

Age Specific Housing for Older People in Derbyshire Dales Health Impact Assessment



*We give shape to our buildings and they in turn
shape us*
(Churchill 1943)



High Peak Borough Council
working for our community



Forward

It is easy to forget that for some people finding, moving into and sustaining a home can be a difficult and sometimes frightening task. It is also possible that those most in need of a new home become so worried about moving home that they refuse the opportunity and instead continue to remain in poor or inappropriate conditions. For those of us who work in the housing sector it is worth remembering that whilst we may have the best intentions about design, cost and appearance of new housing for older people, we run the risk of building a home which is not best suited to future occupiers.

We therefore need to think just that little bit harder about what we are building. We could even try asking those who may one day become the tenants, what they think of the design, about the features the home will have and how they might live there. After all, whilst we are building a house, the people living in it will turn it into a home.

I am particularly grateful to Linda Syson-Nibbs of Derbyshire County Primary Care Trust and the steering group that supported this project. I am also very grateful to the residents of Charles Walker Close in Hlland Ward and Miracle Court in Bakewell who took part in the survey. The steering group learnt a lot from their responses and I personally found them quite humbling. I hope we can take what we have learnt and apply it to future housing developments.

The recommendations provide us with new challenges some of which require additional resources and some which require the people involved to think creatively. Working in partnership and talking to one another will give us a head start in improving the housing options and choice for older people in the future.

Rob Cogings
Principal Strategic Housing Officer
Derbyshire Dales DC and High Peak BC

Executive Summary

1. Older people comprise a growing proportion of the population in the Peak Sub Region¹. The expectations and aspirations of older people are likely to rise over time. Whilst older people are no different to younger people in wanting choice over where they live, the housing solutions to meet their needs will be different
2. Older people are not a homogeneous group and the challenge is to create lifetime housing choices that can support people through the different phases of old age.
3. In the sub region over 78% of people over the age of 60 are owner-occupiers however many are living in accommodation that does not meet their health and social needs.
4. There is a strong body of research demonstrating a powerful link between housing and health in all ages. There is a small but growing body of research indicating that housing does have the capacity to improve health.
5. Within the Peak Sub Region an innovative solution to the housing needs of older people has been developed. Two new, age appropriate housing developments that aspire to Lifetime Home standards have been built in the market town of Bakewell and village of Hulland Ward in the Derbyshire Dales (n=16 units).
6. Tenants were identified from the Council's older persons housing list and priority was given to persons with medical problems who might benefit most from age specific housing.
7. A retrospective health impact assessment of the new developments was conducted between September 2006 and February 2007. The aim was to inform future planning and design policies for this age group in order to maximise the positive impacts on health of any future housing developments and minimise any negative health impacts.
8. The findings showed that residents of the new, age appropriate housing projects had health needs greater than the general population and also of those of a similar age residing in social housing in the neighbouring council area. The move to the new housing did not appear to have a deleterious effect on health.
9. Findings from qualitative interviews with the residents indicated that the new housing contributed to significantly improved quality of life, independence and self-efficacy.

¹ This Includes High Peak Borough Council, Derbyshire Dales District Council and Peak District National Park.

10. Other areas of health benefit identified were as follows:

- The well insulated and easy to heat environment mitigated against avoidable winter deaths
- The age appropriate internal design features such non-slip floors, easy access and provision of wet rooms mitigated against housing related accidents
- Accessibility and proximity to local community services increased uptake of health services and wider community participation
- The exterior design in the vernacular was considered non stigmatising and gave residents a positive psychological experience
- The siting of the developments in areas of low deprivation increased residents' neighbourhood attachment and perception of safety.
- Access to housing advice and support from local housing support workers resulted in housing transition being less stressful than anticipated.
- The option of shared ownership of some properties enabled residents to release equity and increase disposable income

11. Only one area of *potential disadvantage* was identified. This resulted from the increased rental costs and council tax banding experienced by some residents. It was too early in residents' tenure to fully assess this although council tax credit and reduced heating costs are likely to mitigate against this

12. Although the properties aspired to Lifetime Homes standards there were areas of non-compliance e.g. in window design and access to second floor premises.

13. No special attention had been given to sustainability or alternative energy solutions. These have the potential to improve health through increased disposable income.

14. Overall the housing developments were greatly valued by the residents as indicated below.

"I feel I have never lived anywhere else, I feel part of the community because I can get to places now, I wish I could have moved years ago, I know my arthritis will not go away but mentally I feel so much better, everyday things are no longer such a challenge or worry, life is so much less problematic – I love it!"

Steering Group Recommendations

1. Housing stakeholders should bench mark current policies and practices against the *Lifetime Home* standards.
2. Stakeholders should host a *Lifetime Home* standards awareness-raising event for local architects, designers and developers.
3. Opportunities should be sought to create a joint appointment between housing and health or social care, of an occupational therapist to advise on the design of all age appropriate projects. A model for this type of role already exists in the architectural liaison worker employed by the police to promote community safety
4. All new purpose built schemes for older people should employ an adequately trained worker to advise on the internal and external design to ensure it is fully disabled access and older people friendly
5. Prospective tenants should be involved in the design of any future age appropriate housing for medical priority residents
6. All further new purpose built schemes for older people should consider housing sustainability issues such as water recycling, use of solar panels, ground source heat pumps and other energy saving initiatives to mitigate against fuel poverty.
7. All future purpose built schemes for older people should consider how technologies, such as falls detectors, could further assist older people to live independently.
8. Computer access should become a standard fitting in new build accommodation for older people given the increasing importance of Internet access to public services such as housing, health and social care.
9. The impact of the suspension of use of Medical Priority Re-housing (MPR) and separate older persons housing list should be monitored by Derbyshire Dales District Council to ensure vulnerable older people with mental or physical health needs are not disadvantaged in access to housing through the new Choice Based Letting system
10. Following the recent implementation of the new Choice based letting system housing officers who have been released from managing routine waiting lists should target vulnerable older adults who are unable to bid for properties themselves.
11. The Age Concern Housing Option project should be extended to ensure equity of access to this much-valued service

12. Stakeholders should consider imaginative solutions to support individuals who are unable to take up new housing options due to health or social circumstances for example through additional housing support workers.
13. Stakeholders should consider solutions to minimise the stress of moving house, this could include access to practical support to put up curtains etc as well as financial mechanisms to enable residents to meet extra moving costs.
14. The tenants should be surveyed again in 12 months time to reassess their health and well-being following house move to ensure any longer term health impacts are identified.
15. The steering group should make links with housing researchers in West Midlands who conducted a health impact assessment on age specific housing comprising a small retirement community to compare the value of this model of housing for older adults with local initiatives.
16. The steering group should ensure the findings from this health impact assessment are shared with the relevant governing Boards.
17. The steering group should continue to work collaboratively and develop an action plan for the implementation of the above recommendations

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Age Specific Housing for Older People in Derbyshire Dales Health Impact Assessment

1. Introduction

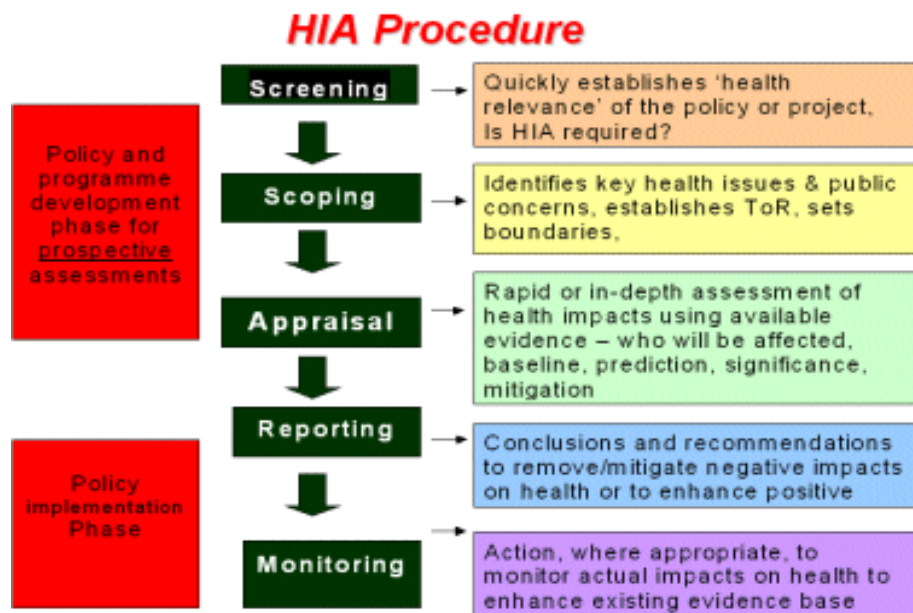
This report describes the findings from a health impact assessment (HIA) of two new, age appropriate housing developments for medical priority older people in the Derbyshire Dales. Derbyshire Dales District Council was awarded funds from East Midlands Regional Housing Board to undertake the HIA in order to inform future older people's housing policy and practice in the Peak Sub Region. The assessment was subsequently commissioned from the public health department of the former High Peak and Dale Primary Care Trust

1.1 What is health impact assessment?

Health impact assessment is a relatively new and developing process that uses a range of methods and approaches to identify how any policy, strategy or specific project may affect the health of people. It is based on the premise that many of the determinants of health lie outside health care systems (Dahlgren and Whitehead 1991), and that;

'Social, economic and other policies in both the public and private sectors are so closely interrelated that decisions in one sector may impact on the objectives of other sectors' (Gothenburg consensus paper WHO1999).

The World Health Organisation (WHO 1999) identifies five stages involved in HIA process as outlined in Figure 1



This report addresses the scoping, appraisal and reporting stages of the HIA process.

1.2 Aims and objects

The aim of the HIA was to assess the health impact of two new, age appropriate housing developments for category A (medical priority) housing waiting list older residents. One development, comprising 10 units is situated in the village of Hulland Ward the other, comprising 6 units, is in the market town of Bakewell.

