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Prevention in health and social care: healthy places

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Report, together with formal minutes relating to the report

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Health and Social Care Committee

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1 Introduction

1. We are carrying out a major inquiry on *Prevention in health and social care*. We announced ten workstreams that will form the basis of that inquiry, of which "healthy places" is one.[1] This is the second of a series of short reports for this inquiry.[2]

2. The places where people live—homes, neighbourhoods and communities—have a substantial impact on their likelihood of developing preventable health conditions. Aspects of place were a very common theme from witnesses responding to our initial call for evidence on *Prevention*. Submissions highlighted issues including housing;[3] town planning;[4] active travel infrastructure;[5] access to facilities for sport and physical activity;[6] availability, quality and convenience of amenities and services;[7] indoor and outdoor air quality;[8] and access to green and blue spaces.[9] Our respondents emphasised that "unhealthy" places generate substantial costs to the NHS and social care, as well as to individuals, the wider economy and society.

3. Socioeconomic determinants of health include the places that people live. These determinants contribute substantially to the likelihood of developing preventable ill health. The Marmot Review, *Fair Society Healthy Lives* (2010), identified striking levels of health inequality between communities.[10] People in poorer areas not only die sooner, but also spend more of their lives living with disability and ill health. Those in the poorest neighbourhoods in England, will, on average, die seven years earlier than people in the richest neighbourhoods, while the average difference in disability-free life expectancy is seventeen years.[11] A ten-year follow-up to the Review re-stated that there is

1 Health and Social Care Committee, The Prevention workstreams, 18 April 2023
2 Our first report on Vaccination was published on 27 July 2023
3 For example: Professor Matt Egan, Dr Jill Stewart, Dr Maureen Seguin, Dr Jakob Petersen and Dr Dalya Marks (PHS0100); UK Collaborative Centre for Housing Excellence (PHS0127); Royal Society for Prevention of Accidents (PHS0188); Lord Nigel Crisp (PHS0228); Bristol, North Somerset, and South Gloucestershire virtual Population Health Improvement Team (PHS0239); Disability Rights UK (PHS0292); Liverpool School of Architecture, University of Liverpool (PHS0301); Northumbria University (PHS0346); Royal College of Physicians (PHS0365); People's Health Trust (PHS0422); Health Equals (PHS0465); The Health Foundation (PHS0491)
4 For example: Dr Mark Green (PHS0059, PHS0613); London Borough of Enfield (PHS0083); Wakefield District Health and Care Partnership (PHS0105); Town and Country Planning Association (PHS0110); Tackling the Root Causes Upstream of Unhealthy Urban Development [TRUUD] (PHS0121); Chartered Institute of Public Finance and Accountancy (PHS0297); Bedfordshire, Luton and Milton Keynes ICS (PHS0549)
5 For example: Faculty of Sport and Exercise Medicine UK (PHS0041); UK Health Alliance on Climate Change (PHS0066); Centre for Sustainable Healthcare (PHS0095); Canal and River Trust (PHS0392); Greater London Authority (PHS0541)
6 For example: Faculty of Sport and Exercise Medicine UK (PHS0041); Dr Russ Jago (PHS0052); Centre for Sustainable Healthcare (PHS0095); Football Foundation (PHS0171); Dr Kajal Gokul (PHS0186); Richmond Group of Charities (PHS0192); Disability Rights UK (PHS0292); Sport England (PHS0476); Women in Sport (PHS0490); Sport and Recreation Alliance (PHS0538)
7 For example: Dr Mark Green (PHS0059); Pharmacy2U (PHS0278); Health Equalities Group (PHS0347); Professor Arpana Verma (PHS0415); National Youth Agency (PHS0534); North Yorkshire County Council (PHS0525); Greater London Authority (PHS0541)
8 For example: UK Health Alliance on Climate Change (PHS0066); Centre for Sustainable Healthcare (PHS0095); Professor Sheena Cruickshank (PHS0208); Royal College of Physicians (PHS0365); Health Equals (PHS0465); Greater London Authority (PHS0541); Professor Catherine Noakes et al. (PHS0572); British Thoracic Society (PHS0567)
9 For example: Dr Mark Green (PHS0059); UK Health Alliance on Climate Change (PHS0066); European Centre for Environment and Health, Exeter Medical School (PHS0218); Groundswell (PHS0250); Professor Arpana Verma (PHS0415); APPG on Air Pollution (PHS0597)
10 Marmot, M., Goldblatt, P., Allen, J. et al., Fair society, healthy lives (the Marmot Review), February 2010
11 Ibid., p.16

"a social gradient in the proportion of life spent in ill health", and that there remain "clear socioeconomic gradients in preventable mortality. The poorest areas have the highest preventable mortality rates and the richest areas have the lowest".[12]

4. The Government recognises the role of place in preventing ill-health. The 2019 Department of Health and Social Care (DHSC) consultation, *Advancing our health: prevention in the 2020s,* states that "the homes and communities in which we live have a big impact on our health".[13] In 2023, the Secretary of State for Levelling up, Housing and Communities, the Rt Hon Michael Gove MP, noted in a speech on the Government's "long-term vision" for housing that:

> The quality of the homes that we live in, the physical nature of our neighbourhoods, the design of our communities, determines so much. Our health, our happiness, our prosperity, our productivity–all depend on where we live.[14]

5. The importance of place in prevention of ill-health is also increasingly recognised in health systems. In July 2022, 42 new Integrated Care Systems (ICSs) were established across England. NHS Confederation suggests that these are well-placed to work towards the smarter use of resources by bringing relevant local partners—including health and care services, local authorities and voluntary and community organisations—"together to make decisions collectively".[15] ICSs have a goal of addressing health inequalities in the specific populations and locations that they serve.[16] NHS Providers makes the case that "hyper-local change is best placed to make the most tangible difference to […] levelling up in health", and says that ICSs offer an opportunity for neighbourhood health initiatives to become not just "projects but the foundational mindset" of health services—the "beating heart" of population health.[17]

6. Although "unhealthy" places and homes generate costs for the NHS, most of the policies that affect whether places support healthy lifestyles are not within DHSC's control. The King's Fund says that "although estimates vary about how much", the communities in which people "are born, live, work and socialise have a significant influence on how healthy they are".[18] Julia Thrift, Director of Healthier Place-making at the Town and Country Planning Association (TCPA), explained:

> The consensus is that the NHS provides about 20% to 30% of the things that keep us healthy, but the overwhelming majority of the factors that keep us healthy are the places where we live and work, and the environments in which we find ourselves.[19]

12 Marmot, M., Allen, J., Boyce, T., Goldbatt, P., Morrison, J., Health equity in England: The Marmot Review 10 years on, February 2020, p.13
13 Cabinet Office and Department of Health and Social Care, Advancing our health: Prevention in the 2020s - consultation document, 22 July 2019
14 Department for Levelling up, Housing and Communities, Long-term plan for housing: Secretary of State's speech, 24 July 2023
15 NHS Confederation (ICS0051)
16 NHS England, "What are Integrated Care Systems?", accessed 22 November 2023
17 Lewis, T., Putting neighbourhoods at the heart of integrated care, 8 December 2021
18 Buck, D., Wenzil, L. and Beech, J., Communities and Health, 5 May 2021
19 Q246 (Julia Thrift). We did not consider workplace issues, including occupational health hazards, as part of this workstream. We may, however, return to this in our future work.

7. **The places where people live—homes, communities and neighbourhoods—affect their health and wellbeing substantially. Place, health inequalities and the likelihood of developing preventable health conditions are inextricably linked. People from less well-off groups, and those who live in less well-off neighbourhoods, have a much higher likelihood of developing life-limiting health conditions and associated comorbidities, and of dying prematurely from the effects of those conditions. Although much of this ill-health is preventable, it is also often not within the power of individuals to control.**

8. **The evidence base on the importance of place in protecting good health is stronger than it has ever been. But as we discuss in the next chapter, we have known about the relationship between health and place for decades, if not longer. It is frustrating that more progress has not been made already. A determined focus on developing "healthy places" that can prevent ill-health amongst those most at risk is now vital in easing pressures on the NHS, and building a sustainable service for generations to come.**

2 Immediate steps

9. The aspects of place that affect the likelihood of the people living in them developing preventable health conditions which were raised most commonly in submissions to our inquiry were:[20]

a) Housing, from its quality to its suitability for particular occupants (for example, older people, large families or disabled people);

b) Aspects of town planning, including the availability of facilities and key services and the design of neighbourhoods and developments;

c) Infrastructure and services that support active and connected lifestyles, such as accessible, affordable and inclusive sports and social clubs and facilities and good quality active travel infrastructure.

