Liz Larkin	West Midlands policy officer	NHF
Paul Williams		NHF
Paul Jays	Former consultant for CSED West Midlands	
Contacts Approached		
Cllr Steve Eling	Chair (also Sandwell Lead Member)	Regional Health Partnership
Jean Templeton	Chair	Regional Homelessness Strategy Implementation Group
Linda Sanders	Chair	ADASS
Ruth Rigby	Regional Resource Team, Midlands Lead (Supporting People)	CLG
Laura Hazel	Chair	Regional Supporting People RIG

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APPENDIX C: VITAL SIGNS 2009/10

National Priority	Vital Signs	Commitment	
Cleanliness and healthcare-associated infections	MRSA number of infections	MRSA levels sustained, locally determined stretch targets taking us beyond the national target.	
	Rates of Clostridium difficile	Clostridium difficile reduction of 30 per cent by 2011, differential SHA envelopes to deliver a 30 per cent reduction nationally by 2011.	
	Achievement of Clinical Negligence Scheme for Trusts risk management standards		
Access to personalised and effective care	Percentage of patients seen within 18 weeks for admitted and non-admitted pathways Supporting measures: Number of diagnostic waits > 6 weeks Percentage of patients seen within 18 weeks for direct access audiology treatment Activity levels Patient-reported experience of 18-week pathways	To ensure that, by December 2008, no one waits more than 18 weeks from referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks)	
	Patient experience of access to primary care Supporting measures: Extended opening hours for GP practices Increased capacity in primary care Patient-reported access to out-of-hours care (indicator to be developed)	At least 50 per cent of GP practices in each PCT offer extended opening to their patients. 700 new GP practices, including up to 500 GPs, nurse and healthcare assistants introduced into the 25 per cent of PCTs with the poorest provision	
	Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral	All patients by December 2009	
	Proportion of women aged 47-49 and 71-73 offered screening for breast cancer	NHS Breast Cancer Screening Programme will be extended to all women aged 47-73 by 2012	
	Proportion of men and women aged 70-75 taking part in bowel screening programme	NHS Bowel Cancer Screening Programme will be extended from 2010 to invite men and women aged 70-75 to take part	
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)	Patients wait no more than 31 days from decision to treat to start of treatment, extended to cover all cancer treatments by December 2008	
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	Patients wait no more than 31 days from decision to treat to start of treatment, extended to cover all cancer treatments by December 2010	
	Proportion of patients with suspected cancer, detected through national screening programmes or by hospital specialists, who wait less than 62 days from referral to treatment	All patients with suspected cancer, detected through national screening programmes or by hospital specialists, wait no more than 62 days from referral to treatment by 2009.	
	Primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services		
	Proportion of people with depression and/or anxiety disorders who are offered psychological therapies		
	Proportion of adults (aged 18 and over) supported directly through social care to live independently at home		
	Proportion of people achieving independence three months after entering care/rehabilitation rate per 10,000		
	Proportion of adults with learning disabilities in settled accommodation		
	Proportion of adults in contact with secondary mental health services in settled accommodation		
	Proportion of adults with learning disabilities in employment		
	Proportion of adults in contact with secondary mental health services in employment		
	Patient-reported unmet care needs		
	Number of delayed transfers of care per 100,000 population (aged 18 and over)		
	Proportion of people with long-term conditions supported to be independent and in control of their condition		
	Timeliness of social care assessment		
	Timeliness of social care packages		
	Ambulance conveyance rate to A&E		
	Proportion of all deaths that occur at home		
	Patient-reported measure of choice of hospital		
	Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)		
	Proportion of carers receiving a 'carer's break' or a specific service for carers as a percentage of clients receiving community-based services		
	Prescribing indicator (to be developed)		
	Number of emergency bed days per head of weighted population		
	Rates of hospital admissions for ambulatory care sensitive conditions per 100,000 population		
	Learning disabilities		
	Improving health and reducing health inequalities	Implementation of the Stroke Strategy	
		Proportion of women receiving cervical cancer screening test results within two weeks	All women should receive the results of their cervical screening tests within two weeks by 2010
		All-age, all-cause mortality rate per 100,000 population	
<75 CVD mortality rate			
<75 cancer mortality rate			
Suicide and injury of undetermined intent mortality rate			
Smoking prevalence among people aged 16 or over, and aged 16 or over in routine and manual groups (quit rates locally 2009)			
Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices, by 12 completed weeks of pregnancy			
Under-18 conception rate per 1,000 females aged 15-17			
Obesity among primary school-age children			
Proportion of children who complete immunisation by recommended ages			
Percentage of infants breastfed at 6-8 weeks			
Effectiveness of Children and Adult Mental Health Service (CAMHS) (percentage of PCTs and local authorities that are providing a comprehensive CAMHS)			
Number of drug users recorded as being in effective treatment			
Prevalence of chlamydia			
Vascular risk score			
Percentage of patients admitted with a heart attack who, upon discharge, are prescribed an anti-platelet, a statin or a beta-blocker			
Healthy life expectancy at age 65			
Rate of hospital admissions per 100,000 population for alcohol-related harm			
Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality Outcomes Framework			
Proportion of people where health affects the amount/type of work they can do			
Hospital admissions caused by unintended and deliberate injuries			
Mortality rate from causes considered amenable to healthcare			
Reputation, satisfaction and confidence in the NHS	Self-reported experience of patients and users		
	Public confidence in local NHS		
	NHS staff survey scores-based measures of job satisfaction		
	Self-reported measure of peoples' overall health		
Finance	Patient- and user-reported measure of respect and dignity in their treatment		
	Parents' experience of services for disabled children		
Finance	Financial balance (PCT)		
	NHS estates energy/carbon efficiency		



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National indicators relevant to housing-related support services.
Highlighted indicators are NHS 'vital signs'.

Number	Indicator	Govt ref
Safer communities		
NI 39	Alcohol-harm related hospital admission rates	PSA 25
NI 40	Drug users in effective treatment	PSA 25
NI 18	Adult re-offending rates for those under probation supervision	PSA 23
Adult health and well-being		
NI 119	Self-reported measure of people's overall health and wellbeing	DH DSO
NI 124	People with a long-term condition supported to be independent and in control of their condition	DH DSO
NI 125	Achieving independence for older people through rehabilitation/intermediate care	PSA 18
NI 131	Delayed transfers of care from hospitals	DH DSO
NI 132	Timeliness of social care assessment	DH DSO
NI 133	Timeliness of social care packages	DH DSO
NI 134	The number of emergency bed days per head of weighted population	DH DSO
NI 136	People supported to live independently through social services (all ages)	DH DSO
NI 137	Healthy life expectancy at age 65	PSA 17
NI 138	Satisfaction of people over 65 with both home and neighbourhood	PSA 17
NI 139	People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently	PSA 17
Tackling exclusion and promoting equality		
NI 145	Adults with learning difficulties in settled accommodation	PSA 16
NI 146	Adults with learning difficulties in employment	PSA 16

(Source: Commissioning housing support for health and wellbeing)

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Number	Indicator	Govt ref
Tackling exclusion and promoting equality continued . . .		
NI 149	Adults in contact with secondary mental health services in settled accommodation	PSA 16
NI 150	Adults in contact with secondary mental health services in employment	PSA 16
NI 141	Number of vulnerable people achieving independent living	CLG DSO
NI 142	Number of vulnerable people supported to maintain independent living	PSA17
Stronger communities		
NI 2	Percentage of people who feel that they belong to their neighbourhood	PSA 21
Local economy		
NI 156	Number of households living in temporary accommodation	PSA 20
NI 158	Percentage decent council homes	CLG DSO
Environmental sustainability		
NI 187	Tackling fuel poverty – people receiving income based benefits living in homes with a low energy efficiency	Defra, DSO

(Source: Commissioning housing support for health and wellbeing)

Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy

APPENDIX D: ANALYSIS OF NATIONAL PERFORMANCE FRAMEWORK INDICATORS AND THEIR INCLUSION IN WEST MIDLANDS LAAs 2009

Blue denotes a housing related indicator
Green denotes a health and wellbeing indicator
Yellow denotes a childrens' indicator
Purple denotes a social exclusion indicator