The objectives were as follows:

1. To understand the health status of the residents and identify any changes in health following housing move.
2. To understand the relationship between health and housing in older people
3. To compare the findings from the two housing projects to identify any geographic specific issues affecting health
4. To formulate and prioritise specific recommendations to maximise the positive impacts on health and minimise or remove negative impacts of future new appropriate housing developments for decision makers
5. To provide new information to the relevant Local Authorities and the Peak Park Authority to inform the planning and design of future age appropriate accommodation for category A medical priority residents

1.3 Steering group

A steering group was established comprising representatives from all the interested stakeholders as follows:

- Mary Carr and Peter Abbott *Policy Planning Officers Peak District National Park Authority*
- Rob Cogings *Principal Strategic Housing Officer Derbyshire Dales District Council and High Peak Borough Council*
- Mick Bond *Research Manager Derbyshire County Primary Care Trust*
- Kate Morten *Research Officer Derbyshire Dales District and High Peak Borough Councils*
- Angela Parnell *Housing Option Project Leader Age Concern Derby and Derbyshire*
- Rebecca Renshaw *Housing Assistant Peak District Rural Housing Association*
- Linda Syson-Nibbs *Nurse Consultant Public Health Derbyshire County Primary Care Trust*

The group was responsible for establishing the HIA boundaries, the key areas to be assessed and optimum methodology to be employed. The group also provided background organisational information. In addition the research manager undertook the quantitative data analysis, the research officer undertook a review of anonymised qualitative data from tenants housing application forms. The nurse consultant conducted the literature review, carried out the interviews and wrote the final report. The group met four times during the period of assessment and a further two times to advise on the reporting framework and dissemination of findings.

2. Background Policy

2.1 Housing and health policy

The need for 'joined up public policy was specifically highlighted in the cross government strategy *Saving Lives: our Healthier Nation* (DOH 1999). The strategy acknowledged the wider socio economic determinants of health such as housing, income and employment and their impact on health and health inequalities. The white paper identified housing as a specific theme on the premise that '*good quality housing inevitably has an important impact on health*'. The unique housing needs of older people were reinforced in the *Older Peoples National Service Framework* (2001).

This is recognised in *Tackling Health inequalities A programme for Action* (DOH 2003) which sets out plans to tackle health inequalities and stresses the importance of working with people aged over 50 years as a key group in order to make speedy progress in raising life expectancy.

The government's *Best Value in Housing* framework recognises that housing should not be looked at in isolation but should be considered together with other local authority services including services that are provided to enable people with support and care needs to live independently in the community (ODPM 2001). This represents a shift of focus in social care and health policy away from institutional solutions towards the promotion of independence and provision of care as close to home as possible.

Consideration of these issues for older people is crucial given the policy drive to enhance local councils strategic role in housing. They need to consider the requirements of older people living in different tenures including owner-occupiers, those renting privately and those in social housing.

2.2 Older people's housing needs

There are a number of national demographic trends that are shaping the housing needs of older people. These are identified in the Government's *Quality and Choice for Older Peoples' Housing: a strategic framework* (2000) and include the following:

- The number of older people aged over 60 is increasing
- The number of frail older people is increasing
- The number of older people who owner occupiers is increasing
- The expectations and aspirations of older people are likely to rise over time

Whilst older people are no different to younger people in wanting choice over where and how they live their lives the solutions to these needs will be different. Increasing age and worsening health are inextricably linked but do not necessarily have to lead to loss of independence or poorer housing experiences. Historically this has probably been the case as the decline of extended family carers has increased older peoples reliance on external care and support services thus serving to increase the need to review current approaches to housing provision in older age.

Older people are not however a homogenous group; the *Older Peoples NSF* (DOH 2001) describes three different phases of old age:

- Those entering older age which may be described as being as young as 50 or not until retirement age of 65years,
- The transitional phase that encompasses the seventh and eighth decades when long-term health conditions may impact more significantly
- Frail old age when conditions such as strokes or dementia result in people requiring more intensive care and support.

The challenge for housing strategists is to create housing choices that are life long and can support older people through these stages.

Quality and Choice for Older Peoples' Housing: a strategic framework (2000) lays out the findings from national Listening Events with older people in relation to housing. Key messages included:

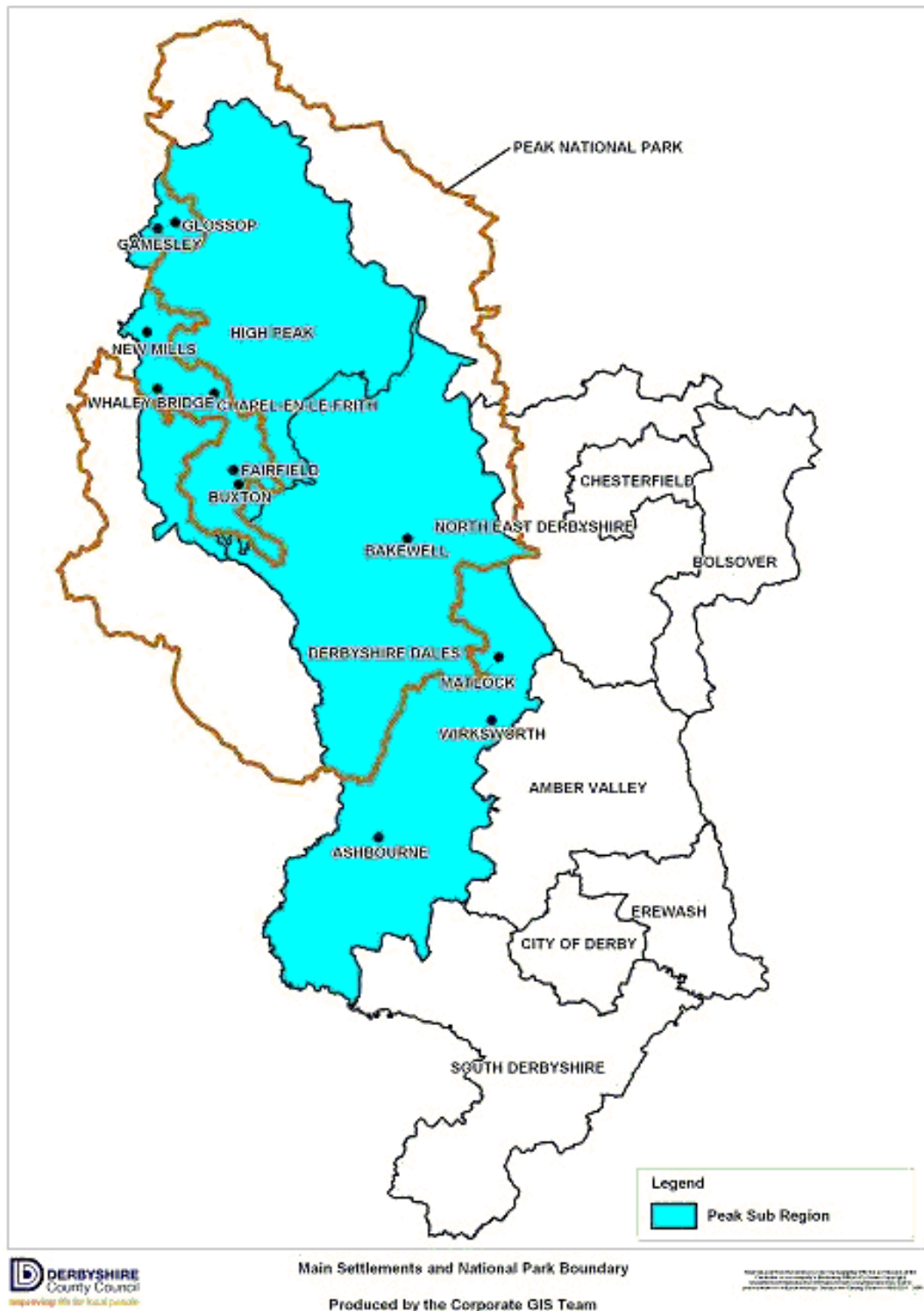
- New homes design should take into account the needs of older people including those from ethnic minorities
- Increased insulation, help with heating and other energy saving measures
- More home security improvements, local safety advice services and practical help services around the home and garden and better transport facilities
- More independent living opportunities and better quality of sheltered housing
- Less waiting times for adaptations and equipment
- More flexibility and choice in housing, care and support options and clearer information and advice on what is available

3. Local context and setting

3.1 Study Area Profile

Derbyshire Dales District Council and High Peak Borough Council are neighbouring local authorities situated in Derbyshire. More than half of both these administrative areas lie within the rural Peak District National Park Authority. The two Councils combined their strategic housing service into one team covering the Derbyshire area of the Peak Park sub region. The study area covers this part of the sub region which in it's entirety also encompasses the National Park outside of Derbyshire.

Map to show, Derbyshire and the National Park



Using DEFRA's Rural/ Urban District Classification (2005) Derbyshire Dales is classified as *Rural 80* (at least 80 % of the population living in rural

settlements or market towns) and High Peak as *Rural 50* (between 50 % and 80 % of the population living in rural settlements or market towns districts).

Overall the indicators of health for the people living in Derbyshire Dales are better than average when compared with England, the East Midlands and with other similar authorities. However the relatively prosperous appearance of the rural areas as a whole masks pockets of multiple deprivation that effects substantial numbers of the population (DCC 2006)

The hidden nature of rural deprivation arises from the use of area-based composite measures of deprivation, such as the Indices of Multiple Deprivation, which are biased towards urban areas. In rural areas poverty is scattered and exists on a house to house basis that cannot be identified through ward based or other small area statistics (super output areas)

Sparse rural areas have a higher proportion of households in income poverty with almost one household in three living on less than 60% of the English median household income (< £15,861). Rural household incomes have a complex composition, wages are important but so are other source such as pensions and benefits (Countryside Agency 2006).

Certain groups are particularly at risk of rural disadvantage and social exclusion and these include elderly people living alone and elderly couples reliant on the state pension

The area mirrors and magnifies the national demographic trends previously described. For example within the Peak Park is it is estimated that 47% of the population will be aged 60 and over by 2026 and 20% aged 75 or over. This profile results from the natural ageing of the population, exacerbated by the pattern of migration, with net out-migration in the 17-30 year age group set against a background of very small numbers of new dwelling completions per year (Cathie Marsh Centre for Census and Survey Research 2007)

The Peak sub region is one of the most attractive rural parts of the country and this has contributed to its housing challenges as follows;

1. A large buy to let sector fulfilling the needs of the holiday market,
2. The second highest market prices in the East Midlands (EMRA2006),
3. A diminishing social housing stock
4. Planning constraints arising from the need to maintain the character of the National Park.
5. Large percentage (78%) of older adult owner occupiers in Derbyshire Dales area

The provision of affordable housing is one most important issues facing the sub region and within this meeting the housing needs of older adults is particularly challenging.