Housing

10. Housing has long been recognised as an important determinant of health. Helen Garrett, Principal Consultant at the Building Research Establishment (BRE), told us that "we have known of the links between housing and health for many years, right back to the times of the Victorians and the poor housing and impacts on health then".[21] The APPG on *Healthy homes and buildings* noted that we spend 90% of our time indoors and that for many people, the majority of this will be at home.[22] High-profile cases such as the death of Awaab Ishak from a respiratory condition caused by mould in the housing association-owned flat in which he lived, have recently brought the relationship between health and housing into sharper focus,[23] while the Covid-19 lockdowns created a "once-in-a-lifetime 'stress test' for the nation's housing stock".[24]

11. The Health Foundation's research demonstrates that several aspects of housing affect the likelihood of residents developing preventable health conditions. They include:[25]

a) Quality, including excessive cold and energy efficiency of housing stock; building ventilation, both in keeping outdoor pollutants out and preventing indoor air pollution; and hazards resulting from disrepair.

b) Tenure and housing security: stress associated with frequent moves, the risk of falling into debt due to moving costs, and the weakening of social and community ties are all health risks associated with a lack of security of tenure. There is also a higher likelihood of living in a non-decent home under some tenures: for example, in the Private Rented Sector (PRS).

20 See references in previous chapter.
21 Q200 (Helen Garrett). See also Professor Jill Stewart, "Dr Addison and the Sanitary Inspectors", 11 August 2019
22 APPG for Healthy homes and buildings, Building our future: laying the foundations for healthy homes and buildings, October 2018, p.3. See also APPG for Healthy homes and buildings (PHS0xxx)
23 Courts and Tribunals Judiciary, Awaab Ishak: Prevention of future deaths report, 21 November 2022
24 Liverpool School of Architecture, University of Liverpool (PHS0301). See also Professor Jill Stewart, "Covid-19 and home", 30 July 2020
25 The Health Foundation, Evidence hub: housing, accessed 22 November 2023

c) Housing that is inappropriate for its occupants: for example, homes that cannot be adapted for disabled people or older residents,[26] or overcrowded accommodation, which is linked with experiencing psychological distress.

David Finch, Assistant Director at the Health Foundation, told us that households that experience one of these factors are more likely to experience additional ones, compounding the risks to health. He explained:

> It is not just the overcrowding and the home being at a non-decent standard; it is the fact that it is both at the same time that is worse. Even when you control for some other factors, there is still that overriding strong association. If you have a poorer-quality home, you are more likely to have poorer health.[27]

12. The BRE estimates that leaving people in the poorest 15% of housing stock in England—defined as housing containing at least one Category 1 hazard under the Housing Health and Safety Rating System (HHSRS)[28]—costs the NHS in England £1.4 billion per year in first year treatment costs alone.[29] Category 1 hazards are those likely to cause the most extreme health outcomes, including death, permanent paralysis or loss of consciousness, loss of a limb or serious fractures.[30] Expanding the definition of "poor housing" to include all homes with a "significant" HHSRS hazard brings the figure to £2 billion per year for England, which the BRE says is "still an under-estimate" of the full costs.[31]

13. The BRE's research suggests that homes in the private rented sector (PRS) are over-represented in terms of numbers of poor quality homes and the costs caused to the NHS. PRS homes represent around 19% of homes (4.7 million) but comprise around a quarter of all poor housing (25%) and its associated cost to the NHS (26%).[32] Some 40% of PRS homes are flats, including 11% of converted flats, which commonly date from pre-1919 and are more likely to have Category 1 hazards compared with all other types of dwellings.[33] Around 620,000 PRS homes have one or more Category 1 hazard, representing a cost to the NHS of around £290 million per year.[34]

26 See also National Housing Federation (PHS0620)
27 Q210 (David Finch)
28 The HHSRS is used by local authorities to assess health and safety risks in social and private rented residential properties. Category 1 hazards, depending on their severity, can include fire and electrical risks, excess cold, excess heat, damp and mould, fall risks, and risks from air pollution (for example, gas appliances emitting carbon monoxide).
29 Garrett, H., Margoles, S., Mackay, M., and Nichol, S., 2023 briefing paper: the cost of poor housing in England by tenure, 2023. For further detail on methodology see Nichol, S., Roys, M. and Garrett, H., Briefing paper: the cost of poor housing to the NHS, 2015.
30 See, for example, Cotswold District Council, Housing Health and Safety Rating System Category 1 Hazards, [no date], accessed 20 November 2023
31 BRE Group, "News and insights: the cost of poor housing to the NHS", updated 2023, accessed 20 November 2023
32 Garrett, H., Margoles, S., Mackay, M., and Nichol, S., 2023 briefing paper: the cost of poor housing in England by tenure, 2023, p.13
33 Ibid.
34 Ibid.

The Decent Homes Standard

14. The Department for Levelling Up, Housing and Communities (DLUHC) is responsible for the Decent Homes Standard (DHS), which outlines a minimum standard that social rented sector (SRS) properties should meet.[35] Under the current DHS, which has not been updated since 2006, "decent" homes must:

- meet the statutory minimum standard for housing as assessed using the HHSRS. Homes which contain a Category 1 hazard are considered non-decent;
- provide a reasonable degree of thermal comfort;
- be in a reasonable state of repair; and
- have reasonably modern facilities and services.

15. The DHS applies only to properties in the SRS. This means that there is no legal minimum standard for PRS homes. The DHS has been under review for several years.[36] The 2020 *Social housing white paper* initially committed to review, while the 2022 *Levelling up white paper* committed to halve the number of non-decent homes in both the SRS and PRS by 2030.[37] The Government has said the reviewed DHS, when complete, will cover both the SRS and PRS.[38] The review was relaunched in June 2023. The Government said in July 2023 that it hoped to launch a consultation on a new draft DHS "later this year", which at the time of writing had not yet been published.[39] In October 2023, the Government re-stated that it was committed to introducing a DHS for the PRS "as soon as parliamentary time allows".[40] The Renters (Reform) Bill, which is currently before Parliament, does not contain provision to achieve this.[41]

16. **Homes in the private rented sector contribute disproportionately to both the total number of poor quality homes and the costs that poor housing causes to the NHS. The existence of a statutory minimum standard for housing in the social rented sector is not enough on its own to protect tenants and the health service from the many preventable health impacts of poor quality and unsafe housing. The Renters (Reform) Bill contains some welcome steps to further protect tenants. But recent high profile cases involving tenants in social housing have demonstrated that the health impact of poor quality housing can be catastrophic. Over three years after the Government first committed to review and then extend the Decent Homes Standard to the private rented sector, no legal minimum quality standard exists to protect tenants in private rentals.**

35 Department for Levelling up, Housing and Communities, and Ministry of Housing, Communities & Local Government, A decent home: definition and guidance, 7 June 2006

36 See National Housing Federation, "Decent Homes Standard" [no date] for a summary of reviews since 2020.

37 Department for Levelling Up, Housing and Communities, The charter for social housing residents: social housing white paper, 17 November 2020; Department for Levelling up, Housing and Communities, Levelling up the United Kingdom, 22 February 2022

38 Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government, Decent Homes Standard: review, 8 February 2021

39 Department for Levelling Up, Housing and Communities, June 2023 - update on government's work to improve the quality of social housing, 30 June 2023

40 WQ203723

41 Department for Levelling Up, Housing and Communities, Renters (Reform) Bill 2023–24 (as introduced), 8 November 2023

17. ***We recommend the Government proceeds without delay in the consultation necessary to update the Decent Homes Standard for the social rented sector and in implementing a Decent Homes Standard for the private rented sector. It should set out a timetable for doing so in response to this report.***