<i>NI</i>	<i>Name</i>	<i>PSA DSO</i>	<i>or</i>	<i>Dept.</i>	<i>Number of LAs</i>
154	Net additional homes provided	PSA 20		CLG	12
155	Number of affordable homes delivered (gross)	PSA 20		CLG	11
135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	DH DSO		DH	9
116	Proportion of children in poverty	PSA 9		DWP	8
120	All-age all cause mortality rate	PSA 18		DH	8
123	Stopping smoking	PSA 18		DH	8
39	Rate of hospital admission per 100,000 for alcohol related harm	PSA 25		DH	7
121	Mortality rate from all circulatory diseases at ages under 75	DH DSO		DH	7
130	Social Care clients receiving Self Directed Support per 100,000 population	DH DSO		DH	7
136	People supported to live independently through social services (all adults)	PSA 18		DH	6
40	Number of drug users recorded as being in effective treatment	PSA 25		DH	5
142	Percentage of vulnerable people who are supported to maintain independent living	CLG DSO		CLG	5
141	Percentage of vulnerable people achieving independent living	CLG DSO		CLG	4
187	Tackling fuel poverty - % of people on income based benefits living in homes with a low energy efficiency rating	DEFRA DSO		DEFRA	4
115	Substance misuse by young people	PSA 14		DCSF	3
156	Number of households living in temporary accommodation	PSA 20		CLG	3
158	% on decent council homes	CLG DSO		CLG	3
159	Supply of ready to develop housing sites	CLG DSO		CLG	2
53	Prevalence of breastfeeding at 6 - 8 weeks from birth	PSA 12		DH	2
50	Emotional health of children	PSA 12		DCSF	1
54	Services for disabled children	PSA 12		DCSF	1
122	Mortality from all cancers at ages under 75	DH DSO		DH	1
124	People with a long-term condition supported to	DH DSO		DH	1

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NI	Name	PSA DSO	or Dept.	Number of LAs
	be independent and in control of their condition			
125	Achieving independence for older people through rehabilitation/intermediate care	DH DSO	DH	1
126	Early access for women to maternity services	PSA 19	DH	1
129	End of life care - access to appropriate care enabling people to be able to choose to die at home	DH DSO	DH	1
131	Delayed transfers of care	DH DSO	DH	1
133	Timeliness of social care packages following assessment	DH DSO	DH	1
139	The extent to which older people receive the support they need to live independently at home	PSA 17	DWP	1
145	Adults with learning disabilities in settled accommodation	PSA 16	CO	1
119	Self-reported measure of people's overall health and wellbeing	DH DSO	DH	0
127	Self reported experience of social care users	PSA 19	DH	0
128	User reported measure of respect and dignity in their treatment	DH DSO	DH	0
132	Timeliness of social care assessment (all adults)	DH DSO	DH	0
134	The number of emergency bed days per head of weighted population	DH DSO	DH	0
137	Healthy life expectancy at age 65	PSA 17	DWP	0
143	Offenders under probation supervision living in settled and suitable accommodation at the end of their order or licence	PSA 16	CO	0
147	Care leavers in suitable accommodation	PSA 16	CO	0
149	Adults in contact with secondary mental health services in settled accommodation	PSA 16	CO	0
157	Processing of planning applications	CLG DSO	CLG	0
160	Local authority tenant satisfaction with their landlord services	CLG DSO	CLG	0

APPENDIX E: DETAILED JSNA CONTENT REVIEW

Coventry JSNA

Approach

Coventry JSNA has a short Scoping Document containing initial emerging key messages for Commissioners. This is a summary of the JSNA main document/analyses.

Coventry JSNA also has a longer document called Developing the Joint Needs Assessment of Health and Social Care for Coventry. This document is very comprehensive in its use of other Strategies and Plans. It not only refers to them but also includes the main relevant points where these are applicable.

Coventry includes a detailed analysis of Priority Neighbourhoods linking these with health indicators.

Coventry JSNA provides an analysis of health indicators for its BME communities.

Coventry JSNA includes identification of additional work and analyses required.

Coventry JSNA recognises the need to engage with stakeholders from the whole of health, social care and related areas to refine and develop commissioning across the city.

Evidence of key analysis and trends is in a separate book called The Coventry JSNA Databook 2008.

Housing/Health Related Themes

Coventry JSNA includes the following housing/health related themes:

- Gaps in housing provision Independent living
- Choice in housing provision (location and type) independent living
- Projecting future demands on housing for independent living
- Assistive technology for independent living of older persons
- Housing and self directed support
- Location of smoking cessation interventions
- Meeting need and demand for affordable housing
- Housing preferences of older people
- Aspirations of older people to downsize
- Housing and support needs of older people
- High density housing, crime and quality of life
- High density housing and street cleanliness
- Decent housing

- Improved standard of housing all tenures
- Meet needs vulnerable people in terms of housing, care and support
- Housing for people with mental health problems
- Housing choice for people with learning disabilities
- Meeting housing needs of offenders
- Improve homelessness service
- Modernise social housing in city
- Housing aspirations and quality of life in neighbourhoods
- Impact of independent living on planning, lifetime home standards and mobility needs
- Housing construction needs to be adapted to cope with climate change
- Climate change may make houses damp and lead to respiratory diseases
- Poorly insulated/heated homes and cold cause of illness and deaths in older people
- Poorest private sector homes highest heating costs and carbon footprint
- Energy Efficiency
- Improving quality of life in neighbourhoods
- Lower life expectancy in priority neighbourhoods
- Lower life expectancy in locations with BME communities
- Infant mortality higher in priority neighbourhoods
- Accidental fires and arson higher in priority neighbourhoods
- Vulnerable communities in priority neighbourhoods and affects of climate change
- Renewable energy systems and climate change

Dudley JSNA

Approach

Dudley PCT and Local Authority are producing a JSNA as part of a Health and Social Care Commissioning Framework. It will guide how services are commissioned over the next five years. It will focus on achieving better outcomes and service quality, increasing patient/user involvement and satisfaction, and using resources to maximum effect.

The Dudley JSNA is essentially a detailed analysis of the population demographics, need, demand, capacity and resources and how the PCT and Local Authority will plan for the future health, care and wellbeing needs of the population. The reason for doing a JSNA is because the request (demand) for health and social care can often appear to outstrip the availability (capacity) of services.

The aims of the Dudley Joint Needs Assessment are:

- i) to build a picture of current services i.e. baseline; and
- ii) to gather information to plan, negotiate and change services for the better and improve outcomes for the population.

Dudley's JSNA has an Executive Summary, and four other parts. These are:

- Part 1 Demography
- Part 2 Health Risks
- Part 3 Horizon Scanning
- Part 4 Community Care

There is some Ward based analysis for Health data and there is analysis at a smaller area for the English Indices of Deprivation.

Housing/Health Related Themes

Dudley JSNA includes the following housing/health related themes:

- Affordable housing and low incomes
- Need for more balanced housing stock
- Newly forming and concealed households and access to housing market
- Increase in home based care and high tech activity
- Geographical variations in major health risk factors
- Telecare to support users in their own home through care package
- Future development of telemedicine to monitor patients in home environment
- Ambulatory, community and home based services to increase
- Current and future needs of older households
- Support services and adaptations to keep older people in homes

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- Assessment of existing sheltered housing stock in meeting today's preferences
- Need for extra care accommodation for frail elderly
- Out migration patterns and housing demand
- Digital technology and social inclusion/quality of life
- Tourism and housing development of town centres
- Assistive technology in the home
- Low referrals to social care from Local Authority and Housing Associations

Herefordshire JSNA

Approach

Herefordshire JSNA has a particular focus on the disadvantaged. It begins with the background followed by what is known of the demography, social and environmental context, lifestyle risk factors and the burden of ill health and disability.

Herefordshire JSNA draws on some local needs assessments and socio economic profiling that has already been carried out. It refers to various Strategies and Plans such as the Local Area Agreement, Community Plan, and Children and Young Peoples Plan. It also mentions some needs assessments carried out in relation to people with physical disabilities, learning disabilities and mental health problems.

Herefordshire JSNA also takes into account regional and national sources of data and intelligence.

The material referred to in the JSNA was taken into account in the story of place in the Local Area Agreement, and it was further developed to inform the review of the Sustainable Community Strategy.

The Herefordshire JSNA follows the DH 2007 Guidance Recommendations in the Core dataset with its five domains; however, the Herefordshire approach extends to all factors that effect people's quality of life and life chances. This is reflected in a gap analysis and prioritised programme to fill the most important gaps.

The Herefordshire JSNA includes some analysis of smaller geographical areas including ONS Lower Super Output Areas.

Housing/Health Related Themes

Herefordshire JSNA includes the following housing/health related themes:

- Decent Homes
- Energy Efficiency
- Overcrowding
- Homelessness
- Difficulty in accessing owner occupation
- Poor housing condition of migrant workforce
- Level residential care and nursing homes for older people
- Independent living for older people
- Voluntary sector community support for independent living
- Living away from home for people with learning disabilities
- Supporting people with learning disabilities to live at home
- Services provided for people with learning disabilities
- Setting up of small homes for people with learning disabilities

Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy

- Services wanted by Users and Carers people with physical disabilities
- Need to replace out of county provision people and reduce nursing/residential care for those with physical disabilities

Sandwell JSNA

Approach

Sandwell recognises:

- the need to involve all stakeholders in identifying needs and acting upon them;
- that it should identify those needs and service requirements that are most important and relevant to its population;
- that in order to identify health and wellbeing needs the assessment process should make use of existing information, identify information gaps and should include the views of service users, patients and the population; and
- the need to look at the plans already in place and the needs of the population in addition to the analysis of socio economic data.