3.2 Current housing options for older adults in the Peak sub region

Within the Peak sub region the social housing stock is managed by two housing associations, Dales Housing Ltd and High Peak Community Housing. Derbyshire Dales District Council retains the management of the housing waiting list. The local authority has a duty to provide information and assistance to the general public but has an extra duty of care to prioritise the needs of vulnerable groups such as those experiencing homelessness or health problems that can be mitigated by housing improvement.

Aside from the social housing stock housing needs can also be met through independent housing associations such as Peak District Rural Housing. They are registered social landlords who work in partnership with the Council.

The Council also works with registered social landlords who provide sheltered housing, which is subsidised social housing that is provided to tenants with serious chronic disease or disabilities. It combines specifically designed housing in a group with additional services such as the support of a warden, an alarm system and laundry service and other communal facilities. This traditionally has been one of the main housing move options for older people with health problems. There is a growing number of private sector sheltered housing schemes in the local area.

Extra care or very sheltered housing can provide high levels of on-site care and support that was previously only available from a residential care home setting. Derbyshire Dales District Council also provides such housing but recognises that it will only meet the needs of a very small proportion of the older population given that the majority of older people live in ordinary houses.

The Council also provides disabled facilities grants to enable people to adapt their homes to meet health needs for example through the installation of ramps or rails to improve property access.

Other initiatives such as the Supporting People scheme are also available to older people and new funding flexibilities have resulted in support not being tied to specific accommodation.

With this in mind the development of new age appropriate housing in local community settings, without the additional support provided in sheltered or extra care schemes, is a new development for the Council. Such schemes aim to enable people to stay in their own homes for as long as possible and represent a move from other more institutional models of provision. They should aim to meet lifetime homes standards.

3.3 Allocation policy

At the inception of the health Impact assessment social housing was allocated according to a social allocation formula that took account of tenant's health and social circumstances. Homelessness or immediate threat of homelessness took precedence over all other social circumstances but points were awarded if prospective tenants reported that their health was at risk in their current accommodation.

In the Derbyshire Dales area around 1500 people a year apply for Medical Priority Rehousing (MPR). Through an assessment process (often contracted out to an independent company) information recorded by prospective tenants on the council housing medical application form is validated and housing officers are made aware of conditions that may benefit from a change of housing. If a change in housing is not likely to benefit the tenant then consideration is given to what other kinds of support the council can offer.

There has been some discussion regarding the value of the Medical Priority Rehousing system for older people. Smith (1989) suggests that older peoples health gains from housing may lie out with medical priority housing system due to diminishing social housing stocks. This has resulted in increasing number of sick people being forced to seek accommodation in the private sector. There is therefore a clear need to ensure those sick people most able to benefit from rehousing are enabled to do so.

Potential tenants for both developments were identified from the Council's Older Person's Housing list (although the Hlland Ward development was owned by the a registered housing association any landlord setting up a new scheme is required to give the local council 100% nomination rights (thereafter the local council has 50% nomination rights). The Older Person's register is for people over the age of 60 years who wish to be considered for specific older persons properties. Priority was given to those at the top of the list with medical problems.

Prospective tenants were also required to demonstrate that they have a local connection to the area they wish to be re-housed in either through work, residency or family member. The local connection clause ensures that local people are prioritised for local housing. These clauses result from local planning policies. For Miracle Court a 10-year local connection was required as it is situated within the Peak District National Park. For Charles Walker Close a 5-year local connection was required in keeping with Derbyshire Dales District Council Housing Policy.

3.4 Choice based letting scheme

During the conduct of this health impact assessment the Peak Sub region has introduced a new allocation process following a successful bid to the ODPM. From March 1st 2007 there will no longer be a specific older persons list. Instead all available properties will be advertised and prospective tenants invited to bid for suitable properties. Age specific property will be identified as such and bids only accepted for those that meeting the defined criteria.

4. Purpose Built Age Specific Housing Projects

4.1 Miracle Court Bakewell

Miracle Court is located in New Street in the centre of the market town of Bakewell. The town is the largest settlement within the Peak District National Park and is located on the river Wye approximately 13 miles south west of

Sheffield. Bakewell has a population of 3,818 of whom 98% are white. The area is the second least deprived ward in Derbyshire.

The accommodation comprises six flats (three ground floor and three first floor) which and a newly built Army Cadet Hall designed and developed through a partnership between Peak District Rural Housing Association, Derbyshire Dales District Council, Peak District National Park Authority, The Housing Corporation and East Midlands Reserve Force and Cadets Association, using combined resources (Derbyshire Dales District Council provided the land and supplemented the Housing Corporation grant with an extra £200,000.)

The properties are designed in the vernacular in keeping with the Prince Wales's *Affordable Rural Housing Initiative Creating a Sense of Place: a design guide* (2006). The flats were designed for older people and are within a few minutes easy walking distance of shops, pub and a weekly market. The local church and GP practice are also within walking distance although on an incline. A community hospital is located approximately ten minutes walking distance away.



Accommodation Design

Each flat comprise a solid front door with spy hole, sash windows, entrance lobby, open plan kitchen/ lounge area, two bedrooms and a wet room. The flats are heated by gas central heating. The upstairs flats are accessed by

stairs only although there is space to install a chair lift if required. At the rear there is a barked garden plot for use by residents and a hard standing drying area. Access to the front of the properties is by four steps with a handrail.

4.2 Charles Walker Close, Hulland Ward

Charles Walker Close is a new development situated in the village of Hulland Ward four miles east of Ashbourne on the A517 just on the edge of the Peak District. The village is in fact the centre of a small number of hamlets and is ranked amongst the least deprived quartile of wards in Derbyshire. It has a population of 1,773 of whom 99.16 % are white (ONS 2001). The area is predominately mixed farmland although a large concrete works also provides local employment. Local services include a village shop, garage, two pubs, church and GP practice.

Peak District Rural Housing Association acquired the units from a private developer with funding from Derbyshire Dales District Council and a Housing Corporation grant. The Close is located next to open countryside and links to the main road. It comprises ten units, six available for shared ownership and four for rent.



Accommodation Design

The units were all of a single house type design on one floor with one double and one single bedroom. Each has access to a small private garden. Access

is by a flat tarmac courtyard around a cul –de-sac designed to give pedestrian priority .The houses built of reconstructed stone with stone cills and eaves were designed and built by a private developer to meet the specific housing needs of people over the age of 55 years. The living and dining spaces and kitchens and bathrooms are all designed for limited mobility. The kitchens have adjustable work surfaces to accommodate wheel chair users and the bathrooms are wet rooms with shower and non-slip flooring. The properties are gas centrally heated.

5. Methodology

This HIA was retrospective in design, as residents had already moved into the new accommodation before the commencement of assessment. A range of methods were employed to inform the appraisal process as follows

- Review of published research on health and housing
- Review of other relevant published housing health impact assessments
- Review of anonymised data from tenants housing application forms
- Structured interviews with sample of residents (n= 7)
- Semi structured interviews with steering group members
- Health survey of residents using SF36 questionnaire (n=30)

This mixed methodology enabled new local qualitative and quantitative data to be collected and evaluated in the context of other published research and housing health impact assessments.

5.1 Ethical consideration

The health Impact assessment involved consulting local residents about their current and past housing and also collecting health and well being information. The work did not involve withholding services or treatments. The work did require consideration of informed consent and data confidentiality, which are discussed later in this report. The research manager discussed the proposed health impact assessment with the Chair of the local Ethics Committee and was advised that formal ethical approval was not required.

5.2 Health questionnaire survey

One objective of the HIA was to understand the health status of these residents and identify any changes in health following their move to the new accommodation. Unfortunately it was not possible to collect pre and post move objective health measures as the residents had already moved into the new accommodation before the HIA was commenced

The Short Form (SF36) questionnaire (appendix 1) (Ware1993) was used to survey residents' health. It is a well-validated tool commonly used to assess health that was developed originally in the United States. It has the benefit of containing one question relating to respondents health over the previous 12 months. The SF36 was also used as part of an HIA of the redevelopment of three council estates situated North Eastern Derbyshire. A structured review of generic self assessed health tools in older people recommended the use of SF36 where detailed and broad ranging assessment of health was required in community dwelling older people with limit morbidity (Haywood, Garratt and

Fitzpatrick 2005). The SF36 consists of 35 questions or dimensions and these are subdivided into 8 'domains' that are listed below.

- a) Physical functioning (10 items)
- b) Social functioning (2 items)
- c) Role limitations due to physical problems (4 items)
- d) Role limitations due to emotional problems (3 items)
- e) Mental health index (5 items)
- f) Energy/vitality (4 items)
- g) Pain (2 items)
- h) General health perception (5 items)

In addition there is one question about change in health status over the last year, known as health transition that does not contribute to the scales above. A number of other topics were included to give more in depth understanding of the circumstances of those surveyed these were;

- a) How much does your health limit your ability to feed yourself?
- b) How much does your health limit you from getting up from a chair?
- c) How much does your health limit your ability to walk in your home?
- d) Long term limiting illness
- e) Gender
- f) Age
- g) Who respondent lives with

5.3 Study sample and distribution

Eligibility to the two new housing developments was restricted to those over the age of 65 years who had identified themselves as having medical conditions that prioritised their position on the local authority-housing waiting list. The SF-36 questionnaire and an accompanying letter (appendix 2) were sent to all new residents n= 26 in September 2006. The accompanying letter explained the purpose of the questionnaire and also contained a tear off slip seeking consent to a follow up interview by a member of the Primary Care Trust. Derbyshire Dales District Council Housing research officer sent out the questionnaire and letter to preserve client confidentiality. One reminder letter was sent

5.4 Resident interviews

Seven residents gave written consent to be interviewed further about their recent housing experiences. One telephone interview was conducted and the remaining 6 interviews were conducted in the residents' own homes.

The interviews were structured using an interview schedule designed by the steering group to address the key housing and health themes (see appendix 3) The interviews were then analysed using the key housing and health themes identified by Thompson Petticrew and Morrison (2003) and Howden-Chapman (2004)

5.5 Case studies

Case studies have also been included to give resonance to the findings. Personal details have been altered to preserve confidentiality

6. Results

6.1 Review of published research

In order to improve the utility and predictive value of health impact assessments Thompson Petticrew and Morrison (2003) identify the need to incorporate existing research data into the assessment. A literature search of electronic databases was conducted to identify relevant studies.