Obligations to repair hazards

18. On 9 January 2024, DLUHC announced a consultation that proposed new legal requirements for social landlords to address hazards, such as damp and mould, within specified timescales.[42] It is proposed under "Awaab's law" that social landlords should investigate hazards within 14 days, start fixing them within a further 7 days, and make emergency repairs within 24 hours. Landlords who fail can be taken to court where they may be ordered to pay compensation to tenants. The consultation runs from 9 January 2024 for eight weeks, and the Government has committed to bringing in secondary legislation to support its outcome "as soon as practicable".[43] The measures in the consultation are not applicable to properties in the PRS. DLUHC analysis published in November 2023 suggests that around 3.6% of PRS properties have a Category 1 hazard damp or mould hazard,[44] compared to 0.2% of properties in the SRS.[45]

19. ***It is welcome that the Government's has proposed measures to protect social sector tenants from the worst impacts of unhealthy homes, via the implementation of "Awaab's law". We recommend that the Government act quickly on the outcome of its consultation on this topic for social sector tenants. It should also consider how similar safeguards could be extended to tenants in the private rented sector who are affected by housing hazards, such as damp and mould, that can pose an immediate danger to health.***

National quality standards

20. We heard that the absence of hazards is not enough to ensure that housing is protective of good health. The BRE's Helen Garrett explained that homes can be free from immediate dangers, but still not conducive to preventing ill-health, and that they can be vulnerable to developing hazards in future: for example, if they are too small, converted to low quality standards, or provide insufficient ventilation or protection from noise, light and outdoor air pollution.[46]

21. Several national standards exist that aim to support the development of high-quality housing. These include the Nationally Described Space Standard on internal space in new dwellings,[47] and The National Model Design Code, which sets out "clear design parameters to help local authorities and communities decide what good quality design looks like in

42 Department for Levelling Up, Housing and Communities, Awaab's Law: consultation on timescales for repairs in the social rented sector, 9 January 2024

43 Ibid.

44 Department for Levelling Up, Housing and Communities, Guidance: damp and mould in the private rented sector, 7 September 2023

45 Regulator of Social Housing, Damp and mould in social housing: initial findings, February 2023

46 Q205 (Helen Garrett); Q203, Q211 (Dr Henry Burridge); See also: CO Research Trust (PHS0283); Coltraco Ultrasonics (PHS0286); School of Architecture, University of Liverpool (PHS0301); Professor Catherine Noakes et al. (PHS0572); APPG on Air Pollution (PHS0597), Dr Mark Green (PHS0613)

47 Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government, Statutory guidance: Technical housing standards: nationally described space standard, 27 March 2017

their area".[48] Both are the responsibility of DLUHC. In his speech on the Government's long-term vision for housing, the Secretary of State for DLUHC emphasised that building quality new developments—rather than those that meet bare minimum standards—should be a priority.[49]

22. We heard particular concerns about dwellings created by Permitted Development Rights (PDR). There are two main categories of PDR: "change of use" PDRs allow developers to convert premises such as offices and retail premises into housing, and householder PDRs allow owners to make certain changes to properties that they own, which can include Houses in Multiple Occupation (HMOs). Using PDR means that planning permission is not required. The Town and Country Planning Association's (TCPA) *These are homes* photobook provides examples of poor-quality housing created via PDR.[50] The TCPA told us that through PDRs:

> The government's strong focus on meeting housing targets has emphasised the quantity of homes delivered to the detriment of ensuring good quality homes and places. […] For instance, homes are being created that are extremely small, are far from essential amenities such as shops and schools, or are difficult to reach on foot as there are no pavements.[51]

23. The Levelling up, Housing and Communities Committee highlighted similar concerns about dwellings created through PDR in 2021.[52] Responding to the Committee's report two years later, in 2023, the Government highlighted that it had introduced "new quality requirements", bringing forward legislation requiring new homes delivered via PDR to "meet the nationally described space standards and provide for adequate natural light in all habitable rooms".[53] The TCPA describes these as "minimum safeguards".[54]

24. In July 2023, the Government launched a consultation on expanding PDR, including to allow for conversions of buildings such as hotels and hostels into homes.[55] The TCPA says that it is "entirely unclear" from the consultation documents whether the Government envisages that the same minimum safeguards that currently apply would apply to the 2023 proposals. It said that it is "vital that the space standard is consistently applied across all types of [PDR] conversions, based on clear evidence of the benefits to daily functioning, and mental and physical wellbeing".[56] The Local Government Association said in response to the Government that "premises such as offices, barns, and shops are not always suitable for housing", and that further PDR expansion risks "creating poor

48 Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government, Guidance: National model design code, 14 October 2021

49 Department for Levelling up, Housing and Communities, Long-term plan for housing: Secretary of State's speech, 24 July 2023

50 Town and Country Planning Association, These are homes photobook, February 2023

51 Town and Country Planning Association (PHS0613)

52 Levelling Up, Housing and Communities Committee, Permitted development rights, Third report of Session 2021–22, HC32, 22 July 2021

53 Department for Levelling Up, Housing and Communities, Permitted development rights: response to the Select Committee report, 18 May 2023. See The Town and Country Planning (General Permitted Development etc.) (England) (Amendment) Order 2021 (legislation.gov.uk)

54 Town and Country Planning Association, Expanding Permitted development rights: a response from the TCPA to the consultation by the Department for Levelling Up, Housing and Communities, para.1

55 Department for Levelling Up, Housing and Communities, Consultation: Permitted development rights, 24 July 2023

56 Town and Country Planning Association, Expanding Permitted development rights: a response from the TCPA to the consultation by the Department for Levelling Up, Housing and Communities, para.4.4

quality residential environments that negatively impact people's health and wellbeing".[57] Shelter stated that while it was good to see housing high on the Government's agenda, "converting takeaways and shops into homes and restricting building to city centres won't help. It could risk creating poor-quality, unsafe homes that cause more harm than good".[58]

25. The TCPA told us that—safeguards on space in existing PDR legislation aside—adherence to policies that support building quality in new housing developments are "material considerations" for granting full planning consent in local plans. This means that they are not mandatory and are subject to "development viability" constraints. The TCPA therefore explained that "the standards can often be ignored if developers consider them too expensive to implement".[59]

26. **An absence of hazards is not enough on its own to ensure that housing protects residents' health. Space, design and location matter, and these should not be the preserve of those who are able to afford more expensive housing. Several standards exist to support the development of housing that is more widely protective of good health. Dwellings created under Permitted Development Rights (PDR), which comprise some of the most egregious examples of housing that is bad for health that we have seen during this inquiry, are now subject to minimum safeguards on space and light. These are welcome and much-needed but they are also an exception: adherence to any kind of quality standard is voluntary for the vast majority of developments and dwellings. Building enough homes is important, but the Government must require developers to aim higher, with quality housing and development that protects residents' health.**

27. ***We recommend the Government consult on both the content of existing design and space standards as they relate to health, and on the implications of making such standards mandatory for new dwellings—both for developments requiring standard planning consent, and for both householder and change of use PDR developments.***

Neighbourhoods and the planning system

28. The former Public Health England (now the Office for Health Improvement and Disparities [OHID] and the UK Health Security Agency) suggests that the quality of the built and natural environment is one of the key environmental determinants of health. The 'built and natural environment' refers to factors that can be influenced by town planning: the "characteristics (objective and subjective) of a physical environment in which people live, work and play". These include "schools, workplaces, homes, communities, parks/recreation areas, green (i.e. visible grass, trees and other vegetation) and blue spaces (i.e. visible water)".[60] According to the Chief Medical Officer for England, Professor Sir Chris Whitty:

> If you look back over the last 150 years, more has been done for public health by proper planning than almost any other intervention (except, perhaps, vaccination).[61]

57 Local Government Association, LGA submission to the Ministry of Housing, Communities and Local Government on Supporting Housing Delivery and Public Service Infrastructure, 21 January 2021

58 Shelter, Shelter responds to Secretary of State, Michael Gove's "mixed bag" speech on housing, 24 July 2023

59 Town and Country Planning Association (PHS0613)

60 Public Health England, Spatial Planning for Health: an evidence resource for planning and designing healthier places, 2017, p.6

61 Cited in Town and Country Planning Association (PHS0110)

What do "healthy neighbourhoods" look like?