The following five stage process was established:

1. Summarise the current knowledge on the health, care and wellbeing needs of the local population to include the results of consultations where available
2. Review existing strategies and plans for action where necessary
3. Present findings to those people with responsibility for making key decisions on expenditure priorities
4. Engage local communities and stakeholders to ensure that priorities are the right ones and people are taking responsibility for their health improvement
5. Re-prioritise programmes of action in light of the evidence of need and of the effectiveness of interventions available to address this, and the aspirations of local people

Sandwell's JSNA includes:

- some geographical analyses of smaller areas such as Wards and ONS Lower Super Output Areas;
- maps and graphs to enhance analyses; and
- main geo-demographic MOSAIC Groups that exist in Sandwell.

Sandwell JSNA recognises that in relation to housing it needs to develop:

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- better measures of the National Indicator targets rather than the proxies currently being used; and
- a map of housing conditions and household health and well being needs.

Housing/Health Related Themes

Sandwell JSNA includes the following housing/health related themes:

- Housing standards determinant of health
- To create good quality and accessible homes
- Housing important role in health and well being, and delivery of adult social care and health services
- Role of housing for those with long term needs includes accessibility and adaptability
- Issues such as damp housing, uneven floors, lack of support rails etc. making it difficult to maintain health and well being
- Decent homes
- Decent homes essential for independent living
- Causes of fuel poverty
- Estimates households in fuel poverty
- Older people and fuel poverty
- Under occupancy and fuel poverty
- Energy Efficiency – SAP Ratings
- Concealed households
- Addressing homelessness results in health and social benefits
- Home accidents and health
- Use of private sector to provide temporary accommodation to alleviate homelessness
- Young People Leaving Care
- Vulnerable households
- Housing for people with mental health problems
- Gap in stable housing provision for drug users

Shropshire County JSNA

Approach

Shropshire JSNA can be seen as a whole or split into three parts; a one page Key Point summary, an Executive Summary and a full assessment.

Shropshire JSNA will be a living document on the PCT's and Council's website with hyperlinks to ongoing needs assessments.

Information in the JSNA builds on existing and current data sources and strategies held by the PCT and across the Council's community services and children services Directorates. The JSNA uses the LAA Evidence Base developed by the Shropshire Partnership as its foundation.

Information from qualitative surveys will be added to the JSNA so that communities' experience of existing services and thoughts on future design can be integrated into commissioning decisions.

Shropshire JSNA includes some geographical analyses of smaller areas including South, North and Central areas and ONS Lower Super Output areas. It also includes some maps to enhance the analyses.

The Joint Member Board, which consists of members of the PCT and Council, approved the JSNA on 3 June 2008, and declared it as the bedrock of commissioning decisions in relation to health and social care.

Housing/Health Related Themes

Shropshire JSNA includes the following housing/health related themes:

- Health determinants
- Health inequalities
- Young single homeless
- Appropriate housing for older people
- Housing for Lone Parents
- Helping people with mental health problems living at home
- Development of Assistive technology
- Long term health conditions and assistive technology
- Older persons and assistive technology
- People with learning disabilities in residential care and nursing homes
- Supporting people with learning disabilities to live in their own home
- Fire risks in the home
- Quality of life and independence for vulnerable adults
- End of Life Care
- Rural regeneration zone

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- Alcohol and drugs perceived problems in deprived neighbourhoods

Solihull JSNA

Approach

Solihull JSNAs Supporting documents listed at the end are Understanding Solihull, the Public Health Annual Report and various health strategies/needs assessments, the Children and Young Peoples plan and an Older Persons Quality of Life Strategy.

Solihull's JSNA contains analysis of Census data, English Indices of Deprivation, Hospital Episode Statistics, internal and other datasets. It includes trends and comparative data.

Solihull JSNA includes maps and graphs to enhance the analysis.

Solihull JSNA includes small area analysis at the Ward and ONS Lower Super Output Area level.

Solihull JSNA uses geo-demographic datasets, Places and People by Beacon & Dodsworth, and Acorn Classifications to look at health patterns and predict future health concerns.

Housing/Health Related Themes

Solihull JSNA includes the following housing/health related themes:

- Deprivation associated with housing tenure, overcrowding and poor house condition
- Location and type of housing affects deprivation
- Social housing correlation with higher deprivation
- Overcrowding higher in social housing
- Home environment affects health
- Pockets of high living environment (English Indices of Deprivation) deprivation in Solihull
- Links between certain geo-demographic groups and higher limiting long term illness
- Future health concerns and geo-demographic groups

Staffordshire County JSNA

Approach

The aims of the Staffordshire JSNA are as follows:

- Analysis of data identifying the health and well being status of local communities
- Identification of inequalities
- Include patient/carer and local community views
- Use evidence of effectiveness of interventions to shape the future investment and dis-investment of services

The Staffordshire JSNA will help achieve the following outcomes:

- Define achievable improvements in health and well being outcomes for the local community
- Help to target services and resources where there is most need
- Support health and local authority commissioners
- Deliver better health and well being outcomes for the local community
- Underpin the LAA and the choice of local outcomes and targets

To ensure that the Staffordshire JSNA is based on best practice the following components have been incorporated:

- Demographic and socio economic analysis
- Analysis of health status
- A service user/carer perspective (including community views where available)
- Involvement of both health and local government organisations
- Consideration of health inequalities/areas of greatest need
- Priorities for investment/service redesign to inform commissioning decisions

Staffordshire also has a Childrens JSNA. This profile provides a needs analyses to support the Children and Young Peoples Plan 2008. It acknowledges data gaps and plans to work on them.

Staffordshire provides some geographical analyses of data for its Districts and also some data to ONS Lower Super Output Area.

Staffordshire JSNA includes maps, charts and streetmaps to enhance the analyses.

Housing/Health Related Themes

Staffordshire JSNA includes the following housing/health related themes:

- Unfit housing stock

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- Costs of accommodation people with dementia
- Self funding in care homes
- Children in serious housing needs

Stoke-on-Trent JSNA

Approach

The objectives of the Stoke on Trent JSNA are:

- To Identify current and future health and well being needs of local communities in light of existing services and informs future service planning taking into account evidence of effectiveness
- To Identify the big picture in terms of health and well being needs and inequalities and inequalities of the communities in Stoke on Trent

Stoke-on-Trent will include the following in the JSNA process:

- The analysis of the data held by government agencies, the NHS, the City Council and partners such as the Police and Connexions
- Using the analysis to think about the future
- Determining what the priorities might be over the next three to five years
- Consulting with as many people as possible to test whether the priorities Stoke-on-Trent have identified are reasonable from the community point of view

The approach Stoke-on-Trent has taken locally is to put together a development process as follows:

- Phase 1: review the work undertaken to date and produce a JSNA report for October 2008 highlighting gaps.
- Phase 2: commission analysis of the core data as required by the Department of Health to be completed by mid 2009 and to include as part of this predictive modelling based on a range of “what if” scenarios.
- Phase 3: ensure Stoke on Trent PCT and the City Council have put in place an electronic system for the routine updating of data and analysis for the core data set as prescribed by the Department of Health.

Stoke-on-Trent has adopted a particular approach to tackling inequalities in health outcomes and improving health and well being. This particular approach uses life expectancy as the key measure of health and identifies the major areas where action is needed if we are to successfully reduce inequalities in health outcomes.

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The complete JSNA report was unavailable therefore the Summary has been reviewed here.

The Summary does not include any analysis of smaller area geographies; however, it does refer to other reports on local needs that contain geographical profiles including one with Ward data on health and social care.

Housing/Health Related Themes

Stoke-on-Trent JSNA Summary includes the following housing/health related themes:

- Experience of housing and other factors affects lifestyles and way people view lives
- Lifestyles and way people view lives affects ill health
- Ill health due to lifestyles and way people view lives affect life expectancy
- Initiatives to tackle deprivation including housing
- Identification of local needs in relation to social care, housing and health
- Poverty reduction
- Improving lifestyles communities
- Data systems to be developed to capture needs of local people with physical and sensory disabilities, mental health needs and learning disabilities

Telford and Wrekin JSNA

Approach

Not yet available.

Housing/Health Related Themes

Not yet available.

Walsall JSNA

Approach

Walsall has a focus on tackling health inequalities in its JSNA. It also has a Health Inequalities Strategy. It has a Core dataset for 2008 and an Interim JSNA Summary.