A large body of research exists investigating the health of populations and their housing conditions and a number of comprehensive reviews of housing literature have been conducted (Raw and Hamilton 1995; Peat, Dickenson et al 1998; Wilkinson 1999, Fuller-Thompson, Hulchanski et al 2000; Homes and Tuckett 2000). The reviews concluded that the body of research evidence indicates that poor housing is strongly linked to poor health. However the extent to which the link is causal is less clear as is the extent to which poor health can be bettered by improved housing. For example poor housing conditions often co exist with other indicators of deprivation such as poor education, unemployment and ill health. These confounding factors make it difficult to assess the overall impact of housing conditions

Thompson Petticrew and Morrison (2002) conducted a systematic review of experimental and non-experimental housing interventions, which measured quantitative health related outcomes from 1887 to 2000 (n=>1000). The authors found very few high quality intervention studies, which addressed the impact of housing on health. However a summary of the most methodologically robust studies (n= 19) indicated that housing does have the capacity to improve health, For example eight of the nine studies which measured mental health showed improvements and one study demonstrated a 'dose response' effect. Improvements in physical outcomes were less clear with similar studies showing both positive and negative effects.

The authors also identified some studies that showed adverse effects of housing improvement and in one study mortality rates increased. This was attributed to doubling of rents, which effected householder ability to afford an adequate diet.

Three of the studies reviewed addressed medical rehousing (Elton and Packer 1987; Smith et al 1997 and Cole and Farrries 1986). All the studies reported improvements in self-reported physical and mental health. No studies controlled for confounding effects and only one was a prospective study but the sample size was small (n=56) (Elton and Packer 1987). All three studies addressed re housing on mental health grounds and none were age specific.

Finally a review of housing and public health reviews undertaken by The National Institute of Health and Clinical Excellence (NICE 2005) yielded similar findings to those of Thompson Petticrew and Morrison (2002) but in addition noted the lack of evidence of effectiveness of housing related interventions that related to the broader macro policy environment such as housing allocation, lack of housing, housing tenure and housing investment.

6.2 Housing health impact assessments (HIA)

Veerman et al (2005) undertook a review of published quantitative health impact assessments to assess the methods used. This identified one housing study relating to the assessment of a new home energy efficiency scheme (Kemmer et al 2000). From a review of other published health impact assessments only one other study was identified that addressed the health value of purpose built age appropriate housing for older people.

Kinston, Bernard, Biggs et al (2001) conducted a study to assess the health impact of age specific housing. The sample comprised all the tenants of a retirement community in the West Midlands (n=47) who were matched with older people attending three, day centres in the same geographical area. The findings showed that the retirement community maintained their physical and mental health at one-year post move whilst the community control group had a significantly decreased health status as measured the SF36 (a generic measure of health status). The authors conclude that purpose built retirement communities can help maintain health status in older adults.

Other housing assessments focused on the health benefits of housing improvements rather than new builds. For example Gilbertson Green and Ormandy (2006) conducted a HIA of the Sheffield Decent Homes housing improvement programme. They used the Housing Health and Safety Rating System (ODPM 2006) to assess the housing stock pre and post intervention and then used these findings to estimate the health impact on the target population that included older people. Health benefits were identified and the costs saving to health and social care were estimated, for example through falls prevention and prevention of winter deaths in older people.

Given the current paucity of research providing a causal link between health and housing Thompson Petticrew and Morrison (2003) developed a table of synthesised findings indicating the expected health effects of specific housing improvements to assist in the conduct of housing health impact assessment. Howden-Chapman (2004) undertook a similar exercise through a compilation of a glossary of housing and health. The intermediate housing factors identified in both these papers have been combined to provide a framework for analysing the qualitative data described in section 6.4 of this report .

6.3 SF36 Results and analysis

Fifteen residents completed the health questionnaire resulting in a response rate of 57% (n= 15). The small sample size mitigated against the use of a full range of statistical analysis but where possible comparisons have been drawn with the UK census populations and results from the North East Derbyshire District Council HIA (2000).

Sample characteristic and current health

The sample was predominately female (10 women 5 men) and ages ranged from 62years to 82 years with a mean age of 75years. The residents had resided in their new properties from between three and nine months.

Residents were asked to rate their current health (excellent, very good, good fair and poor)

Table one to show resident self-rating of their current health status

Response	Number	Percent
Very good	1	6.7
Good	6	40.0
Fair	6	40.0
Poor	2	13.3
Total	15	100.0

Only 13.3 % of residents rated their health as poor and 46.7 % rated their health as good or very good. Given that all the residents were re housed for medical reasons this might appear surprising however assessment of health is a subjective measure and this score may reflect the current general well being of respondents as well as the stoic nature of the older generation.

Long term limiting illness

Residents were asked if they had a long term limiting illness (LLTI) that limits or restricts daily activities. This question is used routinely in the UK census.

Table two. Number of residents with a long term limiting illness

Response	Number	Percent
Yes	11	73.3
No	3	20.0
Missing	1	6.7
Total	15	100.0

According to the UK Census the most common LLT illnesses are musculoskeletal disorders, followed by heart and circulatory problems and then respiratory disease (National Statistics 2001). Eleven residents (73.3%) reported a long term limiting illness whilst nationally 53% of all people aged 75-79 reported a long term limiting illness (National Statistics 2001). Some respondents are spouses as well as carers and this may account for this percentage not being higher given the medical priority rating of respondents. A very recent unpublished study of the health of older people living in rural areas found a mean of 56% of people who reported a LLTI. However variations existed between different geographical areas, where older people living in areas of high deprivation reported higher levels of LLTI (83%) compared with lower levels (33%) in areas of low deprivation (Baird, Jackson and Peters 2007). Illness and deprivation are inextricably linked. No

deprivation data was collected on the geographical areas residents moved from but the two new housing developments are located in areas of very low deprivation.

Effects of limiting long term illness

The table below shows the effect of LLTI on daily activities of living ranked by frequency

Table three. Current limitations of long-term illness

Activity	Limited a lot	Limited a little	Total
Vigorous activity	13	1	14
Lifting/carrying shopping	4	10	14
Climb stairs	8	5	13
Bending	5	6	11
Walk 1 mile	9	2	11
Walk several hundred yards	5	6	11
Get up from chair	2	6	8
Walk 100 yards	2	3	5
Walk inside home	1	3	4
Bath /dress	3	1	4
Feed self	1	1	2

The most common limitation was vigorous activity, followed by lifting/carrying shopping climbing stairs and bending. Only four residents reported problems with bathing /dressing, this is in contrast to the information gathered from interviews with respondents about their prior housing circumstances where problems with bathing were reported equally with problems climbing stairs.

Pain

Residents were asked how much bodily pain they had. Nine (66.7%) had moderate or severe pain that interfered with their lives moderately to severely.

Emotional well-being

The table below shows emotional well being

Table Four. Emotional Well-being

Feeling	All/most of time	Good deal of time	Some of the time	Total
Nervous	2	3	1	6
Down in dumps	2	2	3	7
Calm and peaceful	1	1	7	9
Down hearted/depressed	1	1	1	3
Have you been happy	4	4	3	11
Tired	5	3	4	12

A small number of residents reported feeling nervous and or down in the dumps but the majority reported feeling happy, if not all of the time at least some of the time.

Health compared with one year ago

Residents were asked how their health compared to one year ago. The majority (n=11) indicated that their health was about the same or better than a year ago (73%) whilst four reported their health to have worsened.

Table Five. Health compared with one year ago

Response	Number	Percent
Much better than one year ago	1	6.7
Somewhat better than a year ago	1	6.7
About the same as one year ago	9	60.0
Somewhat worse than one year ago	2	13.3
Much worse than one year ago	2	13.3
Total	15	100.0

One year ago all of the residents were still in their old housing having resided in the new housing for between five and nine months. The majority reported that their health was about the same compared with one year ago. Despite the prevalence of long-term illnesses only four reported worsening health and two said their health had improved compared with one year ago.

Deterioration on Health

The table below shows the cross tabulation of resident's self report of their current health with that how they would rate it over the last twelve months.

Table Six Cross tabulation of health now compared with 12 months ago

Health Now	Health over the last 12 months?				Total
	Good	Fairly good	Not good	Missing	
Very good	1	0	0	0	1
Good	2	3	0	1	6
Fair	0	4	2	0	6
Poor	0	0	2	0	2
Total	3	7	4	1	15

Increasing age does not inevitably lead to a deterioration of health but the two are closely linked especially in the presence of a long-term limiting condition. The majority of residents (86%) had not seen deterioration in their health following house move. Just two residents reported their health to be generally poor now and not good over the last twelve months.

Hulland Ward and Bakewell residents' health compared other populations

The SF36 is a quality of life measure that can be used to compare one population group with another. The same measure was used for health impact assessment of the remodelling of three council housing estates in North Eastern Derbyshire District Council in 2000. The results from the two populations were compared using a statistical measure known as an independent samples T Test. The analysis was conducted using data from people aged over 60 in the North Eastern Derbyshire District Council schemes and all people in the Hulland Ward and Bakewell schemes (youngest aged 62). The results showed that residents in Bakewell and Hulland Ward had more limitations due to physical problems than those aged over 60 living in the three council estates. The full results are given in appendix three.

This finding goes some way to validate the medical prioritising system used to identify those older adults with significant health needs compared to other older age adults.

6.4 Interview results

6.4.1 External housing design

For the purposes of the HIA it was necessary to distinguish between residents' comments regarding design faults that would impact on the health and safety of the older adult occupants as opposed to design preferences or more generic building deficits or faults, the latter have not been included in this report.

Dwelling type

The design of houses has been linked to health status. For example high rise flat dwelling has been linked to social isolation and stressful living conditions. The increasing development of stand-alone retirement flats and multi unit dwelling by the independent sector has yet to be assessed in terms of health benefit.

Several of the interviewees commented on their preference for a traditional style of housing that did not stand out as being different from the rest of the community and was non stigmatising. They did not want to live in properties that could be singled out as old peoples homes. The 'house' style design of the Charles Walker Close bungalows was praised as was the design of Miracle Court both of which residents felt was in keeping with the local surroundings

Outside space and garden

At Charles Walker Close the bungalows all had small gardens and this was greatly appreciated. Many residents had left larger properties with unmanageable gardens that felt burdensome. The new smaller plots however gave residents the opportunity to potter in the garden, which was a valued pastime that reportedly enhanced their quality of life.

At Miracle Court the properties had access to shared concrete standing at the front. One resident had taken responsibility for this area. This resident had filled it with planted tubs and pots that were a source of great pleasure to all the residents.