29. In 2017, Public Health England's Healthy Places team conducted a systematic evidence review on the impact of town planning on public health.[62] The review identified policies related to planning that have proven most effective in protecting population health. These policies are summarised in Box 1.

Box 1: Public Health England: policies to support healthy neighbourhoods

Neighbourhood design: Enhancing the "walkability" of neighbourhoods; building complete and compact neighbourhoods; enhancing connectivity with safe and efficient infrastructure.

Food environment: Ensuring the availability of healthy, affordable food for the general population; enhancing community food infrastructure, such as allotments and urban agriculture.

Natural and sustainable environments: Reducing exposure to environmental hazards (e.g. air pollution); access to the natural environment; adaptation to climate change.

Transport: Provision of active travel infrastructure and public transport; prioritising active travel and road safety; enabling mobility for all ages and activities.

Source: Public Health England, Spatial Planning for Health: an evidence resource for planning and designing healthier places, 2017

30. Other projects emphasise similar policies and approaches. For example:

- NHS England led the Healthy New Towns project from 2016 to 2019 to test approaches to public health in new housing developments. The ten "demonstrator sites" aimed to improve population health and reduce inequalities by: creating environments to promote physical activity and healthy lives; developing new models of care, such as "health and wellbeing hubs"—bringing together health services, leisure services, and community-controlled spaces; and stimulating connectedness and community-led activities that promote health and wellbeing, linked to NHS services through social prescribing. The principles derived from the programme for creating healthy neighbourhoods included collective planning, including with local community and voluntary organisations; connecting, involving and empowering people and communities; creating compact neighbourhoods and supporting active travel; enabling healthy play and leisure; enabling healthy eating; and providing integrated health and wellbeing services.[63]

- The *Building for a Healthy Life* toolkit was published in 2020 by Design for Lives, a design research organisation.[64] It provides guidance that "encourages healthier lifestyles to be planned into new housing developments", written in partnership

62 Public Health England, Spatial Planning for Health: an evidence resource for planning and designing healthier places, 2017

63 The King's Fund, Healthy New Towns four years on: the legacy of a national innovation programme, 3 May 2023; NHS England, Healthy New Towns Network, accessed 14 September 2023

64 Design for Homes, Building for a healthy life, July 2020

with Homes England,[65] NHS England and NHS Improvement.[66] The toolkit emphasises improved walking, cycling and public transport links, with reduced carbon emissions and better air quality.

- The Consumer Data Research Centre, led by Dr Mark Green at the University of Liverpool, has produced a map of neighbourhood health across the UK, based on levels of healthy 'assets' and 'hazards'. These include the retail environment (such as prevalence of pubs and fast food, tobacco, and gambling outlets); health services (access to GPs, hospitals, pharmacies, dentists, and leisure services); the physical environment (blue and green space); and air quality (levels of nitrogen dioxide, particulate matter, and sulphur dioxide).[67]

31. The National Planning Policy Framework (NPPF) sets out the Government's planning policies for England and how these should be applied by local authorities.[68] The NPPF was first published in 2012 and has been revised several times since, with the most recent major revision in December 2023.[69] The primary requirement relating to health under both the previous and current version of the NPPF is that:

> Planning policies and decisions should aim to achieve healthy, inclusive and safe places which […] enable and support healthy lifestyles, especially where this would address identified local health and well-being needs–for example through the provision of safe and accessible green infrastructure, sports facilities, local shops, access to healthier food, allotments and layouts that encourage walking and cycling.[70]

32. The TCPA told us that health is not woven through the NPPF.[71] The TCPA's Julia Thrift explained that the NPPF is necessarily "a very technical document" which "mentions an enormous number of different things, all of which are material considerations".[72] Health is therefore only one of many issues for councillors and local authorities to consider, and prioritising it is challenging. Julia Thrift explained that her "day job is supporting councils and communities to try to prioritise health in the planning process, but it is an uphill process".[73]

33. The Government has taken steps beyond the NPPF to better integrate health and planning, including bringing together Departmental expertise. In June 2023, Active Travel England (ATE), an executive agency of the Department for Transport, announced

65 Homes England is an executive non-departmental body of DLUHC. It describes itself as "the government's housing and regeneration agency" and says that "affordable, quality homes in well-designed places are key to improving people's lives". See Gov.uk, Homes England [no date], accessed 4 December 2023

66 Homes England, Press release: Homes England backs a new "healthy housing" toolkit by Design for Homes, 23 July 2020; Homes England, Building for a healthy life, July 2020

67 Dr Mark Green (PHS0059, PHS0613)

68 Department for Levelling Up, Housing and Communities, National Planning Policy Framework, 19 December 2023, para. 96

69 Department for Levelling Up, Housing and Communities, National Planning Policy Framework, 19 December 2023

70 Ibid., para 92

71 Town and Country Planning Association (PHS01110)

72 Q255 (Julia Thrift)

73 Q253 (Julia Thrift)

that it would become a statutory consultee for all large housing developments in England, equating to around 3,100 planning applications per year, or 60% of new homes.[74] ATE said:

> The new role will enable ATE to help planning authorities in their work to implement good active travel design–for example, by ensuring developments include walking, wheeling and cycling connectivity to schools and local amenities. This will help improve public health, save people money and reduce harmful emissions.[75]

Chris Boardman MBE, Active Travel Commissioner for ATE, explained that this means that ATE is able to provide support and guidance to local authorities on designing and implementing active travel programmes, as well as controlling funding for initiatives and ensuring that they are designed to be effective, well-used and inclusive.[76] He said:

> The skills [in implementing active travel infrastructure] are something we lack. One of the big functions of Active Travel England, although we were set up as an inspectorate, is to train. We have some of the best people, who have come from local authorities, to […] share best practice, and train and give the guidance that we encourage [local authorities] to embed in their planning policy and in their transport strategies.[77]

34. We heard that there are other, comparable opportunities to compensate for local authorities' limited resources, knowledge and skills and help them prioritise health to a greater extent than the NPPF allows for. Chris Naylor, Senior Fellow at the King's Fund who led the evaluation of the Healthy New Towns programme, told us that crucial to building healthier communities is:

> Trying to develop a shared vision across the NHS, public health planning teams and developers for how to create a healthy place; getting health into local policy frameworks, planning policy frameworks; and understanding the specific health needs and assets of the local population you are talking about.[78]

Chris Boardman also told us that he would "like to hear the voice of health" in "more conversations across more Departments" to help co-ordinate work around developing healthier communities and assessing planning applications.[79]

35. Julia Thrift explained that although many councils "are very concerned about the health of their populations and really want to improve population health", "there is no legal requirement for planning to consider health outcomes", and "there is no big policy

74 Active Travel England, News story: Active Travel England to be consulted on all large planning applications, 1 June 2023. Large planning applications are those for developments equal to or exceeding 150 housing units, 7,500 m^2 of floorspace or an area of 5 hectares.
75 Ibid.
76 Q162 (Chris Boardman)
77 Q187 (Chris Boardman)
78 Q281 (Chris Naylor)
79 Q199 (Chris Boardman)

requirement for planning to consider health outcomes".[80] Instead, health is "one of many things that could be considered and [this] makes it very difficult for councillors to prioritise health".[81] She continued:

> It is very difficult for [councils] to reject a planning application on the grounds that it will not support good health. They can do their best to have a local plan that supports good health, they can bring in public health evidence, but it is just not a priority. Directors of public health are not statutory consultees. OHID […] is not a statutory consultee.[82]

36. Until the dissolution of Public Health England (PHE) in 2021, its Healthy Places team worked to "ensure that the design of the built and natural environment contributes to improving public health and reducing health inequalities".[83] PHE's Healthy Places work included providing system leadership across Departments, executive agencies, and stakeholders; building skills and capacity in local teams; developing the research evidence base on public health in planning; and building networks and partnerships with stakeholders, including local public health teams.[84] Following PHE's dissolution, its public health responsibility was transferred to OHID.[85] In oral evidence on 21 February 2023, the Deputy Chief Medical Officer for England, Jeanelle de Gruchy, alluded to OHID's work to ensure health is considered as part of town planning. She suggested OHID might:

> Look at what the evidence base is for health and health promotion of something like active transport or housing, and then work with the chief planner in DLUHC on looking at the National Planning Policy Framework and maybe changes that could happen there.[86]

The most recent major revision of the NPPF, issued in December 2023, made no changes to substantive requirements relating to health, although the Government's consultation response on the same topic noted that "several respondents" had suggested that "the consideration of health and wellbeing [in the NPPF] should be strengthened".[87] There is limited information in the public domain on how OHID has continued PHE's work on Healthy Places, and how this work is being used.