The Core Dataset includes data on the English Indices of Deprivation, Census data on tenure and overcrowding/occupancy rating, house prices, fuel poverty, decent homes, and living arrangements for those with Learning Disabilities and Mental Health problems.

The Core Dataset and Health Inequalities dataset include some Ward based analyses of health data.

Walsall's interim JSNA Summary is about data, people, issues and action. It includes qualitative data on peoples needs in addition to quantitative data. It identifies health and well being issues and priorities emerging. It identifies action to be taken in the short and longer term to reduce health inequalities and achieve better health and well being outcomes.

It informs the Local Area Agreement and includes information from other Strategies.

It includes suggestions for improvements including more housing and other data, and a more detailed geographical analysis for parts of the borough.

Walsall NHS has established a working group to look at areas of housing and health related interventions with the overall aim of reducing the detrimental impact of housing on health and well being within the borough. As well as data sharing between partners to understand the links between housing and health better, early work has also identified several streams of work funding related specifically to mental health, the elderly and social housing regeneration.

Housing/Health Related Themes

Walsall Interim JSNA Summary includes the following housing/health related themes:

- Energy efficiency
- Heat through Warmth
- Links between illness, deprivation and housing quality
- Adaptations
- Supported housing options
- Older people living alone
- Older people housing options
- Independence, health and social inclusion older people through home ownership

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- Intensive home care for older people
- Overcrowding
- Fuel poverty
- Decent homes
- Care pathways housing, health and social care
- Housing for people with learning disabilities and greater choice
- Help to live at home for people with mental health problems
- Fall Prevention
- Improving sustainability and standard of current and future homes
- More affordable housing
- Working with credit unions to alleviate debt due to lack of access to discounts for tenants
- Care at home and earlier preventative interventions
- More options young person temporary accommodation

Warwickshire County JSNA

Approach

The Joint Strategic Needs Assessment is a process undertaken in partnership across Health and Social Care and this JSNA has been undertaken jointly between Directors of Public Health, Adult Social Services and Children's Services.

JSNA is the process by which the current and future health and well being needs of Warwickshire's population are identified. The resulting document is a summary of the main health and well being needs of the county. The JSNA is designed to provide an understanding of the need for health and social care in the short term (three to five years) and the longer term (five to ten years).

The JSNA has been informed by a Foundation report that contains numerical and modelled data drawn from a range of sources as well as information from consultation exercises conducted by the County Council and PCT to capture the views of stakeholders, patients, service users and carers including adults, children and young people.

This is the first JSNA produced for Warwickshire which incorporates comments received on a draft version during a consultation period which ran to 31 January 2009. It will be regularly refreshed and updated as new information comes to light and we get additional feedback from Warwickshire residents about their needs. The County Council and NHS Warwickshire are committed to updating the JSNA on an annual basis. It is the intention that the document will be available on-line and that web-based tools will be developed to facilitate access to the data that underpins the JSNA.

Warwickshire JSNA includes some geographical analyses of its local authority areas and also the ONS Lower Super Output Areas.

Warwickshire JSNA includes some maps and tables to enhance analyses.

Warwickshire already has well established partnerships in place. These partnerships, which include district and borough council colleagues and other key partners, play an important role in assessing the needs of Warwickshire communities, developing action plans and performance managing to ensure delivery of outcomes. A range of mechanisms including the Local Area Agreement, Sustainable Community Strategies, joint commissioning strategies and housing and homelessness strategies underpin this work. These partnership and strategy arrangements will inform and be informed by this and future JSNAs.

Housing/Health Related Themes

Warwickshire JSNA includes the following housing/health related themes:

- Factors that impact on health and well being
- Need outstripping demand for some Supporting People client groups
- Primary healthcare needs homeless and offenders often unmet
- Health needs of Gypsies and Travellers, and homeless people
- Increased choice and control of people normally admitted to Care homes
- Good quality residential and nursing home provision
- End of life care
- Housing need information to be incorporated for maintaining independent living & health well being
- Care delivered at home or close to home results consultation
- Hard to reach groups for healthcare
- Pressure on housing stock from migrant workers
- Need for affordable housing
- Poor condition housing
- Referrals for abuse and neglect low from Housing sector
- Excess winter deaths among vulnerable groups
- Housing preferences older people
- Housing for asylum seekers and refugees
- Extra Care Housing
- Deprivation and Regeneration work
- Self Care and more flexible care in the home for long term conditions
- End of Life Care
- End of Life Care in Care homes
- Disabled Facilities Grants

Wolverhampton JSNA

Approach

Joint Strategic Needs Assessments are intended to explore health and well being needs of different groups in the local population - now and, where possible, projected into the future.

Looking at the short and longer term, the Joint Strategic Needs Assessment (JSNA) should provide an evidence base that commissioners can use to inform their decisions about service planning and design.

The JSNA is intended to link to other strategic and action planning processes. For example, it should form a 'baseline' for the Sustainable Communities Strategy and link into the Local Area Agreement (LAA). Meanwhile, demonstrating a good understanding of the needs of local people is core both to the World Class Commissioning competencies set out in the Department of Health's Commissioning Framework for Health and Well being and the new Comprehensive Area Assessment framework.

The JSNA aims to identify groups whose needs are not currently being met. There is a strong focus on identifying inequity and inequalities between different groups.

The Wolverhampton JSNA includes analysis of smaller areas such as Priority Wards.

The Wolverhampton JSNA uses MOSAIC household data (a geo-demographic segmentation model) at the postcode level to identify key high-risk groups with high needs in terms of health and social care. This can assist in targeting services to the areas where these groups are located. The Mosaic data has enabled the creation of Index Scores and future projections to assist with the analyses.

Wolverhampton JSNA identifies the need for a databank run by partners from which to draw on in the form of a database linked to mapping tools, and investment in skills of staff responsible for data analysis.

Wolverhampton JSNA recognises the need for involvement of stakeholder groups and the wider population, and regular reviews of the JSNA as an ongoing process.

Housing/Health Related Themes

Wolverhampton JSNA includes the following housing/health related themes:

- Poor health linked to deprivation and housing among other factors
- Access to primary care services lower in deprived areas
- Higher emergency hospital admissions social housing in deprived areas
- Links between health and other inequalities such as housing

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- Social housing and health outcomes
- Social housing and unhealthy lifestyles
- Social housing and access to leisure services
- Social housing and hospital admissions
- Older people in social housing with high care needs highest service users
- Pregnant teenagers and need for supported housing
- Poor housing and poor health
- Social housing, social exclusion and poor health
- Overcrowding, inadequate amenities and poor health
- Decent homes
- Vulnerable people and decent homes
- Families with no central heating
- Health inequalities and BME communities

Worcestershire County JSNA

Approach

This is the second JSNA for Worcestershire. This document builds on the approach taken in 2007/08, and integrates the analysis around the health and wellbeing priorities for adults and children.

There is also a Children's' JSNA for Worcestershire. This needs assessment is predominantly based on secondary data sources as well as the views of children, young people, their families and other stakeholders gathered through a series of consultation exercises. As part of the ongoing process of analysing the needs of children and young people in Worcestershire, data and information have been mapped at a super output area level using Instant Atlas to help identify local needs, thus enabling us to plan service delivery at a local level. Relevant data for a series of outcomes have been mapped on the basis of the home postcodes of children and young people's. These maps can be accessed at:

www.worcestershire.gov.uk/chsmapping

This JSNA considers eight priorities identified by the Worcestershire Joint Commissioning Group:

- Ageing population
- Alcohol
- Dementia
- Employment of those with mental health problems or learning disabilities
- End of life/Palliative Care
- Child and Adolescent Mental Health
- Teenage Pregnancy/Sexual Health
- Disabled children

It combines work undertaken across the children, young people and adult client groups. There are two clear themes of physical and mental health throughout the document, which is more transparently evident in some cases than others.

The JSNA crosses the time period of two Local Area Agreements, both of which have priorities in terms of health and well being. These are:

Existing (Round Two) Local Area Agreement

- To increase life expectancy and reduce morbidity in adults (reward)
- To reduce incidence of coronary heart disease and cancer
- To improve the quality of life of older people
- To improve the quality of life of older people with a limiting long term illness (reward)

Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy

- Health inequalities
- Improved life choices for people with mental health problems

New Local Area Agreement (2008-2011)

- To support and improve the leading of healthy lifestyles and wellbeing of adults, children and young people
- To improve the quality of life and independence of older people and those with a long term illness
- To reduce levels of inequality within the community

The priorities within the new Local Area Agreement have been fully aligned with the refreshed Sustainable Community Strategy.

