



Chartered
Institute of
Environmental
Health

Local Government Association Housing Commission

Submission of the CIEH

February 2016

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1. Executive Summary

- 1.1 Local authorities play a crucial role in building and helping to create sustainable and cohesive communities.
- 1.2 Variations between and within different cities, towns and neighbourhoods in terms of social outcomes (e.g. life expectancy, early deaths, educational attainment, exposure to crime) can only be exacerbated unless local authorities are at the heart of the challenge for local authorities challenge in place-building.
- 1.3 Social and geographical mobility between, and within, neighbourhoods are crucial in tackling health inequalities through the creation of sustainable communities.
- 1.4 Community ownership of problems, involvement in local decision-making, opportunities to participate in community regeneration initiatives, as well as the quality of interactions between local public service organisations and members of the local community, are factors that need to be taken into account in developing and maintaining sustainable places and communities.
- 1.5 The cost of poor housing to the NHS for households aged 55 years or more (for first year treatment costs) is £624m, with these costs dominated by excess cold hazards and those associated with falls, both on stairs and on the level.
- 1.6 The evidence for the mental health and wellbeing impacts of housing, especially poor housing conditions, is less developed than that supporting physical health impacts.
- 1.7 Enormous benefits can accrue for older people through the installation of simple, relatively cheap adaptations in the home, such as handrails or other support mechanisms. The evidential case for home adaptations and Disabled Facilities Grants, not least in the savings to the NHS and care services, is overwhelming.
- 1.8 Interventions that improve housing conditions have been shown to result in improvements on mental health measures, including reduced anxiety or depression, psychological distress, and improved patient reported health score. Providing a warm home has been clearly shown to benefit both young and old in relation to their feeling of wellbeing as well as reducing the physical risks that can arise from cold homes.

2. Place shaping, community and infrastructure - in particular looking at the role of councils in shaping homes within prosperous places and communities
 - 2.1 Our decision where to live is shaped by a range of factors, including the presence of family members and friends, the quality of local schools, where we work, or the availability of essential services and facilities.
 - 2.2 The primary determinant of housing choice is the relative cost of housing. Unless we are in a high income bracket, or have considerable other financial resources at our disposal, choice is likely to be constrained. Where our relative disposable income is considerably lower than many other households, choice may virtually disappear. Renting, either in some form of social housing or in the private rented sector, may be the only available options but this depends also on availability and the local access criteria.
 - 2.3 Crucially, whether we find ourselves living in a substantial detached property in a leafy suburb, or renting a one-bedroom flat in a high rise tower block from a social landlord, our housing circumstances inevitably place us within a specific part of a city, town, or village. There are clearly some places that are better to live in than others, but there are no localities without either some positive or negative attributes. For example, many individuals identify the strong sense of community spirit and social cohesion that exists within otherwise deprived inner city neighbourhoods. Conversely, living in a remote rural settlement with no shop, post office, GP surgery, etc. may be fine if you have access to your own transport but it is an altogether different proposition if you have little income, poor physical health and are reliant upon public transport.
 - 2.4 Our housing circumstances therefore locate us within a specific place and neighbourhood – and this in turn provides us greater opportunities to embrace, or problems to overcome. Similarly, the role of the local authority in building and helping to create sustainable and cohesive communities is crucial.
 - 2.5 Variations between and within different cities, towns and neighbourhoods in terms of social outcomes (e.g. life expectancy, early deaths, educational attainment, exposure to crime) will persist and attempting to alleviate these inequalities is integral to the local authority's challenge in place-building.
 - 2.6 People experience social problems and forms of deprivation and/or exclusion because where they live provides them with advantages and disadvantages over and above their own personal characteristics and circumstances.
 - 2.7 Where we live usually has a primary function as a place (e.g. residential, commercial, industrial, or recreational). Providing this function well brings with it prosperity and positive outcomes, and it can be a good place to live in. However, if our neighbourhood is functioning poorly, and does not possess any other attributes that can compensate for this, then our locality has the potential to expose us to disadvantage and poor outcomes.
 - 2.8 If the function of our neighbourhood changes during the day (e.g. the switch from being a retail centre to a night time economy), or during the year (e.g. the ebb and flow of individuals such as students), then this can equally expose certain groups to negative situations which can impact upon health outcomes.

- 2.9 The extent to which our neighbourhood is connected or isolated from other communities can either expose us to problems spilling over from other areas, or prevent the spread of positive outcomes such as improvements in disposable incomes or employment prospects. Housing problems, and in turn health inequalities, occurring in our neighbourhood may be caused by factors within neighbouring communities rather than what is going on within our own neighbourhood.
- 2.10 The level of connection between, or isolation from, other neighbourhoods can also be shaped by transport networks. The degree of connectivity can enable the creation of an economically, socially and environmentally sustainable place, but its absence can serve to further concentrate social problems within an area. In this context, social and geographical mobility between, and within, neighbourhoods can play a crucial role in tackling health inequalities through the creation of sustainable communities.
- 2.11 We also need to acknowledge that the long-term improvement of social outcomes within a neighbourhood can be down to transforming the reputation of a locality as much as it can be the product of direct policy interventions designed to tackle material forms of deprivation and exclusion. In this regard, the role of the local authority in influencing these factors is critical.