37. **Local authorities and councils necessarily consider a wide range of criteria in assessing planning applications. This, alongside pressures on their resources and skills, makes it difficult for them to prioritise ensuring that planning promotes health. The lack of changes to requirements relating to health in the revised National Planning Policy Framework is a disappointing missed opportunity to make promotion of health a higher priority for planning authorities.**

38. **The former Public Health England's Healthy Places team had a clear remit to support healthy development. Following PHE's dissolution and the division of its**

80 Q253–254 (Julia Thrift)
81 Q253 (Julia Thrift)
82 Q254 (Julia Thrift)
83 Public Health England., PHE Healthy Places, updated 5 February 2021
84 Ibid.
85 Office for Health Improvement and Disparities, Gov.uk
86 Q44; Q11 (Jeanelle de Gruchy)
87 Department for Levelling Up, Housing and Communities, National Planning Policy Framework, 19 December 2023, para. 96; Department for Levelling Up, Housing and Communities, Government response to the Levelling up and Regeneration Bill: reforms to national planning policy consultation, 19 December 2023

responsibilities, there is a lack of clarity over which part of DHSC is now responsible for this role, and a lack of formal integration between DHSC and the organisations responsible for assessing planning applications. These is, however, encouraging evidence elsewhere of Departments enabling a greater focus on health in planning: for example, Active Travel England's statutory role assessing applications for large housing developments. There are clear opportunities to go further in this vein: for example, by clarifying and formalising OHID's role.

39. ***We recommend that OHID be made a statutory consultee for new large housing developments, building on role already accorded to Active Travel England in supporting inclusive, effective and health-protecting development.***

Supporting healthy communities: social prescribing

40. Factors that affect the likelihood of developing preventable health conditions are often related to wider social and community issues, rather than strictly medical needs. These can have a substantial impact on the NHS. The College of Medicine told us that in England, approximately 1 in 4 primary care appointments are related to unmet social needs, such as loneliness, financial stress, or poor housing. They explained that this means that "a sustainable health service will need to think more local and also better involve whole communities in achieving its aims".[88]

41. We heard a similar case made in relation to improving people's access to physical activity, whether through sports and leisure, active travel, or opportunities for active play for young people.[89] OHID suggests that physical inactivity is associated with 1 in 6 deaths in the UK and is estimated to cost the UK £7.4 billion annually, which includes £0.9 billion to the NHS alone.[90] This cost is disproportionately incurred amongst groups that experience wider disadvantages and health inequalities.[91] OHID states that physical activity has "significant benefits for health, both physical and mental", and "can help to prevent and manage over 20 chronic conditions and diseases, including some cancers, heart disease, type 2 diabetes and depression".[92] The Chief Medical Officers for the United Kingdom stated in 2019 that "if physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat".[93]

42. Where someone lives and their own resources are key determinants of whether they are able to access services, programmes and activities that can prevent poor health. The building blocks of a physically active lifestyle—which can bring wider benefits such as

88 College of Medicine (PHS0396)

89 For example: Faculty of Sport and Exercise Medicine UK (PHS0041); Dr Russ Jago (PHS0052); UK Health Alliance on Climate Change (PHS0066); Centre for Sustainable Healthcare (PHS0095); Football Foundation (PHS0171); Dr Kajal Gokul (PHS0186); Richmond Group of Charities (PHS0192); Playout Out (PHS0230); Canal and River Trust (PHS0392); Sport England (PHS0476); Women in Sport (PHS0490); Sport and Recreation Alliance (PHS0538); Greater London Authority (PHS0541)

90 Office for Health Improvement and Disparities, Guidance: Physical activity: applying All Our Health, 10 March 2022

91 Sport England, People and places: the story of doing it differently, February 2021

92 Office for Health Improvement and Disparities, Guidance: Physical activity: applying All Our Health, 10 March 2022

93 Department of Health and Social Care, Welsh Government, Department of Health (Northern Ireland) and Scottish Government, UK Chief Medical Officers' physical activity guidelines, 7 September 2019

increased connection with the community—are not available equally to everyone, and they are likely to be particularly challenging to access for people from some socioeconomic groups.[94] Sport England explained:

> Many of the things that stop people from being active are just not in their power to change. The places, faces, policies and conventions that make up the system we live in have a large role in shaping our behaviour and the choices we make.[95]

43. Although the programmes and services that could address these needs sit outside the Department's immediate responsibilities, the NHS has levers that can help to improve people's access to them—taking strain off the health service by providing non-medical interventions that can prevent, delay or arrest the development of health conditions. Respondents told us that social prescribing has a crucial role to play.[96] NHS England describes social prescribing as "an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing".[97] We heard that using social prescribing effectively could "lead to 4.5 million fewer GP appointments per year, with those patients receiving community-based social solutions to their unmet social needs", saving a total of £275 million.[98] In relation to community activities, social prescribing operates in three parts. It requires: a GP or other healthcare worker, school worker, housing association or community association to make a referral (a prescription) for a non-medical intervention; a link worker to connect the individual referred to a suitable service or programme; and range and capacity in programmes, often provided by the voluntary sector, in the local community for people to participate in.

44. There are inequalities in access to social prescribing. Usage is heavily concentrated in older age groups—especially retirees.[99] We heard, however, that supporting young people's participation in physical activity in particular can deliver substantial benefits in preventing illness in later life, and that social prescribing could be key to enabling access. StreetGames—an organisation that facilitates young people's access to sport in their communities—outlined the difficulties that young people have in accessing social prescriptions.[100] Their Head of Sport and Health, Paul Jarvis-Beesley, said:

94 Sport England, People and places: the story of doing it differently, February 2021; StreetGames, Doorstep Sport and empowerment, 2021

95 Sport England, People and places: the story of doing it differently, February 2021, p.5

96 The Optimal Aging Programme (PHS0009); Professor Claudia Cooper (PHS0020); Locality (PHS0047); National Academy for Social Prescribing (PHS0073); Ms Jacqueline Hotchkiss Cross and Mr Conor Ogilvie-Davidson (PHS0094); National Association of Link Workers (PHS0107); Dr Juliet Wakefield (PHS0151); Culture, Health and Wellbeing Alliance CIC (PHS0164); Football Foundation (PHS0171); Royal College of Physicians Edinburgh (PHS0108); National Centre for Creative Health (PHS0226); Groundswell (PHS0250); University of Oxford/Oxford Centre for Evidence-Based Medicine (PHS0257); Dr Adam Benkwitz and Dr Laura Healy (PHS0296); Dr Maria Grazia Turri (PHS0310); The Life Rooms (PHS0332); Ways to Wellness (PHS0343); Barnardo's (PHS0368); LTA (PHS0420); Sport England (PHS0476); Sport and Recreation Alliance (PHS0538);

97 NHS England, Social prescribing, accessed 23 November 2023

98 College of Medicine (PHS0396)

99 National Academy for Social Prescribing (PHS0073)

100 Q167 (Mark Lawrie)

> NHS England has described social prescribing as an 'all-age service' but its availability is far from evenly distributed across our age groups, and that is partly down to the local decision-making and partly down to national priorities and guidelines.[101]