Windows

Miracle Court presented the greatest external design challenges as it was located in the Peak Park and therefore subject to significant planning restrictions to preserve the local character. The use sash windows at Miracle court were aesthetically pleasing and in keeping with the local character but considered by some residents to be too heavy and difficult to open.

Access

Good age appropriate housing design should *ensure that there is in built flexibility that can cater for a variety of needs particularly relating to access and mobility* (DETR 2001). All those interviewed reported significant access problems with their previous accommodation and this was one of the major reasons for seeking a change of accommodation.

Both the new builds complied with Part M of the Building Regulation covering access and facilities for disabled people. The good access improved residents quality of life, for example one resident was now contemplating the hire of buggy as access and storage was no longer a barrier. Other residents reported that they were now able to make more use of mobility aids.

Physical structure of housing

The physical structure of houses encompasses building materials, which can impact on health, for example through the release of asbestos from textured

ceiling or inadequate ventilation resulting in damp and mould. The construction materials used included local stone and adhered to all modern building regulations and safety standards and residents raised no concerns. The properties were all built to the Housing Corporation Scheme Development Standards. The properties were designed with consideration and reference to Lifetime Homes Standards which have an emphasis on accessibility through the use of design features that can accommodate change health needs from cradle to grave (Joseph Rowntree Foundation Lifetime Homes Standards 1999). There are a total of 16 Lifetime Home Standards. Miracle Court did not meet the standards for external access or window design.

Internal housing design

Whilst many of the internal design features identified in the Lifetime Homes Standards were achieved at no stage in the design process were potential service users involved nor was expert advice sought from an occupational therapist or other health professional regarding the optimum internal design. The designers instead adhered to broad guidance for disabled people with a presumption that all older people were or would be wheelchair users. Only one tenant at Charles Walker Close was a wheelchair user and there were none at the time of relocation at Miracle Court. Generally however interviewees were very pleased with the internal layout of both the schemes.

Kitchen

The residents who were interviewed viewed the kitchen as an important space. It needed to be clean easy to use and maintain and as safe as possible. Kitchens are a major source of home accidents in the young and old. At Miracle Court the adjustable height kitchen works surfaces were generally not appreciated as they prevented efficient use of the space beneath them. Conversely the wall-mounted cupboards were not easily reached by all tenants. There was general dissatisfaction with the oven and hob layout at Charles Walker Close. The oven was sited next to the kitchen door and could only be opened when the kitchen door was open due to positioning of the handles. The hob and oven were on different sides of the kitchen and this was thought by some residents to be a potential safety hazard.

At Miracle Court some generational issues were raised by residents regarding the open plan kitchen /diner area as they were unused to cooking and eating in the same room (at Miracle court there was sufficient space for residents to eat at a bar or small table in the kitchen) There were no concerns about the arrangement of units or the cooker at Miracle Court.

Bedrooms

The most frequently praised design element of the two schemes was the inclusion of two bedrooms. Traditionally older people's accommodation has consisted of a one bedroom flat or bungalow. The extra bedroom enabled family and friends to stay and also gave residents the reassurance that should live in care be required space was available. The ability to receive houseguests was reported to be a significant boost to self-esteem and

independence. Several residents had many years of makeshift sleeping arrangements, as they had been unable to get upstairs in their previous accommodation

Bathroom

The modern wet rooms were similarly praised. Many residents had experienced problems with self-care and washing facilities in their previous accommodation. A number of interviewees had been unable to wash independently in their previous homes. Two had experienced the indignity of getting stuck in the bath. The new wet rooms had enhanced their privacy and dignity as well as independence. One resident thought it unusual that no full-length mirror had been fitted, as these are necessary for self-care and hygiene purposes for individuals with mobility and continence problems. There was satisfaction regarding the positioning of grab rails.

Communications

The telephone socket was sited in the hall. Several residents highlighted the problem of standing to use the phone in the hall; they had always relied on hands free sets that could be taken to a comfortable seat. This required an electric plug socket as well as telephone socket and several residents identified the inconvenience and additional cost of this. The time taken to connect the telephones was also a source of concern and residents felt vulnerable and during this time.

Technologies

Neither scheme has made use of new technologies to support independent living, for example through the installation of movement, lighting and heating sensors. Neither scheme had a separate telephone point and electric socket for Internet access. A number of residents made frequent use of the internet for home shopping and accessing information and commented on the additional cost of addressing this. The Internet is assuming greater importance in health care both as a source of advice (e.g. NHS Direct) but also as method of accessing care (Choose and book and electronic repeat prescription arrangements)

Maintenance

The new builds were considered easier to maintain than residents previous accommodation and did not compromise safety. Most felt able to change light bulbs and tackle all cleaning jobs except for outside windows. Those that could not undertake their own cleaning continued with pre-existing home helps type arrangements.

6.4.2 Indoor atmospheric environment

This refers to the quality of air inside dwellings, which can become contaminated from side effects of particular heating systems, poor ventilation and environmental tobacco smoke. Where dwellings are located on busy roads contaminants from vehicle exhaust can be sucked on through windows, or underfoot occupants can walk inside contaminants. Randon is a particular problem in the Peak sub region. It is a colourless odourless naturally occurring radioactive gas that seeps into homes from the bedrock below. Both

the new builds were on radon free sites. No other external environmental pollutants were identified, as the dwellings were both setback from roads. None of residents interviewed had left properties that were damp, but several had left properties that were close to busy roads.

6.4.3 Internal conditions

Winter warmth

Low Indoor air temperature can contribute significantly towards ill health and morbidity among older people. Cold energy inefficient houses lead to cold related illnesses such as heart attacks and strokes as well as respiratory diseases, high health costs and increased winter deaths (Aylin et al 2001) for example between 2002 and 2003 there were 22,700 more deaths in England during the winter compared with the summer months. The World Health Organisation recommends houses to be heated to 21c in the main living room and 18c in other occupied rooms.

As new builds the two sites comply with current Building Regulations and are therefore likely to be more energy efficient than residents previous dwellings. The improvement on thermal standards of housing has been demonstrated to curb excess winter deaths (Healy 2003) Residents moved into the properties from September 2006 onwards. There was a unanimous view that the properties were easy to heat and keep warm. Several commented on how well insulated the properties appeared to be and they felt less cold than they had done in their previous properties. Two resident had brought electric fires with them which to date they had no need for.

Fuel poverty

Fuel poverty occurs when a householder is unable to afford to heat their home to a level required for health and comfort and when more than 10% of the household income would need to be spent heating the house to comfort levels. Several residents had commented on the high heating costs of their previous accommodation. At the time of the interviews not all the residents had received their first utility bill so it was not possible to identify those at risk of fuel poverty. Although there was a general perception that this would not be an issue several residents commented on the challenge of deciding on a fuel provider and were not sure that they had made the best choice.

Light

Both near and far vision deteriorates with age and internal lighting is an important factor for the health and safety of older people. Charles Walker Close was praised for its light and airy design for example the internal lobby area was illuminated by natural light from a roof funnel. Conversely Miracle Court was criticised for its very dark hallway, compounded by the solid front door. This aside there were no other concerns expressed about natural or artificial lighting in doors.

6.4.4 Household over crowding

Crowding in households can increase risk of infectious diseases, and also impact adversely on mental health. None of residents were living in overcrowded conditions.

6.4.5 Current health status of occupants

Those already in poor health or in vulnerable population groups such as the very young or old will be more susceptible to the ill effects of poor housing. Medical factors also influence access to housing whether it is in the public sector where accommodation is allocated according to need or in the housing market where access is determined by ability to pay.

All the occupants had been identified for re housing on the grounds of medical priority or need to care for someone with a medical priority. The previous section on the health questionnaire described in detail the health profile of those occupants who completed the health questionnaire (57% n= 15/26).

The majority were living with limiting long terms conditions although a very small percentage appeared to be in very good health. These may have been spouses/carers of those with health problems. Although anecdotal evidence from steering group members indicates that one or two residents had needs that were considerably less than other residents.

Since it was not possible to obtain pre move health data it is not possible to compare health pre and post move. However interviewees were very clear in their subjective beliefs about the health effects of their new accommodation. All expressed a belief that their quality of life had improved, through increased independence and control over daily activities of living and sense of security. Self-esteem also appeared to have improved primarily from living in what they perceived to be a desirable location in high quality new accommodation.

6.4.6 Housing related injuries

Houses are a common source of accidental injury. The elderly are particularly vulnerable to home injuries primary through slips trips and falls commonly from stairwells and loose carpets inside and driveways outside (Howden and Chapman 2004). Falls in the elderly account for significant costs to the health community through hospitalisation and later admission to a care home (Scuffam et al 2003). Fires are also a potential major hazard particularly among those who smoke. Once again the intrinsic design of the properties mitigated against housing related injuries, through the inclusion non slip floors in the kitchen and bathrooms, grab rails, minimal steps and stairs and fitting of smoke detectors. To date no accidents have been reported by residents.

6.4.7 Housing as a psychological space

Howden and Chapman (2004) describe housing, *as a private space with a public face, which can be seen as a symbolic extension of self*. They also highlight housing as material asset as well as a psychosocial symbol of achieved status. Where housing is poor this can lead to chronic stress generalised dissatisfaction, both of which can impact negatively on physical and mental health. All residents in the two new builds had varying degrees of housing dissatisfaction that had prompted them to seek alternative housing. There was no sense from the interviewees that the housing move had been

detrimental to health but rather had enhanced well being. Housing can also provide a sense of security and protection from the outside world. Only two interviewees identified concerns about security in their previous accommodation but all reported feeling secure in the new accommodation. The location was as important to this feeling as the fitting of safety devices such as window locks. At Charles Walker Close the developer had attempted to sell residents a home security alarm system but none took up the offer.

6.4.8 Tenure

Home ownership has been independently associated with improved health primarily through the degree of security and control it can provide (Hiscock et al 2000). This may not be generalisable to many older UK adults for whom ownership can result in burdensome maintenance, and unaffordable running costs. This can lead to detrimental mental health. The residents of Charles Walker Close and Miracle Court moved from a range of tenures including, private rented, owner occupied and sheltered accommodation. The new tenures were either rented or shared ownership with the Housing Association. Those residents that had elected to become shared owners felt this was a good solution as it enabled some capital to be unlocked whilst retaining the rest for family members to inherit.

6.4.9. Financial impact

Poverty and health are inextricably linked and consideration should therefore also be given to wealth impact of housing.