The document covers many of the indicators detailed in “The JSNA Core Dataset” (Department of Health/Association of Public Health Observatories, 2008). It begins with demographic information, and then focuses on specific priorities. Underlying data and geographical mapping is available via “Profiling Worcestershire” at www.worcestershire.gov.uk/chsmapping.

Worcester JSNA contains some geographical analyses of its six districts and some at the ONS Lower Super Output area level.

Worcester JSNA includes graphs and maps to enhance its analyses.

Housing/Health Related Themes

Worcestershire County JSNA includes the following housing/health related themes:

- Alcohol misuse and problems with housing and homelessness
- Projected increase in older single persons living alone
- End of life care in the home
- Support for people with mental health problems to live at home
- Support for people with learning disabilities to live at home
- Lack of central heating and poor health in the elderly
- Accommodation needs for gypsies and travellers
- Link between poor housing and substance misuse
- Targeting of services for substance misuse to geographical hotspots
- Adaptations to housing for those with physical and sensory disabilities
- Links between mental and physical health, domestic abuse and good quality housing in a sustainable environment
- Role of housing in deterring offenders
- Decent housing
- Affordable housing and demand/supply
- Homelessness
- Hidden homelessness

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- Housing and support needs of children and young people
- Lack of access to private rented market for young people
- Low income households and health problems for children.

APPENDIX F: SHMA CONTENT RELATING TO HOUSING AND HEALTH

SHMA	Theme	Extract	Page no.
C1	Health	<p>The Government's proposals for housing policy are set out in the Green Paper Homes for the Future: More Affordable, More Sustainable. The Green Paper is based on three main Government objectives:</p> <ul style="list-style-type: none"> • more homes to meet growing demand • well-designed greener homes, linked to good schools, transport and healthcare • more affordable homes to buy and rent 	37
C1	Health	The condition of the housing stock is examined with reference to the decent homes standard and the new Housing Health and Safety Rating System (HHSRS).	69
C1	Health	The Housing Health and Safety Rating System replaced the Fitness Standard as a criterion of the Decent Homes Standard on 6th April 2006. 'A home should be above the current statutory minimum standard for housing, in a reasonable state of repair, have reasonably modern facilities and provide a reasonable degree of thermal comfort' (HMA Guidance)	81
C1	Health	The Housing Health and Safety Rating System (HHSRS) process identifies defects within a dwelling and scores the potential risk of this hazard to the health and safety of persons using the building. Key hazards considered within an assessment include the risk of falls, hot surfaces and materials positioned inappropriately, above average risk of fire, damp and mould growth and excessive cold. Unlike the fitness standard the HHSRS takes into account the likely risk to possible occupiers of the building. Housing stock, which is classed as being subject to a Category 1 Hazard require a mandatory response from a Local Authority as they are considered to have an unacceptably high risk of serious injury or mortality.	81
C1	Health	<p>Changing Lives is Staffordshire County Council's change programme which aims to improve services for older people and people with disabilities. The Changing Lives vision is to promote independence, inclusion and wellbeing for older or disabled residents, by enabling them to:</p> <ul style="list-style-type: none"> • have more control over their lives • live safe, healthy and fulfilled lives • have an active role in a stronger and prosperous community, and • access the support they need in order to be as independent as they choose 	140
C1	Health	There are three main drivers to change in this area. First and most important is what older people and people with disabilities have said about how they want to live and about the support they need. Second is the Government's	140

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SHMA	Theme	Extract	Page no.
		White Paper Our Health, Our Care, Our Say which sets out requirements for community-based services that help people remain in their own home. The third and final driver is the predicted increase in the number of older people who will require support, and the financial pressures this will bring.	
C1	Health/Social Care	Changes within the health and social care sector have meant greater emphasis is given to preventative measures and maintaining a healthy population into older age is seen as a key priority. The 60+ age group is seen as the target population where there is most to gain by improving health and reducing inequalities and focusing on preventative measures. The older generation aged over 75 still require these preventative measures, but they are the population most likely to be frailer and have increasing demand for health and social care services affecting their housing needs and choices.	142
C1	Health	Lichfield District has the highest proportion of people aged 60 – 64 with 29.5% of the over 60 population, followed by Tamworth with 28.9%. Both these districts have more than 70.0% of their older population in the ‘younger’ age group of 60 – 75 resulting in population forecasts of an increasing older population, both in absolute numbers and proportionately and suggesting that service provision should include a key target of engaging with the younger older population moving into their older life and keeping them fit and healthy.	143
C1	Health/Social Care	Giving older people the choice to continue to live in their own homes for as long as they can requires partnership working between housing, primary care, community health services, social services as well as a variety of voluntary organisations. Services will include the provision of timely adaptations to the home, support services for health and social care as well as organisations to assist older people to maintain their homes.	143
C1	Health	Birmingham has the highest percentage of the older population living in social rented accommodation with 25.8%, followed by 24.2% in Tamworth. Birmingham’s Plan for Older People notes older people are disproportionately represented in the council’s housing stock with research suggesting 34.0% of council tenants are aged over 60. Repair programmes to meet Decent Homes standards will need to take account of the negative health and well being impact of such work on older residents.	144
C1	Health	Key themes running through the Supporting People Strategies and Housing Strategies of the four districts of the C1HMA are: <ul style="list-style-type: none"> • Provision of further floating support services to enable vulnerable people to continue to live at home. Different districts identify a range of client groups requiring enhanced services. • For example Lichfield District considers priority should be focused on increasing provision to ex-offenders and those with mental health problems, those with learning difficulties and people with drug and alcohol problems. Birmingham identifies a wider spread of needs which includes these groups, along with refugees, young people at risk and teenage parents. Tamworth views future provision focused on young people, people with a 	150

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SHMA	Theme	Extract	Page no.
		<p>physical or sensory disability, substance misuse problems, mental health difficulties, ex-offenders and homeless people.</p> <ul style="list-style-type: none"> Partnership working including councils, health services, voluntary and independent organisations. Tamworth's Housing Strategy states the intention to work with a range of partners to deliver coordinated special needs housing projects and support services in the Borough. Development of additional supported housing. 	
C1	Housing related support	The capacity of people with special needs to live with maximum independence in housing depends on levels of support. One key mechanism for delivering housing related support services to vulnerable people is through the Supporting People Programme.	149
C1	Housing related support	Solihull's strategy 'All Our Tomorrows' includes the following principle regarding provision: Give relative priority to the development of extra care housing in order to maximise older people's independence and to reduce the use of care homes by frail ambulant older people. Extra care housing schemes allow people to be tenants in their own right and receive a flexible package of domiciliary care and housing related support	146
C2	Health	The condition of the housing stock is examined with reference to the decent homes standard and the new Housing Health and Safety Rating System (HHSRS).	68
C2	Health	The Housing Health and Safety Rating System replaced the Fitness Standard as a criterion of the Decent Homes Standard on 6th April 2006. A home should be above the current statutory minimum standard for housing, in a reasonable state of repair, have reasonably modern facilities and provide a reasonable degree of thermal comfort (HMA Guidance)	78
C2	Health	The Housing Health and Safety Rating System (HHSRS) process identifies defects within a dwelling and scores the potential risk of this hazard to the health and safety of persons using the building. Key hazards considered within an assessment include the risk of falls, hot surfaces and materials positioned inappropriately, above average risk of fire, damp and mould growth and excessive cold. Unlike the fitness standard the HHSRS takes into account the likely risk to possible occupiers of the building. Housing stock which is classed as being subject to a Category 1 Hazard require a mandatory response from a Local Authority as they are considered to have an unacceptably high risk of serious injury or mortality.	78
C2	Health/Social Care	With the growing populations of older people across different generations and different ethnic groups, the housing needs of a person aged 85 and those of a person aged 60 are likely to be very different. The type of accommodation needed may be different and the demand for health and social care services is likely to increase as a person ages.	140
C2	Health	Maintaining independence and giving people the choice to continue to live in their own homes for as long as they can is a key national and local driver bringing increased partnership between housing, primary care, community health services, and social services as well as a variety of voluntary organisations.	140