Similarly, Barnardo's, the children's charity, said that "current models of social prescribing are focused on adults while services for children and young people are largely underdeveloped". They explained that there "is no dedicated funding or Government strategy for children and young people's social prescribing".[102]

45. Programme such as StreetGames' Social Prescribing Youth Network and Barnardo's LINK programme aim to improve the availability of workers who are trained to work with children and young people in their communities on social prescribing.[103] This is the middle part of the prescribing pathway, which StreetGames' Chief Executive Mark Lawrie described as providing a vital "friendly face of the health system": an approachable, trusted source of support in local communities, attuned to local young peoples' specific needs.[104]

46. In spite of the work of these and similar organisations, we heard that there are barriers to greater use of social prescribing. Tim Hollingsworth OBE, Chief Executive of Sport England, told us that GPs can be particularly hesitant to issue social prescriptions to groups for whom social prescribing is less often used.[105] He explained that "there is evidence overall that GPs have been trained through a clinical process to not have the same confidence" in offering social prescriptions.[106] He said:

> One of the things that we should all recognise is that we do not necessarily set up our GPs to understand the benefit of physical activity and to feel confident in prescribing it. We know from data that around two thirds of people, particularly those with a long-term health condition which they are looking to manage, are looking for health and support from their GP as to how they can manage it through activity, but GPs are very wary of [social] prescribing and about three quarters have admitted that they do not feel confident.[107]

47. **Frontline health and social care staff do not only deal with immediate medical needs. People also present to the health service with issues that relate to unmet social needs, which can in turn, over time, develop into medical needs. Increased use of social prescribing can both relieve pressure on clinical pathways and protect good health through enhancing people's connections with, and ability to participate in activities in their local communities—particularly for people who often lack resources to access these activities independently. There is potential for health services to make much greater use of this approach amongst groups that are currently underserved by social prescribing, such as young people. Many GPs, however, do not feel as confident working with social prescription pathways as they do with the clinical pathways**

101 Cited in Sport for Development Coalition, Inaugural Coalition Town Hall: Sport for development has 'critical role' to play in social prescribing, 22 September 2021

102 Barnardo's, The missing link: social prescribing for children and young people, 10 October 2023, p.5

103 StreetGames, Youth social prescribing, accessed 22 November 2023; Barnardo's, Children and young people social prescribing, accessed 22 November 2023

104 Q165 (Mark Lawrie)

105 Q166; Q171 (Tim Hollingsworth)

106 Q171 (Tim Hollingsworth)

107 Q166 (Tim Hollingsworth)

that their training focuses on. Building confidence amongst frontline providers in recommending social provision will be key to both protecting and improving individuals' health, and promoting more cohesive, health-enhancing communities.

48. ***We recommend DHSC work with NHS England and existing networks and providers to develop a national strategy for social prescribing. This should aim to improve understanding amongst frontline clinical practitioners of the benefits of social prescribing and to improve their confidence in offering social and community-based solutions to unmet social needs, and to increase use of social prescriptions for young people across all referral routes, including hospitals, schools and other educational and community settings. It should include resources, guidance and case studies, and should focus in particular on groups that are currently underserved, where the greatest long-term preventative impacts may be accrued.***

3 Building healthy places for the future

49. In the previous chapter, we considered a range of specific place-related issues that can contribute to the likelihood of people living with, or dying prematurely from, preventable health conditions. DHSC has some levers within its direct control that can help to address these issues, by providing immediate access to place-based services and programmes that protect good health. But building healthier communities now and for the future will require a much longer-term, co-ordinated approach. The Royal College of Physicians explains that "prevention is vital to ensuring that people live longer, healthier lives".[108] It continues:

> Bold action is needed across government to tackle health inequalities and reduce the avoidable demand on our health and care services. With NHS waiting lists still at record highs, reducing health inequalities–and avoidable illness overall–is key to creating more sustainable demand for healthcare.[109]

System-level support for healthy placemaking

50. Recent system changes should provide a foundation for these changes. Our previous report on *Integrated Care Systems: autonomy and accountability* highlighted that the ICSs "have been designed to support a focus on longer-term issues, like population health and tackling health inequalities".[110] The NHS Long Term Plan, published in 2019, contains commitments to strengthen the health service's work on prevention through enabling this collaborative work. It says that ICSs and their constituent parts will support long-term collaborative work "as the NHS continues to move from reactive care towards a model embodying active population health management".[111] It continues:

> ICSs [will] provide stronger foundations for working with local government and voluntary sector partners on the broader agenda of prevention and health inequalities. They will in turn be supported by expanded teams across groups of neighbouring GP practices who work together under the primary care network contract and with local NHS, social care and voluntary services.[112]

Through this structure, the Long Term Plan posits that ICSs will "help people stay healthy and also moderate demand on the NHS".[113] It says that this work sits alongside initiatives aimed at supporting individual behaviour change to prevent ill-health—for example,

108 Royal College of Physicians, RCP view on health inequalities: a call to action for a cross-government strategy, October 2023, p.6

109 Ibid., summary

110 Health and Social Care Committee, Integrated Care Systems: autonomy and accountability, Seventh report of Session 2022–23, HC587, 30 March 2023, summary

111 NHS England, The NHS Long term plan, January 2019, para 2.6. ICSs have two statutory constituent parts: an Integrated Care Partnership that brings together NHS, local authorities and other organisations, including those from social care, and an Integrated Care Board which is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the budget and arranging for the provision of services in the area. The ICB must have regard to the ICP's integrated care strategy when planning and delivering services.

112 Ibid., para. 2.6

113 Ibid., p.7

around smoking, alcohol use and obesity—and is a "complement to—not a substitute for—the important role of individuals, communities, government, and businesses in shaping the health of the nation".[114]

51. As an immediate measure, our report on ICSs recommended that all Integrated Care Boards should include a public health representative, such as a public health director or public health lead, to ensure a continued focus on prevention.[115] We concluded that this would be "especially necessary at this early stage of development for ICSs but should be maintained as ICSs evolve".[116] In response, the Government said that it agrees that "there should be a continual focus on the prevention agenda", but that "it is important to grant ICSs the freedom to create the architecture and governance for their ICP and ICB that enables them to best serve their population".[117]

52. We heard further evidence for our proposed approach in evidence to this inquiry. Dr Jeanelle de Gruchy, Deputy Chief Medical Officer for England, told us that public health directors are "really important in knowing what is happening with local population health, both where it is the same as national and where it might be different".[118] She said that they are:

> Very good at looking across systems and ensuring that they can provide system leadership in the local area between the council, council services, the services that they commission […] and services commissioned and provided through the NHS, for example.[119]

She described a greater role for as public health directors in ICPs as "a real opportunity to look at how we can do this differently".[120]

53. Similarly, the King's Fund's Chris Naylor, who led the evaluation of NHS England's Healthy New Towns programme, said that where the programme had led to longer-term benefits beyond the trial period, "putting in a small amount of investment" for dedicated people in the local system "to connect all those dots and to catalyse [ongoing work]" had been a key factor.[121] In contrast, where this continuity function had not occurred, trial areas had struggled to maintain and build on the health benefits of the programme. The Healthy New Towns evaluation noted the limitations of short-term approaches to healthy placemaking both in terms of funding and development, stating that "a three-year programme represents a small fraction of the time it takes to plan and build a major new development, which can often be 20 years or more".[122]

54. Our inquiry on ICSs also heard that they and their constituent parts will need to balance their objectives on prevention with often intense short-term, operational