Physical, built and natural environments

- 2.12 The nature of the physical and built environment within a neighbourhood can be a positive force for good in shaping health outcomes. But some physical environments can also be a source of harm, and a barrier to tackling the underlying causes of housing problems and poor health. The presence of specific facilities (e.g. factories), or food outlets (e.g. takeaways, off licences) clearly can exert a direct link on health. Access to services, transport networks and infrastructure can equally impact upon health outcomes (e.g. there is a link between traffic congestion and asthma).
- 2.13 The House of Lords Select Committee on National Policy for the Built Environment in its report "[Building Better Places](#)"¹ includes among its conclusions that *'the link between people and place is lost in decision-making concerning the built environment...and exert(s) a long-term negative impact upon health and wellbeing'*.
- It goes on to recommend *'...a number of strategies for improvement to streets, highways and the public realm, combined with additional measures intended to promote greater joint working between health and planning professionals and better local monitoring of health impacts resulting from the built environment.'*
- 2.14 The physical and built environment can also shape our mobility, social networks and the interactions that can promote individual and community inclusion, or create forms of exclusion. Alienation from our neighbourhood because of, for example, fear of crime brought about by poorly designed housing can directly impact upon our physical and mental health.
- 2.15 Our housing should be a gateway into the wider community, not a source of refuge from the real (or perceived) perils of living within a particular street or neighbourhood. Use of physical spaces and movement between locations cannot only shape our social connections, and opportunities to participate in community activities and decision-making, but it can also prevent us taking action to improve our health outcomes through increased physical activity levels. The presence of green spaces and other

¹ House of Lords Select Committee report "Building Better Places" (February 2016)

natural environments which can provide opportunities for physical activity and social connections varies considerably across different neighbourhoods, and the degree to which these are used is often shaped by both their physical up-keep and perception of them as a safe place.

- 2.16 The desirability, but also sustainability, of specific neighbourhoods is shaped by access to essential services and the opportunities that they offer. Good schools and training opportunities, stable employment, healthy food options, opportunities for physical exercise and recreation, essential resources (e.g. post offices, banking facilities, broadband) are as essential in shaping health outcomes as are the presence of GP surgeries, hospitals, mental health services, pharmacies, community health and support services, and access to health education.
- 2.17 Guaranteeing access to public services is, however, of little use if the quality of these services is poor. In many affluent neighbourhoods, it is the poor quality of public services used by individuals who do not have the means to go private that is the primary cause of place poverty as opposed to the scale of social problems and deprivation. Beyond the quality of direct service provision, the competence of local public service organisations in targeting resources and interventions, strategic decision-making and leadership, delivering integrated services and partnership working, and involving local citizens in local decision-making are also key factors in shaping the impact of neighbourhoods upon individuals and households.
- 2.18 Turning around communities and localities with high levels of deprivation, social problems and levels of stigma ultimately depends as much upon engendering a sense of belonging and identity amongst members of the local population as it does upon resources and policy initiatives. Identity and belonging are clearly shaped by personal circumstances and many individuals would not choose to put down roots in a neighbourhood which either exposes them to further problems or fails to offer them any meaningful opportunities. A positive connection with a neighbourhood, however, is equally shaped by levels of trust, community spirit, the presence of support networks and levels of self-help and resilience. Community ownership of problems, involvement in local decision-making, opportunities to participate in community regeneration initiatives, as well as the quality of interactions between local public service organisations and members of the local community, are factors that need to be taken into account in developing and maintaining sustainable places and communities.

3. Health and quality of life for an ageing population: the role of housing in preventing onward costs onto health and social care services

The physical and mental health impacts of poor housing conditions

- 3.1 The inequalities in the prevalence of poor housing, combined with the mental health impacts, mean that there is a clear case for action: housing is an important social determinant of health, and there is a need to improve housing conditions in order to help to reduce health inequalities. Drawing on data from the English Housing Survey 2011 and 2012, the BRE/PHE Briefing (2015)² showed that two million older people live in homes that do not meet the Decent Home Standard, with 1.3 million in a home with a serious hazard, resulting in high costs to the NHS, particularly due to cold related health problems and falls.
- 3.2 In 2012 there were 9.5 million households aged 55 and over (43% of all households), more than one fifth of the older households (21-22%) lived in a home that failed the Decent Home Standard, mainly because of the presence of a Category 1 hazard. There were 1.3 million households aged 55 years and over who lived in a dwelling with at least one Category 1 hazard.
- 3.3 As Garrett and Burris reported, the older households living in non-decent homes in 2012 included:
- 815,000 households aged 55-64;
 - 652,000 households aged 65-74; and
 - 533,000 households aged 75 and over.
- 3.4 780,000, or 8% of all households aged 55 years and over, including 11% of those aged 55-64 and 6% of all other older households, were in fuel poverty. In 2012 there were 2.3 million households in total in fuel poverty in England so 34% of those households in fuel poverty were aged 55 years or over.
- 3.5 The BRE/PHE Briefing estimates that the cost of poor housing to the NHS for households aged 55 years or more (for first year treatment costs) is £624m, with these costs dominated by excess cold hazards and those associated with falls, both on stairs and on the level. The proportion of older households living in a home with all four accessibility features (level access, flush threshold, WC at entrance level and sufficiently wide doors and circulation space) was similar for all older age groups, ranging from 4% (aged 55-64 years) to 7% (aged 80 years or over). Around a fifth of dwellings occupied by all the age groups aged 65 years and over had none of these key features, and this proportion was higher for households aged 55-64 years (24%).
- 3.6 The evidence for the mental health and wellbeing impacts of housing, especially poor housing conditions, is less developed than that supporting physical health impacts. There is often a clear pathway between a housing hazard and a physical health impact. The evidence for physical health outcomes are often medium or large scale and quantitative, whilst much of the evidence found relating to mental health is based on a smaller scale and is often qualitative studies. The result is that in relation to physical health, it is easier to make statements about the relationship between housing hazards and health due to the consistent and robust quantitative studies. In respect of mental health, the nature of the research base makes it more difficult to reach general