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SHMA	Theme	Extract	Page no.
C2	Health	The Coventry Older Peoples Housing Strategy includes as a key priority developing partnerships with private developers and RSLs in order to develop affordable non-sheltered, extra care and non-extra care housing schemes of mixed tenure; including older people with learning disabilities and those with mental health needs and BME elders.	142
C2	Health	Warwickshire Supporting People Strategy (2005 -2010) outlines the levels of housing related support provided to assist people to live independently in appropriate accommodation. Major priorities are: (i) increased and rationalised floating support (ii) tackling shortage of move-on accommodation (iii) further capacity for people with mental health problems (iv) services to people with learning disabilities (v) county-wide tenancy support for deaf people.	145
C2	Health	Table 85 shows the level of overcrowding and lack of central heating for West Midlands households by ethnic group. The data has been compiled from 2001 Census figures by the University of Birmingham Department of Health and Epidemiology. The table can be used as an indicator of housing quality, with overcrowding defined as having at least one room too few for the number of people in the household.	145
C2	Housing-related support	Expectations around space have changed, and types of housing-related support required differ from the past because of the expectations for continuing independence and choice.	137
C2	Housing-related support	Warwickshire Supporting People Five Year Strategy fleshes out the need for housing-related support for older people. Supporting People has a key role in helping older people to live independently at home, taking account of key issues in private housing which include an ageing population, and rural isolation.	141
C3	Health	In terms of employment, the agricultural and manufacturing sectors are expected to decline whilst the greatest growth is expected in the fields of education, health & social work. The decline in manufacturing must be considered to be a threat to the economic future of the C3 sub-region, particularly in Sandwell, Walsall and Telford and Wrekin as more than 20% of jobs are currently concentrated in this sector.	51
C3	Housing support	The local studies in Sandwell, South Staffordshire and Wolverhampton all pointed out that demand for supported housing from existing households is primarily for sheltered housing in the social housing sector and independent accommodation with external support, and that resources should focus on the provision of home based support services and adaptations for older people living at home in both social rented and owner occupied housing, in addition to providing more older persons accommodation in general. These reports note that although a high proportion of older people may have their own resources to meet their accommodation and care needs and provision should not be exclusively in the social rented housing sector, others will need financial support to enable them to access housing support services.	93

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SHMA	Theme	Extract	Page no.
North	Health	The condition of the housing stock is also examined with reference to the fitness standard, decent homes standard and the new Housing Health and Safety Rating System (HHSRS).	84
North	Health	The condition of housing stock within these five districts can be assessed by different measures ranging from the minimum fitness standard to basic quality standards of acceptable accommodation including the Decent Homes Standard and assessment through the Housing Health and Safety Rating System	95
North	Health	However baseline assessment of the condition of housing stock in all districts under each of these different criteria is not yet available as some districts most recent private sector stock condition surveys predate the major changes to housing legislation brought in by the introduction of the Housing Health and Safety Rating System in April 2006 which replaced the fitness standard. Some also predate the introduction of the decent homes target to include vulnerable people living in non-decent homes.	96
North	Health	The Housing Health and Safety Rating System (HHSRS) replaced the unfit dwelling criteria for assessing the quality of current housing stock in an area from April 2006. The process identifies defects within a dwelling and scores the potential risk of this hazard to the health and safety of persons using the building. Key hazards considered within an assessment include the risk of falls, hot surfaces and materials positioned inappropriately, above average risk of fire, damp and mould growth and excessive cold. Unlike the fitness standard the HHSRS takes into account the likely risk to possible occupiers of the building. Housing stock which is classed as being subject to a Category 1 Hazard require a mandatory response from a Local Authority as they are considered to have an unacceptably high risk of serious injury or mortality.	100
North	Health	Maintaining independence and giving people the choice to continue to live in their own homes for as long as they can is a key national and local driver bringing increased partnership between housing, primary care, community health services, social services as well as a variety of voluntary organisations. Effective housing for older people and people with specific needs requires this partnership approach.	168
North	Health	Changing Lives is Staffordshire County Council's change programme which aims to improve services for older people and people with disabilities. The Changing Lives vision is to promote independence, inclusion and wellbeing for older or disabled residents, by enabling them to: <ul style="list-style-type: none"> • have more control over their lives • live safe, healthy and fulfilled lives • have an active role in a stronger and prosperous community, and • access the support they need in order to be as independent as they choose 	169
North	Health	There are three main drivers to change in this area. First and most important is what older people and people with	169

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SHMA	Theme	Extract	Page no.
		disabilities have said about how they want to live and about the support they need. Second is the Government's White Paper Our Health, Our Care, Our Say which sets out requirements for community-based services that help people remain in their own home. The third and final driver is the predicted increase in the number of older people who will require support, and the financial pressures this will bring.	
North	Health	Newcastle-under-Lyme Housing Strategy also highlights that there are 2,500 people over 75 with Limiting Long-Term Illness and poor health, some of whom would benefit from extra-care housing. There was also an identified need for improved advice and possible remodelling of older people's housing services.	171
North	Health/Social Care	With the growing populations of older people across different generations and different ethnic groups, the housing needs of a person aged 85 and those of a person aged 60 are likely to be very different. The type of accommodation needed may be different and the demand for health and social care services is likely to increase as a person ages.	178
North	Health	Table 97 shows the level of overcrowding and lack of central heating for West Midlands households by ethnic group. The data has been compiled from 2001 Census figures by the University of Birmingham Department of Health and Epidemiology. The table can be used as an indicator of housing quality, with overcrowding defined as having at least one room too few for the number of people in the household.	189
North	Housing support	<p>Actions in support of this aim include:</p> <ul style="list-style-type: none"> • Partnership work with Supporting People and partners to develop a range of housing support services, including extra care • community based care/support services • further development of Home Improvement Agencies, handy person and other support schemes in the home • home safety checks • assistive technology 	170
North	Housing related support	Expectations around space have changed, and types of housing-related support required differ from the past because of the expectations for continuing independence and choice.	174
North	Housing related support	Staffordshire Supporting People Strategy (2005 – 2010) outlines the levels of housing-related support provided to assist people to live independently in appropriate accommodation.	181
West	Health	For people experiencing mental health problems, current supported housing was not commissioned for people with multiple or complex needs. Provision is targeted in the areas of shared ownership (e.g. via Advance Housing's own home scheme), floating support and remodelling transitional supported housing.	161
West	Health	Shropshire's Homelessness Strategy identified vulnerable groups that need to be included and supported to prevent and reduce homelessness; including: <ul style="list-style-type: none"> • care leavers and young people 	165

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SHMA	Theme	Extract	Page no.
		<ul style="list-style-type: none"> • former armed forces personnel • asylum seekers • black and minority ethnic groups and Travellers • people fleeing domestic violence • people with mental health issues • offenders • drug and alcohol users • rough sleepers 	
West	Health	On an area basis, Shropshire Homelessness Review highlights key issues for each Local Authority. Bridgnorth, with 14.6% in the private sector compared to the regional average of 7%, recognises that vulnerability of private sector tenants, high rent levels, and scarcity of available private sector housing contributed to homelessness. Young people presenting as homeless have increased, and services have been scarce, with lack of move-on accommodation. There is a need for more single person accommodation for people with mental health issues. Overall, lack of full, detailed information, and a need for better partnerships and more permanent housing are identified as key points.	166
West	Health	Oswestry, like the other districts, identified a shortfall of affordable housing. The biggest cause of homelessness was the loss of private sector accommodation. There were no direct access hostels in Oswestry area for homeless people. The Homeless in Oswestry Action Partnership (HOAP) and the Oswestry Homeless Prevention partnership (OHPP) were active with clients. Levels of need for services for homelessness were not well known. Challenges of partnership working with Health, Probation and Social services remained.	167
West	Health	As the county town, there is a migration of young homeless people into Shrewsbury, this being a priority area for work with Supporting People. Another priority area is work with homeless people with mental health issues. Key issues include: furnishing accommodation, need for 24 hour support, providing responsive services across rural areas.	168
West	Health	County-wide, there appears to be a need for support towards maintaining tenancies, better joined-up work, up-dated and accessible information, and better targeting of services to young people and people with complex needs e.g. mental health issues. The overall target over three years is to bring together homelessness strategies across the West Midlands, highlighting prevention.	168
West	Health	The mainly rural nature of Shropshire and Herefordshire means that they are likely to experience a number of the rural housing need issues identified in national research. In recognition of the social and economic issues faced by rural populations (often compounded by isolation), a network of free, confidential support groups has been set up in the West Midlands. The Rural Support Network offers support to residents of rural areas of the West Midlands, including those with health problems and financial difficulties. The network includes the Herefordshire Rural Stress Action Group and	173

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SHMA	Theme	Extract	Page no.
		the Shropshire Rural Stress Support Network.	
West	Housing support	Shrewsbury & Atcham's Housing Strategy highlights housing support and disability adaptations.	154
West	Housing-related support	Herefordshire's Supporting people Five Year Strategy fleshes out the need for housing-related support for older people. Supporting people has a key role in helping older people to live independently at home, taking account of key issues in private housing which include an ageing population, and rural isolation.	154
West	Housing related support	Subject to funding, key aims of the Herefordshire Supporting People (SP) partnership include: (i) a housing related support service to complement the Local Authority's re-ablement strategy and to complement Extra Care provision (ii) a supported housing scheme with assistive technology (iii) early intervention floating support services for people with early stages of dementia or Alzheimer's disease.	156
West	Housing-related support	Shropshire Supporting People Strategy (2005 – 2010) outlines the levels of housing-related support provided to assist people to live independently in appropriate accommodation. A major priority is delivering floating support county-wide, with additional longer stay supported for some less independent older people and people with physical disabilities/learning disabilities. The support available falls short of need: for example Shrewsbury & Atcham housing needs assessment estimated that approximately 1,237 household members felt they needed care or support which is not provided.	154
West	Housing related support	The two Shropshire and Herefordshire Supporting People Strategies highlight key issues concerning housing related support requirements and unmet need.	161