Accommodation costs

The benefits of improved housing can be outweighed by the unintended adverse effects of increased housing rents. In one study housing costs rose by 14.8% and resulted in tenants having to economise on food (Ambrose 2000). Many of the residents of Charles Walker Close and Miracle Court were still trying to assess the wealth impact of their house move. The outstanding factors related to uncertainty about utility costs and council tax bandings, the later would increase for some and decrease for others. Some had not paid a service charge before (£35 monthly service charge at Charles Walker Close). All the residents said they thought their net costs would be less but those who were formerly owner-occupiers were most confident. The potential savings identified came from reduced reliance on private taxis, transport costs or paid help, and smaller more energy efficient homes to heat.

Moving costs

Some residents were still recovering financially from the additional costs of moving such as the purchase new curtains, fitted carpets and telephone installation. Removal costs were challenging and several residents were moved by family or friends to keep costs down. Cash flow at this time was a problem for some. Others with minimal or no savings who had moved from the private or social rented sector were particularly challenged and looked to family members to help out. One resident suggested that a financial assistance loan scheme should be explored for those without savings.

Sustainability

The wealth impact can also be experienced through the sustainability of the housing provided. Sustainability was not a particular feature of the two new housing sites although the buildings had a good eco rating. Recycling of water, use of solar heat panels or wind energy was not explored and may have been out with the original development budgets.

6.4.10 Neighbourhood effect

The environmental and social features surrounding houses also contribute to the health of the residents. For example early results from a USA experimental study suggest that the relocation of families from areas of deprivation to areas of middle income have shown health gain (Katz et al 2001). Other observational studies have (MacIntyre et al 1993) have shown that that both place and people are important in determining health of residents. Other aspects of neighbourhoods that have an impact of health are the presence local amenities and absence of 'incivilities' such as graffiti, abandoned cars or street rubbish.

Both the new developments were sited in areas of low deprivation with no visible evidence of neglect. Hulland Ward could be described as a 'chocolate box' village whilst the market town of Bakewell has some of the most expensive housing in the East Midlands. Both developments are within easy access of shops and community transport and public transport. The local doctors can also be accessed easily as can the local church, pubs, and community halls. Overall the neighbourhood effect in both areas appears to be very good and no geographical differences were identified. This was most appreciated by those residents who had moved from more urban environments for example one resident reported what a joy it was not to be disturbed by the sound of noisy teenagers leaving a local nightclub.

6.4.11 Neighbourhood attachment

Residents who have lived in the same house or neighbourhood can be described as attached to their homes or community. Such attachment contributes to the overall stability of an area and improves overall social capital.

Residents have a good knowledge of their neighbours and provide reciprocal social contact and support. However many rural communities are reported to be losing their sense of community as incomers destabilise social norms and cultures and often don't contribute or use local services (so called commuter villages).

The planning policies of the Peak District National Park, the Council and independent housing associations mitigate against this by asking potential new residents to demonstrate some connectedness to the community through local residency.

Some Miracle Court residents moved within Bakewell whilst others moved from neighbouring villages. Most residents of Charles Walker Close moved

from the nearby town of Ashbourne or neighbouring villages. All the residents interviewed talked about the value of existing local ties such as friends or family members and how they felt connected to the local community. They also talked of feeling part of immediate community living in the same development. One resident said;

I don't feel housebound even though I didn't go out for 3 weeks when I was ill.

Several residents reported having made new friends and others described a sense of camaraderie whilst another said;

' We don't live in each other's pockets but we are neighbourly and are always there for each other.

Concern has been raised that age segregated communities might increase dependency and service demand. The Bakewell and Hlland Ward units mitigated against this by their small number of housing units and good integration with the local community.

6.4.12 Housing discrimination

Housing discrimination refers to the racism that some groups are more likely to experience when seeking housing. One way in which housing can be discriminatory is through the allocation process. The area is predominately white and no people from black or ethnic minority groups were on the older peoples waiting list. The Council does however operate a system for monitoring black or ethnic minority groups' uptake of local housing. The current housing allocation policy based on local residency to ensure local people can be re-housed locally and this in itself may prevent more racial mixing in rural communities.

How far other vulnerable groups are unwittingly discriminated against should also be considered. There was a concern expressed by some steering group members that the allocation system and medical priority form did not identify well enough those older people in most need of re-housing or those with mental health needs. It is unclear how far the new Choice Based Letting Scheme will help to redress or compound these concerns. Anecdotal evidence to date suggests that the current application forms are not considered conducive to the identification of health needs.

6.4.13 Moving and willingness to move

Moving house is generally considered to a stressful life event. However the effects of moving are determined by how much control individuals have over their circumstances, whether uprooting means loss of friends and community and how satisfied they are with the new housing or neighbourhood. All of the residents interviewed said they were please they moved and would do it again. Steering group member also reported that in their opinion all the residents were very satisfied with their decision to move.

That said all found the process to varying degrees, demanding and stressful. Some said moving would not have been possible without the support of sons

and daughters whilst others reported that the help and support of the Age Concern Housing Option Manager was invaluable *'couldn't have done it without her'*. The main causes of stress identified were, agreeing and negotiating moving in dates with the housing association, managing finances, packing and removal process, identifying utility providers and service connections.

Not everyone offered new housing accepted the offer. Those most in need may not have had the physical, emotional and personal resources to cope with a move and were therefore more likely to tolerate their current housing situation.

6.4.14 Impact on wider community

Consideration should also be given of the wider community effect that goes beyond the potential benefits of those being rehoused.

There had been some local opposition to the development of both sites Bakewell sites. Charles Walker Close was developed on a green field site, which raised some very minor and short-lived local concern whilst Miracle Court was considered a prime town centre site that was hugely marketable. The small-scale nature of both the new sites has in fact enabled them to be absorbed readily into the local community without undue pressure on local services or community resources.

6.5 Case Studies

Case study Mrs A

Mrs A is a 68-year-old woman whose housing needs changed following the break up of her marriage. Mrs A had a long history of asthma and associated lung disease, which left her vulnerable to pneumonia often resulting in hospital admission during the winter months. Her health was further compromised by breast cancer six years ago. During periods of ill health she was breathless and weak and had to sleep downstairs and relied on her husband to help with the house and shopping chores. With only a small investment following the sale of the family house and facing high private rental costs Mrs A was offered the opportunity to part purchase a two-bedroom bungalow. The new bungalow is small enough for her to manage independently and the second bedroom enables friends to stay and will be suitable for carers in the future. She finds it easy to maintain and being single storey she no longer has to sleep on the settee when her breathing is compromised. She believes that she now has a home for life that will meet her needs even if her health deteriorates further. Mrs A commented, *"You're in a trap when you split up at my age... this bungalow is a dream come true"*

Case Study Mr B

Mr B is an 81-year-old widower who described himself as a *'virtual prisoner'* in his own occupied 1960s bungalow. The bungalow was located on a hilly estate approximately a mile from the centre of Bakewell and local services. Mr B has leukaemia and requires regular admissions to hospital for blood transfusions. He was unable to walk very far and was reliant on private taxis

for essential trips. Following the death of his wife from cancer he became increasingly isolated and depressed and dependent on his daughter to help him bath and shop.

He moved to a two-bedroom bungalow and is delighted at his newfound independence. He believes that his health has improved and medication reduced. He has made new friends locally, is able to walk to the local pub, doctor's surgery and shops. His has also taken up a new hobby – surfing the Internet on his home computer. *“This move has altered my life completely, I am never in, and I am free! “*

Case Study Mrs C

Mrs C is a 76-year-old widow with osteo arthritis who was becoming increasingly housebound in her upper floor sheltered accommodation flat. She would have been content to stay but was refused permission to install a stair lift. On a “good day” she could manage albeit slowly the 19 steps to her flat but found the local cobbled pavement hazardous. She became reliant on taxis and home delivery food shopping. She enjoyed cooking and greatly missed not being able to choose her own produce. Her arthritis also limited her ability to undertake normal activities of daily for such as bathing

Mrs C moved to a two-bedroom bungalow and quickly settled into the new environment. *“I feel I have never lived anywhere else, I feel part of the community because I can get to places now, I wish I could have moved years ago, I know my arthritis will not go away but mentally I feel so much better, everyday things are no longer such a challenge or worry, life is so much less problematic – I love it!”*

Case Study Mrs D

Mrs D is 82 year old moved from a 1950s upper floor flat. As a retired professional she never expected to be living on a low income. She became the victim of poor landlord who had failed to maintain sewage system. Sewage from neighbouring flats leaked into her bathroom. She complained to her landlord who then served her notice of eviction. Her blood pressure was very high by the time she was re-housed. Mrs D is thrilled with new bungalow, which she describes as *“absolutely beautiful my friends can't believe how well I have done. nor can I “*. Her mental health has improved and her blood pressure is now normal.

Case study Mrs E

Mrs E had, as newly married women, put her name down on the council housing list 30 years ago. She and her husband lived in the family house following her parent's death and her recent house move was the first since 1927. Following her husbands death she became increasingly anxious and isolated in the large family house. A deteriorated in her arthritis coupled with concerns about her future mobility following planned joint surgery, she accepted the offer of a house move. Whilst she loved the sunny family house she has no regrets about the move. She is no longer socially isolated and feels more part of the community. The second bedroom enables her son to stay when he visits from abroad.

Case study Mr and Mrs F

Mr and Mrs F are an 80 and 79 years old married couple. Mr F has a long term limiting respiratory condition and has been registered disabled for 17 years, his wife is his main carer. In their former house Mr F was unable to climb the stairs so the couple moved their bedroom downstairs but with no downstairs bath or shower he had relied on strip washes for the last 3 years. Through the offer of a shared ownership the couple were able to release some capital from the sale of their previous house. As a consequence Mr and Mrs F can now enjoy a good standard of living in accommodation that is fully accessible. *It's given my wife and I a new lease of life - we've come into utopia!*

Case study Mr and Mrs H

Mr and Mrs G are 72 and 71 years old. Mr G has multiple sclerosis. Mr G can stand but not walk. The couple were social housing tenants living in a first floor flat, accessed by steps. Mrs G had to drag and hoist her husband up the stairs in an undignified way. The access problems also prevented Mr G from getting to his motorised scooter and the lack of disabled car parking also prohibited him from accessing his adapted car. The couple moved into a rented bungalow. Mr H no longer feels socially isolated as he is able to go out independently to the village on his 'scooter', and can even use the disabled access local bus. The couple's quality of life has improved dramatically and they have found a new sense of community in the new neighbours. The Housing Officer reports *'they never stop thanking for allocating them the bungalow it has made a huge difference to their lives'*.