114 Ibid., p.7
115 Health and Social Care Committee, Integrated Care Systems: autonomy and accountability, Seventh report of Session 2022–23, HC587, 30 March 2023, para.39
116 Health and Social Care Committee, Integrated Care Systems: autonomy and accountability, Seventh report of Session 2022–23, HC587, 30 March 2023, para.36
117 Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 on 'Integrated care systems: autonomy and accountability', June 2023, p.20
118 Q33 (Dr Jeanelle dr Gruchy)
119 Q33 (Dr Jeanelle de Gruchy)
120 Q33 (Dr Jeanelle de Gruchy)
121 Q281 (Chris Naylor)
122 Naylor, C., Creating Healthy Places: Perspectives from the Healthy New Towns Programme, The King's Fund, 26 September 2019, p.58

challenges. The nature of such challenges means there is a risk that they will dominate ICS capacity and resources at the expense of longer-term agendas, including prevention.[123] This was re-iterated in initial responses to this inquiry. CIPFA, a professional body for people working in public finance, said that "in the face of scarce resources and challenges facing both the NHS and local government", investment in long-term policy such as prevention "is often seen as an easy tap to turn off".[124] Our previous report concluded that DHSC and NHS England need to recognise this risk and recommended that any refresh of the NHS Long Term Plan should clearly position prevention as a priority, with associated allocated time, capacity and funding.[125]

55. **Integrated Care Systems aim to enable a stronger focus on prevention, and on the specific approaches needed in different communities to help ensure that they are "healthy places". But this is a long-term agenda. The mixed longer-term outcomes of initiatives such as Healthy New Towns demonstrate that building communities that protect good health is not something that can be accomplished through isolated programmes over a few years. The immediate pressures on health services are numerous and compelling, and there is already evidence that these are crowding out longer-term strategies including prevention. Because the numerous costs of "unhealthy places" fall so heavily on the health service, it is essential that the right systems, people and funding are in place for the long term to maintain a focus on prevention and protecting population health.**

56. ***We have previously recommended that all ICBs should include a public health representative, such as a public health director, and that DHSC considers making this a mandatory requirement. In response, the Department said it agreed that prevention needs to be a priority, but emphasised the importance of protecting ICS autonomy. The evidence that we have heard in this inquiry reaffirms our view that having the right people in place is crucial to ensuring the prevention agenda is not crowded out. Given what we have heard about impact that these individuals can have in ensuring a longer-term focus, we recommend that DHSC reconsiders the case for mandating representatives in this role.***

A cross-government approach

57. The range of organisations involved in making "healthy places" is considerable, going well beyond DHSC and the health service itself and encompassing a wide variety of different interests and objectives. Respondents to our initial call for evidence told us that many of these, such as local government bodies, community and voluntary sector organisations, and businesses, sit outside of Government entirely.[126] Within Government, Departments including Levelling Up, Communities and Housing, Transport, Education,

123 Health and Social Care Committee, Integrated Care Systems: autonomy and accountability, Seventh report of Session 2022–23, HC587, 30 March 2023, para.36

124 Chartered Institute of Public Finance and Accountancy (PHS0297)

125 Health and Social Care Committee, Integrated Care Systems: autonomy and accountability, Seventh report of Session 2022–23, HC587, 30 March 2023, para.35–36

126 Locality (PHS0047); Culture, Health and Wellbeing Alliance CIC (PHS0164); 10GM (PHS0394); Business for Health (PHS0435); North Yorkshire County Council (PHS0531); Local Government Association (PHS0582); Prevention Board for the North East and North Cumbria ICB (PHS0553); London South Bank University (PHS0595)

Business and Trade, and Environment, Food and Rural Affairs all have roles to play.[127] Some issues that substantially affect health, such as outdoor air quality and reducing emissions, sit outside DHSC's influence entirely. The benefits of preventing ill-health also go beyond reducing pressure on the NHS and DHSC's budgets. The Royal College of Physicians explains, highlighting several aspects relevant to place:

> Good health is an economic asset. Along with reducing the demand for NHS services, a healthier nation is central to reducing labour market inactivity and improving productivity.
>
> The public consider health and the state of the NHS to be two of the most important issues facing the country. But creating a healthy population cannot be the responsibility of the health system or the Department of Health and Social Care (DHSC) alone. Coordinated work across all government departments is needed to tackle the root causes that make people ill in the first place, such as poor housing, lack of educational opportunity, employment opportunities (including how much money you have), transport and air quality.[128]

58. Professor Sir Chris Whitty explained further that the costs and benefits of many aspects of place-based preventative healthcare are not evenly split amongst Departments. As such, as well as being focused on long-term outcomes, he argued that leadership on the issue needs to come from and be co-ordinated from the top of Government. He said:

> The problem for many of these issues is that the bad side of things going badly for public health ends up in Health, but the cost of solving it is in a different Department; let's say Transport. The cost of putting in cycle lanes and doing all those things is in Transport, both the political cost and the financial cost. The same would be true for DEFRA for some of the air quality issues. At the end of the day, only the Treasury and No. 10 can say, "This is a whole-of-Government problem, and we need to bring that together." It is important for us to work with our colleagues, as I have done very recently with Transport and DEFRA on air pollution, but these problems are whole-of-Government problems.[129]

59. **Healthy places are vital to protecting people's physical and mental health from both direct and indirect consequences and in turn, to building a sustainable health service. "Healthy places" include both the built environment—homes, communities and neighbourhoods—and wider environmental factors, such as air quality and emission levels. The benefits of building healthier places go far beyond DHSC and the health service, and achieving these benefits requires buy-in from a range of Government Departments. In turn, the benefits of healthy places are crucial to a range of wider priorities, including building a stronger, more productive economy and protecting the environment in which we live. The problems caused by "unhealthy places" are**

127 Q164 (Chris Boardman); Royal College of Physicians, RCP view on health inequalities: a call to action for a cross-government strategy, October 2023; Centre for Sustainable Healthcare (PHS0095); Royal Royal College of Physicians Edinburgh (PHS0108); Mental Health Policy Group (PHS0335); The Health Foundation (PHS0491)

128 Royal College of Physicians, RCP view on health inequalities: a call to action for a cross-government strategy, October 2023, summary

129 Q21 (Professor Sir Chris Whitty)

whole-society problems. Tackling them will require long-term thinking and whole-Government solutions, including commitment, leadership and co-ordination from the very top.

Conclusions and recommendations

Introduction

1. The places where people live—homes, communities and neighbourhoods—affect their health and wellbeing substantially. Place, health inequalities and the likelihood of developing preventable health conditions are inextricably linked. People from less well-off groups, and those who live in less well-off neighbourhoods, have a much higher likelihood of developing life-limiting health conditions and associated comorbidities, and of dying prematurely from the effects of those conditions. Although much of this ill-health is preventable, it is also often not within the power of individuals to control. (Paragraph 7)

2. The evidence base on the importance of place in protecting good health is stronger than it has ever been. But as we discuss in the next chapter, we have known about the relationship between health and place for decades, if not longer. It is frustrating that more progress has not been made already. A determined focus on developing "healthy places" that can prevent ill-health amongst those most at risk is now vital in easing pressures on the NHS, and building a sustainable service for generations to come. (Paragraph 8)

Immediate steps

3. Homes in the private rented sector contribute disproportionately to both the total number of poor quality homes and the costs that poor housing causes to the NHS. The existence of a statutory minimum standard for housing in the social rented sector is not enough on its own to protect tenants and the health service from the many preventable health impacts of poor quality and unsafe housing. The Renters (Reform) Bill contains some welcome steps to further protect tenants. But recent high profile cases involving tenants in social housing have demonstrated that the health impact of poor quality housing can be catastrophic. Over three years after the Government first committed to review and then extend the Decent Homes Standard to the private rented sector, no legal minimum quality standard exists to protect tenants in private rentals. (Paragraph 16)

4. *We recommend the Government proceeds without delay in the consultation necessary to update the Decent Homes Standard for the social rented sector and in implementing a Decent Homes Standard for the private rented sector. It should set out a timetable for doing so in response to this report.* (Paragraph 17)

5. *It is welcome that the Government's has proposed measures to protect social sector tenants from the worst impacts of unhealthy homes, via the implementation of "Awaab's law". We recommend that the Government act quickly on the outcome of its consultation on this topic for social sector tenants. It should also consider how similar safeguards could be extended to tenants in the private rented sector who are affected by housing hazards, such as damp and mould, that can pose an immediate danger to health.* (Paragraph 19)