APPENDIX G: HOUSING AND HEALTH DATA SETS

Data Source	Dataset	Subject	Details	Location	Geography
Census Data	Overcrowding	Housing	Overcrowding	www.neighbourhood.statistics.gov.uk www.nomisweb.co.uk	COA, LSOA, LA
Census Data	Central Heating	Housing	Central Heating	www.neighbourhood.statistics.gov.uk www.nomisweb.co.uk	COA, LSOA, LA
Census Data	Limiting Long Term Illness	Health	Consider themselves limiting long term illness	www.neighbourhood.statistics.gov.uk www.nomisweb.co.uk	COA, LSOA, LA
Census Data	Health Not Good	Health	Consider Health not Good (maybe use Over 65's)	www.neighbourhood.statistics.gov.uk www.nomisweb.co.uk	COA, LSOA, LA
Census Data	Tenure	Housing	May influence perception of health, owner occupiers better perception, links between social housing and poor health	www.neighbourhood.statistics.gov.uk	COA, LSOA, LA
Indices of Deprivation	Index of Multiple Deprivation	Deprivation	Measure of relative deprivation. Weighted combination of seven domains of deprivation created from 38 indicators.	www.communities.gov.uk	LSOA
Indices of Deprivation	Health Deprivation	Health	Years of Potential Life Lost, Comparative Illness & Disability Ratio, acute morbidity from HES, Incapacity Benefit	www.communities.gov.uk	LSOA
Indices of Deprivation	Barriers to Housing and Services Domain	Housing and Access to local Amenities	Overcrowding 2001 Census, LA Percentage Households form whom decision on application for assistance under homeless provision of housing legislation has been made, difficulty of access to owner occupation & Road Distance to GP Premises, Road Distance to a Supermarket or General Store, Road Distance to a primary school and road distance to a post office or sub post office	www.communities.gov.uk	LSOA

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Data Source	Dataset	Subject	Details	Location	Geography
Indices of Deprivation	Wider Barriers Sub Domain	Housing	Overcrowding 2001 Census, LA Percentage Households form whom decision on application for assistance under homeless provision of housing legislation has been made, difficulty of access to owner occupation	www.communities.gov.uk	LSOA
Indices of Deprivation	Geographical Barriers Sub Domain	Access to local amenities	Road Distance to GP Premises, Road Distance to a Supermarket or General Store, Road Distance to a primary school and road distance to a post office or sub post office	www.communities.gov.uk	LSOA
Indices of Deprivation	Living Environment Domain	Indoors and Outdoors Environment	Social and Private housing in poor condition (BRE and CLG EHCS), Houses without central heating 2001 Census & Air quality from 2005 from Staffs Uni, and National Atmospheric Emissions Inventory, Road traffic accidents involving injury to pedestrians and cyclists	www.communities.gov.uk	LSOA
Indices of Deprivation	Living Environment Sub Domain Indoors	Housing	Social and Private housing in poor condition (BRE and CLG EHCS), Houses without central heating 2001 Census	www.communities.gov.uk	LSOA
Indices of Deprivation	Living Environment Sub Domain	Pollution – Need for Green Housing	Air quality from 2005 from Staffs Uni, and National Atmospheric Emissions Inventory, Road traffic accidents involving injury to pedestrians and cyclists	www.communities.gov.uk	LSOA
Indices of Deprivation	Income Deprivation	Affordability Housing and effect on health	Income Support, Income Based JSA, Working Tax Credit, Child Tax Credit, Pension Credit Guarantee or NASS	www.communities.gov.uk	LSOA

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Data Source	Dataset	Subject	Details	Location	Geography
Indices of Deprivation	Income Deprivation Affecting Older People	Affordability Housing and affect on health	Proportion of People over 60 living in income deprived households	www.communities.gov.uk	LSOA
Indices of Deprivation	Income Deprivation Affecting Children	Affordability, Child Poverty Links to Health	Proportion of children aged 0-15 living in income deprived households	www.communities.gov.uk	LSOA
JSNA DH 2008 Core Dataset	Data to support JSNAs	Outline of Data to support JSNAs	This is an outline of the data that should be used to support JSNAs and its sources and geography. Information on projections, and measuring health inequalities and data sharing is included on this website. It includes relevant National Indicators that should be used.	www.yhpho.org.uk/default.aspx?RID=10310	Geography is defined throughout Core Dataset
Data Projections	Projections	Data to support JSNAs	This website contains information about which data in the Core dataset has free projections available and if not suggestions for the next best thing such as trend data.	www.yhpho.org.uk/default.aspx?RID=10310	Geography is defined throughout Core Dataset
Projecting Older People Population Information System	Older People Population Projections	Older People Population Projections	Institute of Public Care Website available to Planners and Commissioners of Social Care provision in England.	www.poppi.org.uk/	LA
Projecting Younger People Population Information System	18 to 64 year old population projections	Younger People (18-64) Population Projections	Institute of Public Care Website available to Planners and Commissioners of Social Care provision in England.	www.pansi.org.uk	LA

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Data Source	Dataset	Subject	Details	Location	Geography
HSSA data & BPSA data	Decent Homes	Decent Homes	HHSRS Category 1 Hazards replaces fitness standard decent homes private sector	www.communities.gov.uk	LA
HSSA data & BPSA data	SAP Ratings	Energy Efficiency	Standard Assessment Procedure Ratings for how Energy Efficient homes are Private Sector	www.communities.gov.uk	LA
HSSA data & BPSA data	Various	HMOs, LA Expenditure, homelessness, affordability	HMOs, Vacant Homes, homelessness, rough sleepers, lettings, affordable housing, private sector clearance, disabled facilities grants, capital expenditure and more datasets	www.communities.gov.uk	LA
Live Tables	Various	Housing - Affordability	Live Tables includes House Prices, Housing Renewal, Vacant Homes, Repossessions and many more	www.communities.gov.uk	LA
Table	Gypsies & Traveller Sites	Gypsy & Traveller Sites	Count of Gypsy and Traveller Sites provided by RSLs&Las Jan 2009	www.communities.gov.uk	LA
Clinical & Health Outcomes Knowledge Base	Numerous Health Indicators	Health	Some Indicators listed further on in this table	www.nchod.nhs.uk	Some at LA Level
RSL & LA Core Lettings	Homelessness lettings, Supported Housing Client Group Lettings	Homelessness, Additional Needs Groups, Diversity (Ethnicity & Nationality)	General Needs Statutory and non Statutory Homelessness, Supported Housing Client Groups for lettings in recent period, Travellers & Gypsies, Domestic violence etc.	www.core.ac.uk	LA, & lower levels using GIS

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Data Source	Dataset	Subject	Details	Location	Geography
Supporting People	Client Groups, Homelessness	Housing/Health Additional Needs Groups	Analysis of clients of Supporting People Programme	www.spclientrecord.org.uk	LA
Fuel Poverty	Fuel Poverty	Housing	Households spending more than 10% of income on fuel. West Midlands Regional Health Observatory has produced this at the Lower Super Output Area level for the West Midlands.	www.fuelpovertyindicator.co.uk www.wmro.org/standardTemplate.aspx/Home/Resources/Interactivemaps/Excesswinterdeaths	LSOA
Healthy Lifestyles	Smoking, Obesity, Fruit & Veg, Binge Drinking	Health	NHS Information and Social Care Centre, Healthy Survey for England 2005	www.neighbourhood.statistics.gov.uk	LA
Teenage Conceptions	Number Teenage Conceptions & Rate	Health	Number and Rate of Teenage conceptions	www.nchod.nhs.uk www.dcsf.gov.uk/everychildmatters www.apho.org.uk	LA, PCTs obtain at Ward Level from ONS by request, Experian has at Postcode and Household Level
Compendium Indicators, ONS data	Male and Female Life Expectancy at Birth	Health	General health measure	www.nchod.nhs.uk www.statistics.gov.uk	LA, PCTs may have this at lower levels such as Ward