Case study Mr and Mrs J

Mr J has advanced Parkinson's disease and his physical problems are compounded by his inability to communicate verbally. Mrs J is his main carer. Their lives become increasingly restricted and isolated as his care needs increased and his wife experienced significant mental health problems. In their former accommodation neighbours were out all day and she felt very isolated and alone. The couple are now settled into their new bungalow with a small garden. They have wheelchair access to the garden area and have erected a small greenhouse for Mr J to potter in. Although Mr J's condition is progressive his quality of life and independence has improved. As a consequence Mrs J's mental well-being has also improved. She has also benefited from neighbourly contact and a sense of local community

7 Summary

Table shows a summary of the intermediate factors arising from the new development and their potential impact on health.

7.1 Summary table to show intermediate factors and their health impact

Intermediate factors	Positive Health Impact	Negative Impact
Structure and design of housing	Accommodation newly purpose built conforming to all Building Regulations standards and designed to meet needs of older adults with health problems. Consideration given to <i>Lifetime Homes</i> standards but not fully adhered too. Small private gardens at CWC reported to improve quality of life.	No special attention to sustainability especially renewable energy sources. Sustainable housing could improve health through increase in disposable income and reduction in health inequalities Stairs a barrier to second floor flats at Miracle Court
Internal design	Age appropriate design with Wheelchair access throughout at CWC. Some built in flexibility with good access and internal mobility especially at CWC.	No service user or health expert involvement at the design stage thus some access and function issues not identified early enough e.g. kitchen layout and ability to manage sash windows.
Indoor environment	No identified indoor pollutants. Accommodation on radon free sites. External air quality good no road or other environmental pollutants	None identified
Internal conditions	No damp. Easy to heat homes conforming to modern insulation standards Likely to reduce risk of cold related death in elderly residents	Fuel poverty unlikely but cannot confirm until residents have had winter fuel bills
Crowding	No Overcrowding	None identified
Current health status occupants	Residents are elderly with existing medical problems, therefore more susceptible to the ill effects of poor housing. Age appropriate design and high building standard of accommodation mitigate against this. No residents housed inappropriately. No independent measure of pre move health status obtained however qualitative data suggests health status improved	one identified
Housing related injuries	Purpose built for older adults, non-slip floors, smoke detectors, and easy access. Likely to prevent or reduce housing related injuries and falls	Stairs at Miracle Court increase risk of falls or slips. Oven/hob layout potential safety risk at CWC

Housing as psychological space	Generally in desirable locations of good appearance Not overtly identifiable as 'special' therefore non-stigmatising. Overall a positive psychological experience	None identified
Housing tenure	Home owners likely to be in better health than rental even within occupational social class groups Option of shared ownership enables release of equity and increase in disposable income for previous owner occupiers with positive health enhancing wealth impact	Some rented accommodation but high quality of accommodation and security of tenure will mitigate against ill effects
Wealth impact	For shared owners there is a positive wealth impact through equity release scheme plus reduced council tax banding. Uncertainly about heating costs but likely to be less than previously paid. Reduced costs on private taxis to access local services Those on low incomes claiming housing benefit	Some residents now paying a higher council tax band. Service charge at CWC. Additional costs of moving house e.g. phone, carpets
Neighbourhood effects	Good effect. Low areas of deprivation No graffiti or rubbish. Easy access to local services including pub, shops, church, GP and transport links	None identified
Housing and neighbourhood attachment	Strong attachments. Local connections policy promotes this	None identified
Housing discrimination	No BME groups on older peoples housing list at time of allocation. BME audits conducted regularly by LAs,	None identified
Willingness to move house	None of residents interviewed regretted move. Praise for support from Age Concern Housing Options Advisor and Housing Association Housing Assistant	Those most in need may not have physical emotional and personal resources to cope with a move and may therefore be more tolerant of current housing situation
Impact on wider community	The small number of units have been easily absorbed into communities without swamping local services	Small amount of local opposition to both developments. CWC on grounds of loss of green space and MC on grounds that land could be more profitably used

8. Discussion

The aim of this HIA was to assess the health impact of two new age appropriate housing developments for category A (medical priority) Older Persons housing waiting list residents

Whilst there is considerable evidence linking poor housing and poor health the extent to which this is causal is less clear. Much of the existing evidence addresses the structural and design elements of housing and concerns attempts to improve existing housing to meet better homes standards.

The new build nature of these two developments already addresses the potentials ill effects of sub- standard accommodation. Thus reducing the risks associated with damp, cold etc.

Older people spend more time in their homes compared with working adults (ODPM 2003) so have more opportunity to experience the ill effects of poor housing. Older people are not a homogenous group, and their housing needs change as their health and social needs alter. Housing should have in built flexibility with good access and internal mobility to enable homes to be life long

The purpose built design of the new developments addresses this in both sites but perhaps most successfully in Charles Walker Close where there are no stairs or steps. The purpose built design also mitigates against housing related accidents that commonly occur in older adults.

It was not possible to undertake a pre move / post move health survey of the residents to detect health improvement as residents had already moved into the new accommodation before the HIA had commenced. Such an approach would however have had limited use as it would have been difficult to impose an experimental design that controlled for all possible confounding factors.

The findings of the health survey combined with structured interviews of residents indicate that although a large number of the residents had limiting long term health conditions their ability to manage their illness had improved as had their quality of life and general well being. The factors that most contributed to this outcome were:

- Increased ability to self-care within the home and carrying out normal activities of daily living.
- Improved access to outside services such as shops resulting in increased independence and less reliance on others.
- Psycho/social benefit of second bedroom
- A combination of neighbourhood attachment and effects. Residents were extremely proud of their new homes, felt lucky to have such homes and valued the new communities within which they lived.

There remains some uncertainty about the overall wealth effect of the developments and it is recommended that this be followed up with interviewees at a later stage.

As social housing stocks diminish many sick people are forced to seek accommodation in the private rented sector, with varying outcomes. The two new housing partnership developments described in this report indicate the benefits of small local social housing projects that have given careful consideration of individual needs

The residents of the new developments were identified from the Older Persons Housing List and were a medical priority. The current housing selection system has been based on a system of medical assessment criteria that has not altered to accommodate scarcer social housing resources. The system of allocation on medical grounds therefore needs reviewing to ensure those with greatest need and have greatest potential for health gain are appropriately identified. The introduction of the new Choice Based Letting Scheme may provide the vehicle to do this. Housing officers freed from waiting list management task should be able to invest greater time in identify vulnerable groups and supporting appropriate housing choices.

9. Limitations of the health impact assessment

This assessment has not addressed the economic implications for the wider health and social care communities of the two new housing developments. It does however identify areas of positive health impact that may produce health savings. The key areas are the prevention of accidents in the home especially falls and the prevention of winter death through fuel poverty. In both these domains research evidence has been cited that shows a potential net saving to the local health community.

The assessment may have benefited from a better response rate from the health survey given the overall small number of residents in the cohort. The reasons for not participating are mixed. One tenant was in hospital and too ill. Several others were absorbed in caring responsibilities. However the steering group felt that the majority of respondents did not wish to have any outside intrusion. There was also some anecdotal reports that some residents felt insecure about their tenancy, one commented to the interviewer *'I hope you haven't come to take this away!* If we were to repeat this exercise we would review the letter that accompanied the questionnaire accordingly.

If the Council plans further Health impact assessments it may be helpful to advise prospective residents that this is planned.

The number of face-to-face structured interviews was adequate to identify key issues however they were all self selected and this may have introduced some bias. To counter this we have also included as case studies some residents who did not volunteer to be interviewed due to the ongoing nature of their health problems.

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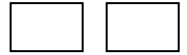
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CONFIDENTIAL



Enclosed are some questions asking you what you think and feel about your own health.

Please give an answer to every question.

Your name and address do not appear on this booklet and the information you give will not be used in any way that could identify you.

HEALTH STATUS QUESTIONNAIRE (SF-36)

The following questions ask you about your health now, how you feel and how well you are able to do your usual activities.

If you are unsure how to answer a questions, please give the best answer you can.

1. In general, would you say your health is:

(Circle one number)

- Excellent 1
- Very good 2
- Good 3
- Fair 4
- Poor 5

2. Compared to one year ago, how would you rate your health in general now?

(Circle one number)

- Much better than one year ago 1
- Somewhat better than one year ago 2
- About the same 3
- Somewhat worse now than one year ago 4
- Much worse now than one year ago 5

For office use

HEALTH AND DAILY ACTIVITIES

3. The following questions are about activities that you might do during a typical day. Does your health limit you in these activities? If so, how much?

				(circle one number on each line)	For office use
		Yes, limited a lot	Yes, limited a little	No, not limited at all	
a.	Feeding yourself	1	2	3	<input type="checkbox"/>
b.	Getting up from a chair	1	2	3	<input type="checkbox"/>
c.	Bathing or dressing yourself	1	2	3	<input type="checkbox"/>
d.	Walking in your home	1	2	3	<input type="checkbox"/>
e.	Walking 100 yards	1	2	3	<input type="checkbox"/>
f.	Walking half a mile	1	2	3	<input type="checkbox"/>
g.	Walking more than a mile	1	2	3	<input type="checkbox"/>
h.	Bending, kneeling or stooping	1	2	3	<input type="checkbox"/>
i.	Climbing one flight of stairs	1	2	3	<input type="checkbox"/>
j.	Climbing several flights of stairs	1	2	3	<input type="checkbox"/>
k.	Lifting or carrying groceries	1	2	3	<input type="checkbox"/>
l.	Moderate activities , such as moving a table, pushing a vacuum cleaner, <u>bowling or playing golf</u>	1	2	3	<input type="checkbox"/>
m.	Vigorous activities , such as running, lifting heavy objects, participating in <u>strenuous sports</u>	1	2	3	<input type="checkbox"/>

4. **During the past 4 weeks, have you had any of the following? problems with your regular daily activities as a result of your physical health?**

(circle one number on each line) For office use

	YES	NO	
a. Have you cut down on the amount of time you spent on your activities?	1	2	<input type="checkbox"/>
b. Have you accomplished less than you would like?	1	2	<input type="checkbox"/>
c. Have you been limited in the kind of activities you could do?	1	2	<input type="checkbox"/>
d. Have you had difficulty in performing your activities (e.g. it took extra effort)?	1	2	<input type="checkbox"/>

5. **During the past 4 weeks, have you had any of the following problems with your regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

(circle one number on each line)

	YES	NO	
a. Cut down on the amount of time you spent on work or other activities	1	2	<input type="checkbox"/>
b. Accomplished less than you would like	1	2	<input type="checkbox"/>
c. Didn't do work or other activities as carefully as usual	1	2	<input type="checkbox"/>

6. During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

(circle one number)

- Not at all 1
- Slightly 2
- Moderately 3
- Quite a bit 4
- Extremely 5

For office
use

7. How much bodily pain have you had during the past 4 weeks?

(circle one number)

- None 1
- Very mild 2
- Mild 3
- Moderate 4
- Severe 5
- Very severe 6

8. During the past 4 weeks, how much did pain interfere with your normal activities (including activities both outside the home and housework)?