² Garrett H and Burris S (2015) *Homes and ageing in England*, Briefing Paper, BRE and PHE, BRE Trust, Watford

conclusions. However there is some evidence of pathways that might link poor housing conditions to mental health outcomes. For example, living in poor housing conditions has been shown to increase stress, and reduce empowerment and control, each of which have clear links with mental health outcomes.

- 3.7 The physical and mental health effects of poor housing disproportionately affect vulnerable people, especially older people, which can be made worse if they are living isolated lives, often without a support network. Enormous benefits can accrue for older people through the installation of simple, relatively cheap adaptations in the home, such as handrails or other support mechanisms. The evidential case for home adaptations and Disabled Facilities Grants, not least in the savings to the NHS and care services, is overwhelming.
- 3.8 The NHS 5 Year Forward View noted that a key condition for transformation across local health economies is a strong primary and out-of-hospital care system, with well-developed planning about how to provide care in people's own homes, with a focus on prevention, promoting independence and support to stay well. Home adaptations for disabled people meet this condition as they can enable independence at home; speed up hospital discharge/reduce readmission; prevent escalation of need e.g. accidents and falls; and support maintenance of physical and mental well-being.
- 3.9 The cost to the NHS and society of poor housing conditions is enormous and growing – and current cost estimates often do not include impacts on mental health. This means that it is possible that cost savings would in fact increase due to the reduction in mental illness – which costs England at least £105bn each year.
- 3.10 **Excess cold** experienced in the winter months can affect or exacerbate a range of health problems, including respiratory and circulatory conditions, cardiovascular disease, mental health and accidental injury for all age groups, but with older people being particularly vulnerable during cold periods leading to excess winter deaths, the majority of deaths occurred among those aged 75 and over.
- 3.11 England's housing stock is made up of relatively energy inefficient properties which can result in homes that are difficult or costly to heat. Despite a decline in excess winter deaths, UK rates suffer in relation to international comparators, and often exceed those in countries with colder climates. Winter deaths can also be affected by and confounded by the prevalence of influenza and air pollution. The use of the HHSRS to identify excess cold as a Category 1 hazard, improvements in property insulation and Winter Warmth schemes may have contributed to this reduction.
- 3.12 Interventions that improve housing conditions have been shown to result in improvements on mental health measures too, including reduced anxiety or depression, psychological distress, and improved patient reported health score. Providing a warm home has been clearly shown to benefit both young and old in relation to their feeling of wellbeing as well as reducing the physical risks that can arise from cold homes.
- 3.13 Excess cold also has an impact with clear evidence linking home temperatures and physical and mental health. The evaluation of the UK Warm Front Scheme for example, found that increasing the warmth of homes had a clear impact on mental health – those with bedroom temperatures of 21°C were half as likely to experience depression and anxiety than those whose bedrooms were only 15°C.

Case Studies

Place Shaping

CIEH Mapping Health Toolkit

<http://www.cieh.org/WorkArea/showcontent.aspx?id=51114>

Health and quality of life for an ageing population

Amber Valley District Council

<http://www.cieh-housing-and-health-resource.co.uk/casestudies/case-study1/>

Durham County Council – Keep Warm Stay Safe Pilot Project

<http://www.cieh-housing-and-health-resource.co.uk/casestudies/bristol-city-council-home-action-zones-healthy-home-programme/>

Islington Council – Partners in Prevention

<http://www.cieh-housing-and-health-resource.co.uk/casestudies/bristol-city-council-home-action-zones-healthy-home-programme/>

Liverpool City Council – Healthy Homes Programme

<http://www.cieh-housing-and-health-resource.co.uk/casestudies/bristol-city-council-home-action-zones-healthy-home-programme/>

North Devon Health and Housing Needs Assessment

<http://www.cieh-housing-and-health-resource.co.uk/casestudies/north-devon-health-and-housing-needs-assessment/>

DFG and Adaptations Good Practice Case Studies

<https://homeadaptationsconsortium.wordpress.com/good-practice/>