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Data Source	Dataset	Subject	Details	Location	Geography
Compendium Indicators, ONS data	Mortality, All Causes	Health	General health measure	www.nchod.nhs.uk	LA
Compendium Indicators, ONS data	Mortality from Accidents	Health	Includes accidents which are not in the home.	www.nchod.nhs.uk	LA
Compendium Indicators, ONS data	Emergency Admissions Children with Asthma	Health	Data can be obtained via PCTs at LA level	www.nchod.nhs.uk	Strategic Health Authority, PCT staff can obtain at LA and PCT level
Compendium Indicators, ONS data	Number of patients had asthma review in past 15 months of those with asthma	Health	This records number of patients with asthma in each PCT area as well as those had review.	www.nchod.nhs.uk	PCT

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Data Source	Dataset	Subject	Details	Location	Geography
Compendium Indicators, ONS data	Mortality from Bronchitis, Emphysema and Chronic Obstructive Pulmonary Disease	Health	Deaths from respiratory diseases	www.nchod.nhs.uk	LA
Compendium Indicators, ONS data	Infant Mortality	Health	2007 data	www.nchod.nhs.uk	LA
Compendium Indicators, ONS data	Low Birth Weight	Health	Low birth weights	www.nchod.nhs.uk	LA
Health Profiles	People Diagnosed with Diabetes	Health Indicator	People diagnosed with diabetes Health Profiles	www.apho.org.uk	LA
Health Profiles	Obese Adults	Health Indicator	Obese Adults Health Profiles	www.apho.org.uk	LA
Health Profiles	Obese Children	Health Indicator	Obese Children Health Profiles	www.apho.org.uk	
Health Profiles	Statutory Homelessness	Housing/Health Indicator	Homelessness Health Profiles	www.apho.org.uk	LA
Health Profiles	Adults Who Smoke	Health	Adults who Smoke Health Profiles	www.apho.org.uk	LA

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Data Source	Dataset	Subject	Details	Location	Geography
Health Profiles	Deaths from Smoking	Health	Deaths from Smoking Health Profiles	www.apho.org.uk	LA
Health Profiles	Binge Drinking Adults	Health	Binge Drink Adults Health Profiles, Birmingham JSNA Baseline Report links alcohol and vulnerably housed people	www.apho.org.uk	LA
Health Profiles	Hospital Admissions from Alcohol Related Harm	Health	Hospital Admissions from Alcohol Related Harm Health Profiles	www.apho.org.uk	LA
Health Profiles	Drug Misuse	Health	Drug Misuse Health Profiles	www.apho.org.uk	LA
Health Profiles	Excess Winter Deaths	Health	Excess Winter Deaths Health Profiles	www.apho.org.uk	LA
Health Profiles	Children in Poverty	Health/Income	Children in Poverty Health Profiles	www.apho.org.uk	
West Mids Public Health Observatory	Hospital Admissions All Ages	Health	All Ages All Causes - This data can also be obtained for accidents, diabetes, respiratory tract infection etc.	www.wmpho.org.uk	West Midlands
Accidents in the Home	HASS&LASS	Health/Housing	ROSPA have UK stats for 2002 but none collected after that.	www.hassandlass.org.uk	UK
Accidents in the Home	Urban Living Research Report	Accidents in Home	The Urban Living teams Research on Health and Housing has compiled data on home accidents from Hospital Inpatient Records extracting codes that indicate occurrence in the home.	Not publicly available data	Can be constructed with a Geographical information system for any area

Research to Identify the Contribution that can be made to Health Outcomes by Regional Housing Policy

Data Source	Dataset	Subject	Details	Location	Geography
RSL & LA Core Lettings data	Vulnerable Households	Health/Housing	Lettings to vulnerable households Supported Housing client groups such as Learning disabilities, mental health, domestic violence, young people leaving care	www.core.ac.uk www.spclientrecord.org.uk	LA and lower levels using GIS geocoding to postcode for Core data
RSL & LA Core Lettings data	Domestic Violence	Health/Housing	Domestic violence number of lettings	www.core.ac.uk www.spclientrecord.org.uk	LA and lower levels using GIS geocoding to postcodes for Core Data
ONS Output Area Classification	Super Groups, Groups and Sub Groups	Geodemographic data	Demography of local areas	www.neighbourhood.statistics.gov.uk	LSOA, COA
Mosaic Household Data	HES & Tenure	Geodemographic data/social marketing	Can be used to predict likelihood of health problems such as teenage conceptions or heavy smoking occurring in small areas such as LSOAs. Useful for targeting resources to smaller areas. Mosaic data is included in the DH JSNA 2008 Core Dataset for those who hold it.	Experian – this dataset is only available at a cost however, many PCTs and some LAs (Birmingham, Sandwell, Wolverhampton) already hold it. www.experian.co.uk For information on the DH JSNA 2008 Core Dataset: www.yhpho.org.uk/default.aspx?RID=10310	Unit Postcode and Household
ACORN/Health Acorn	Population Profile	Geodemographic Data/Social Marketing	ACORN data is included in the DH JSNA 2008 Core Dataset for those who hold it.	Available at a cost. Some local authorities hold this dataset or have used it for analysis. (Coventry). www.caci.co.uk For information on the DH JSNA 2008 Core Dataset: www.yhpho.org.uk/default.aspx?RID=10310	Unit Postcode

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Data Source	Dataset	Subject	Details	Location	Geography
Places and People	Population Profile	Geodemographic Data/Social marketing	Places and People is included in the DH JSNA 2008 Core Dataset for those who hold it.	Available at a cost. Some local authorities hold this dataset or have used it for analysis. (Coventry) Beacon & Dodsworth www.beacon-dodsworth.co.uk For information on the DH JSNA 2008 Core Dataset: www.yhpho.org.uk/default.aspx?RID=10310	COA/LSOA
Personicx Geo	Population Profile	Geodemographic Data/Social marketing	Personicx Geo is included in the JSNA 2008 Core Dataset for those who hold it.	Axciom www.axciom.co.uk	Unit Postcode
ONS Urban/Rural Classification	Urban/Rural Classification	Urban/Rural Classification	2009 Rural Urban Classification may be useful for identifying isolated communities and access issues	www.statistics.gov.uk/geography/nrudp.asp	OA, LSOA, MSOA, Ward, LA
Hospital Episode Statistics	HES data	Health	Can run queries. Data incomplete. May be useful in time.	www.hesonline.nhs.uk	PCT, Strategic Health Authority
Place Survey	CLG data	Satisfaction with Local Area, Over 65s satisfaction with home and neighbourhood	Perception/Satisfaction Health & Well Being	www.communities.gov.uk	LA

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Data Source	Dataset	Subject	Details	Location	Geography
NROSH	Decent Homes Standard On Line Report, Other data on social housing	Decent Homes	Social Housing Database accessible to all RSLs and LAs and all agencies acting on their behalf	www.tenantservicesauthority.org	Original dataset any geographical area
HHSRS	Housing Health Safety Rating System	Private Sector	Chartered Institute of Environmental Health and Building Research Establishment Housing Centre Toolkit and Calculator with which local authorities can compare likely costs of interventions to potential health costs based on estimates of likely number of incidences in the area.	www.cieh.org/policy/good_housing_good_health.html	LA
Excess Winter Deaths Index	Excess of Winter Deaths	Excess Winter Deaths	West Midlands Regional Observatory has created an Excess Winter Deaths index at the LA level for the West Mids, based on the ONS Excess Winter Deaths. This is also used in the Urban Living Area housing and health research as an indicator.	www.wmro.org/standardTemplate.aspx/Home/Resources/Interactivemaps/Excesswinterdeaths	LA

APPENDIX H: GLOSSARY

Care and support describes the activities, services and relationships that help people to stay as independent, active, safe and well as possible, and to participate in and contribute to society throughout the different stages of their lives. People rely on a whole range of support, from their families, friends and communities, as well as from state-funded support such as care in their own home or a care home, financial support from the benefits system and help with housing. All of these services combine to help people live active lives, whatever their priorities and needs may be.

Primary care is the term for the health services that play a central role in the local community: GPs, pharmacists, dentists and midwives. Primary care providers are usually the first point of contact for a patient. They also follow a patient throughout their care pathway. Primary care trusts (PCTs) in England receive budgets directly from the Department of Health.

Secondary care is often acute healthcare (elective care or emergency care) provided by medical specialists in a hospital or other secondary care setting. Patients are usually referred from a primary care professional such as a GP.

Integrated care is when health and social care services work together to ensure individuals get the right treatment and care they need for their health concerns. Public health is the responsibility of the Department of Health and covers health protection, health improvement and health inequalities issues in England, including pandemic influenza, seasonal flu, patient safety, tobacco, obesity, drugs, sexual health, and international health.

The **Supporting People (SP) programme** provides strategically planned housing-related services which are typically parts of packages of support and potentially other services (which may be provided by the public, private or third sector).

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