6. An absence of hazards is not enough on its own to ensure that housing protects residents' health. Space, design and location matter, and these should not be the preserve of those who are able to afford more expensive housing. Several standards exist to support the development of housing that is more widely protective of good health. Dwellings created under Permitted Development Rights (PDR), which comprise some of the most egregious examples of housing that is bad for health that we have seen during this inquiry, are now subject to minimum safeguards on space and light. These are welcome and much-needed but they are also an exception: adherence to any kind of quality standard is voluntary for the vast majority of developments and dwellings. Building enough homes is important, but the Government must require developers to aim higher, with quality housing and development that protects residents' health. (Paragraph 26)

7. *We recommend the Government consult on both the content of existing design and space standards as they relate to health, and on the implications of making such standards mandatory for new dwellings—both for developments requiring standard planning consent, and for both householder and change of use PDR developments.* (Paragraph 27)

8. Local authorities and councils necessarily consider a wide range of criteria in assessing planning applications. This, alongside pressures on their resources and skills, makes it difficult for them to prioritise ensuring that planning promotes health. The lack of changes to requirements relating to health in the revised National Planning Policy Framework is a disappointing missed opportunity to make promotion of health a higher priority for planning authorities. (Paragraph 37)

9. The former Public Health England's Healthy Places team had a clear remit to support healthy development. Following PHE's dissolution and the division of its responsibilities, there is a lack of clarity over which part of DHSC is now responsible for this role, and a lack of formal integration between DHSC and the organisations responsible for assessing planning applications. These is, however, encouraging evidence elsewhere of Departments enabling a greater focus on health in planning: for example, Active Travel England's statutory role assessing applications for large housing developments. There are clear opportunities to go further in this vein: for example, by clarifying and formalising OHID's role. (Paragraph 38)

10. *We recommend that OHID be made a statutory consultee for new large housing developments, building on role already accorded to Active Travel England in supporting inclusive, effective and health-protecting development.* (Paragraph 39)

11. Frontline health and social care staff do not only deal with immediate medical needs. People also present to the health service with issues that relate to unmet social needs, which can in turn, over time, develop into medical needs. Increased use of social prescribing can both relieve pressure on clinical pathways and protect good health through enhancing people's connections with, and ability to participate in activities in their local communities—particularly for people who often lack resources to access these activities independently. There is potential for health services to make much greater use of this approach amongst groups that are currently underserved by social prescribing, such as young people. Many GPs, however, do not feel as confident working with social prescription pathways as they do with the clinical

pathways that their training focuses on. Building confidence amongst frontline providers in recommending social provision will be key to both protecting and improving individuals' health, and promoting more cohesive, health-enhancing communities. (Paragraph 47)

12. *We recommend DHSC work with NHS England and existing networks and providers to develop a national strategy for social prescribing. This should aim to improve understanding amongst frontline clinical practitioners of the benefits of social prescribing and to improve their confidence in offering social and community-based solutions to unmet social needs, and to increase use of social prescriptions for young people across all referral routes, including hospitals, schools and other educational and community settings. It should include resources, guidance and case studies, and should focus in particular on groups that are currently underserved, where the greatest long-term preventative impacts may be accrued.* (Paragraph 48)

Building healthy places for the future

13. Integrated Care Systems aim to enable a stronger focus on prevention, and on the specific approaches needed in different communities to help ensure that they are "healthy places". But this is a long-term agenda. The mixed longer-term outcomes of initiatives such as Healthy New Towns demonstrate that building communities that protect good health is not something that can be accomplished through isolated programmes over a few years. The immediate pressures on health services are numerous and compelling, and there is already evidence that these are crowding out longer-term strategies including prevention. Because the numerous costs of "unhealthy places" fall so heavily on the health service, it is essential that the right systems, people and funding are in place for the long term to maintain a focus on prevention and protecting population health. (Paragraph 55)

14. *We have previously recommended that all ICBs should include a public health representative, such as a public health director, and that DHSC considers making this a mandatory requirement. In response, the Department said it agreed that prevention needs to be a priority, but emphasised the importance of protecting ICS autonomy. The evidence that we have heard in this inquiry reaffirms our view that having the right people in place is crucial to ensuring the prevention agenda is not crowded out. Given what we have heard about impact that these individuals can have in ensuring a longer-term focus, we recommend that DHSC reconsiders the case for mandating representatives in this role.* (Paragraph 56)

15. *Healthy places are vital to protecting people's physical and mental health from both direct and indirect consequences and in turn, to building a sustainable health service. "Healthy places" include both the built environment—homes, communities and neighbourhoods—and wider environmental factors, such as air quality and emission levels. The benefits of building healthier places go far beyond DHSC and the health service, and achieving these benefits requires buy-in from a range of Government Departments. In turn, the benefits of healthy places are crucial to a range of wider priorities, including building a stronger, more productive economy and protecting the environment in which we live. The problems caused by "unhealthy places" are*

whole-society problems. Tackling them will require long-term thinking and whole-Government solutions, including commitment, leadership and co-ordination from the very top. (Paragraph 59)

Formal minutes

Tuesday 16 January 2023

Members present:

Steve Brine, in the Chair

Paul Blomfield

Mrs Paulette Hamilton

Rachael Maskell

James Morris

Prevention in health and social care: healthy places

Draft Report (*Prevention in health and social care: healthy places*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 59 agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134.)

Adjournment

Adjourned till Wednesday 17 January 2024 at 2 pm.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 11 July 2023

Chris Boardman, National Active Travel Commissioner, Active Travel England; **Tom Hollingsworth**, Chief Executive, Sport England; **Mark Lawrie**, Chief Executive, StreetGames — Q159–199

Tuesday 5 September 2023

Dr Henry Burridge, Senior Lecturer, Imperial College London; **David Finch**, Associate Director, Healthy Lives Team, The Health Foundation; **Helen Garrett**, Principal Consultant, Building Research Establishment; **Dr Jill Stewart**, Associate Professor in Public Health, University of Greenwich — Q200–245

Wednesday 18 October 2023

Dr Mark Green, Reader in Health Geography, University of Liverpool; **Julia Thrift**, Director of Healthier Place-making, Town and Country Planning Association — Q246–272

Chris Naylor, Senior Fellow in Health Policy, The King's Fund; **Simon Reeve**, Deputy Director, Public Health Systems and Workforce, Office for Health Improvement and Disparities — Q273–295

Published written evidence

The written evidence that was received can be viewed on the inquiry publications page of the Committee's website.

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2023–24

Number	Title	Reference
1st Special	NHS Dentistry: Government Response to the Committee's Ninth Report of Session 2022–23	HC 415

Session 2022–23

Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
2nd	The impact of body image on mental and physical health	HC 114
3rd	Workforce: recruitment, training and retention in health and social care	HC 115
4th	The future of general practice	HC 113
5th	Pre-appointment hearing with the Government's preferred candidate for the role of Chair of HSSIB	HC 843
6th	Follow-up on the IMMDS report and the Government's response	HC 689
7th	Integrated Care Systems: autonomy and accountability	HC 587
8th	Digital transformation in the NHS	HC 223
9th	NHS Dentistry	HC 964
10th	Prevention in health and social care: vaccination	HC 1764
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346
3rd Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England	HC 112
4th Special	Evaluation of Government commitments made on the digitisation of the NHS	HC 780
5th Special	Government Response to the Committee's Report on Follow-up on the IMMDS report and the Government's response	HC 1286
6th Special	Government Response to the Committee's Report on Workforce: recruitment, training and retention in health and social care	HC 1289

Number	Title	Reference
7th Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce: Government Response	HC 1290
8th Special	Government Response to the Health and Social Care Committee's Expert Panel: evaluation of Government's commitments made on the digitisation of the NHS	HC 1313
9th Special	The future of general practice: Government Response to the Committee's Fourth Report	HC 1751
10th Special	Expert Panel: evaluation of the Government's commitments in the area of pharmacy in England	HC 1310
11th Special	Digital transformation in the NHS: Government Response to the Committee's Eighth Report	HC 1803
12th Special	Government Response to the Committee's Report on Prevention in Health and Social Care: vaccination	HC 1891
13th Special	Government Response to the Health and Social Care Committee's Expert Panel: Evaluation of Government's commitments in the area of the pharmacy in England	HC 1892

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18

Number	Title	Reference
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311