(circle one number)

- Not at all 1
- Slightly 2
- Moderately 3
- Quite a bit 4
- Extremely 5

YOUR FEELINGS

9. These questions are about how you feel and how things have been with you during the past 4 weeks. (For each question, please indicate the one answer that comes closest to the way you have been feeling)

How much of the time during the past 4 weeks:	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time	For office use
a. Did you feel full of life	1	2	3	4	5	6	<input type="checkbox"/>
b. Have you been a very nervous person	1	2	3	4	5	6	<input type="checkbox"/>
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6	<input type="checkbox"/>
d. Have you felt calm and peaceful?	1	2	3	4	5	6	<input type="checkbox"/>
e. Did you have a lot of energy?	1	2	3	4	5	6	<input type="checkbox"/>
f. Have you felt downhearted and low?	1	2	3	4	5	6	<input type="checkbox"/>
g. Did you feel worn-out?	1	2	3	4	5	6	<input type="checkbox"/>
h. Have you been a happy person?	1	2	3	4	5	6	<input type="checkbox"/>
i. Did you feel tired?	1	2	3	4	5	6	<input type="checkbox"/>
j. Has your health limited your social activities (like visiting friends or close relatives)?	1	2	3	4	5	6	<input type="checkbox"/>

HEALTH IN GENERAL

10. Please choose the answer that best describes how true or false each of the following statements is for you

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false	For office use
a. I seem to get ill more easily than other people of my age	1	2	3	4	5	<input type="checkbox"/>
b. I am as healthy as anybody I know of my age	1	2	3	4	5	<input type="checkbox"/>
c. I expect my health to get worse	1	2	3	4	5	<input type="checkbox"/>
d. My health is excellent	1	2	3	4	5	<input type="checkbox"/>

11. Over the last twelve months would you say your health has on the whole been:

- Good?
- Fairly good?
- Not Good?

12. Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?

- Yes
- No

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MB/DV

22nd September 2006

Dear Sir or Madam

Review of age appropriate housing in Bakewell and Hlland Ward

Derbyshire Dales District Council in conjunction with High Peak & Dales PCT wishes to assess the health impact of these two new housing developments targeted at older aged Category A (medical priority) housing waiting list clients. They also hope to use the information to inform the future planning and design of age appropriate accommodation. To understand the impact of moving into the new accommodation we are sending all new tenants a health questionnaire, where possible just before they move in, otherwise shortly after the move. We want to repeat the process six months after they move to see if their health has changed. I would therefore be grateful if you could complete the attached health status questionnaire by 9th October and return it in the envelope provided. This questionnaire has been sent to you on my behalf by staff at Derbyshire Dales District Council.

- Your views are important to us.
- You can withdraw from the review at any stage without affecting the service you receive.
- We will not give your name to anyone else in the health or housing services.
- What you say will not affect the service that you receive.
- Your name will not appear in any report.

We would also like to interview residents to get a more detailed understanding of the impact of the change of accommodation on them. If you are interested in being interviewed please complete the slip on the next page and return it to me along with your questionnaire. If you would like a copy of the final report please complete the attached slip.

If you have any questions about this project please get in touch with me on 01246-514266. If you need help in completing this questionnaire please contact Rebecca Renshaw on 01629-826040 or Angela Parnell on 01629-761147.

Thank you for your help.

Yours sincerely

Mick Bond
Research Manager

Appendix 3 :Interview schedule for age appropriate housing health impact assessment

ID _____

Age _____

Male Female

Live Alone? Yes No

PRE MOVE QUESTIONS

House

Bungalow

Upper floor flat

Ground floor flat

Caravan

Hostel

Other (specify) _____

Previous housing tenure

Owner

Rented

Tied

Other (specify) _____

Was this in Derbyshire? Yes No

Access to previous property

Lift

Ramp

Flat ground

Steps Yes No

If Yes how many? _____

Heating in previous property

Central heating

Gas

Electric

Solid fuel

Was heating system easy to control? Yes No

Cleaning and maintenance of previous property

Windows inside Self Other person (specify) _____

Windows outside Self Other person (specify) _____

Floors Self Other person (specify) _____

Roof Self Other person (specify) _____

Kitchen Self Other person (specify) _____

Bathroom Self Other person (specify) _____

Heating system Self Other person (specify) _____

Garden Self Other person (specify) _____

Plugs and sockets Self Other person (specify) _____

Changing light bulbs Self Other person (specify) _____

Was your property damp Yes No

If you have answered Yes, which rooms (specify) _____

Washing facilities in previous property

Please tick those that apply

Bath

Shower cubicle

Walk in shower

Over bath shower

Special adaptations to previous property

Please tick those that apply

Hand rails

Stair lift

Raised toilet seat

Other adaptations (specify) _____

Area around previous property

Very hilly

Hilly

Reasonable flat

Any security issues? Please comment

Access to community services from previous property?

Please tick where there was a problem

GP

Food shops

Post office

Social club or groups

Hospital

Family and friends

Bus service

Pub/Restaurant

Church

Parking

General issues

1) What was your main reason for moving from your previous property? (Please comment)

POST MOVE QUESTIONS

Current Housing

Bungalow

Upper floor flat

Ground floor flat

Housing costs

Have your housing costs

Increased since your move

Decreased since your move

Stayed the same

If they have changed please comment

Access to current property

Ramp

Flat ground

Steps Yes No

If Yes how many? _____

Heating in current property

Central heating

Gas

Electric

Is heating system easy to control? Yes No

Cleaning and maintenance of current property

Windows inside Self Other person (specify) _____

Windows outside Self Other person (specify) _____

Floors Self Other person (specify) _____

Roof Self Other person (specify) _____

Kitchen Self Other person (specify) _____

Bathroom Self Other person (specify) _____

Heating system Self Other person (specify) _____

Garden Self Other person (specify) _____

Plugs and sockets Self Other person (specify) _____

Changing light bulbs Self Other person (specify) _____

Is your property damp Yes No

If you have answered Yes, which rooms (specify) _____

Washing facilities in current property

Please tick those that apply

Shower cubicle

Walk in shower

Over bath shower

Special adaptations to current property

Please tick those that apply

Hand rails

Stair lift

Raised toilet seat

Other adaptations (specify) _____

Area around current property

Very hilly

Hilly

Reasonable flat

Any security issues? Please comment

Access to community services from current property

Please tick where there is a problem

GP

Food shops

Post office

Social club or groups

Hospital

Family and friends

Bus service

Pub/Restaurant

Church

Parking

General issues

1) Do you have any comments on your experience of moving from your previous property? (Please comment)

2) Do you have any other comments about your new property? (Please comment)

Appendix 4 Full SF36 Analysis

Group Statistics

	Source of data	N	Mean	Std. Deviation	Std. Error Mean
SF-36 PHYSICAL FUNCTIONING (0-100)	Dales Housing HIA	13	41.827	24.8465	6.8912
	NEDDDC housing scheme	228	43.893	31.8677	2.1105
SF-36 SOCIAL FUNCTIONING (0-100)	Dales Housing HIA	14	50.794	31.3405	8.3761
	NEDDDC housing scheme	233	59.371	31.7348	2.0790
SF-36 ROLE-PHYSICAL (0-100)	Dales Housing HIA	12	50.000	43.9525	12.6880
	NEDDDC housing scheme	223	26.495	38.7122	2.5924
SF-36 ROLE-EMOTIONAL (0-100)	Dales Housing HIA	11	63.636	45.8368	13.8203
	NEDDDC housing scheme	216	45.833	46.6237	3.1723
SF-36 MENTAL HEALTH INDEX (0-100)	Dales Housing HIA	12	59.083	22.6734	6.5452
	NEDDDC housing scheme	226	63.726	19.9271	1.3255
SF-36 ENERGY/VITALITY (0-100)	Dales Housing HIA	12	39.583	21.1551	6.1069
	NEDDDC housing scheme	226	42.544	22.7966	1.5164
SF-36 PAIN INDEX (0-100)	Dales Housing HIA	14	53.175	21.8684	5.8446
	NEDDDC housing scheme	233	46.257	29.7732	1.9505
SF-36 GENERAL HEALTH PERCEPTIONS (0-100)	Dales Housing HIA	12	48.750	26.0528	7.5208
	NEDDDC housing scheme	227	43.369	23.1693	1.5378
SF-36 HEALTH TRANSITION (0-100)	Dales Housing HIA	14	41.0714	21.04743	5.62516
	NEDDDC housing scheme	233	37.5536	18.58758	1.21771

Independent Samples Test

		Levene's Test for equality of variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper	Lower
SF-36 PHYSICAL FUNCTIONING (0-100)	Equal variances assumed	2.266	.134	-.230	239	.819	-2.0661	8.9971	-19.7899	15.6576
	Equal variances not assumed			-.287	14.350	.778	-2.0661	7.2071	-17.4886	13.3563
SF-36 SOCIAL FUNCTIONING (0-100)	Equal variances assumed	.176	.675	-.983	245	.327	-8.5769	8.7268	-25.7661	8.6123
	Equal variances not assumed			-.994	14.648	.336	-8.5769	8.6303	-27.0104	9.8567
SF-36 ROLE-PHYSICAL (0-100)	Equal variances assumed	.699	.404	2.035	233	.043	23.5052	11.5500	.7495	46.2610
	Equal variances not assumed			1.815	11.937	.095	23.5052	12.9501	-4.7273	51.7377
SF-36 ROLE-EMOTIONAL (0-100)	Equal variances assumed	1.185	.278	1.236	225	.218	17.8030	14.4004	-10.5738	46.1799
	Equal variances not assumed			1.256	11.080	.235	17.8030	14.1797	-13.3788	48.9849
SF-36 MENTAL HEALTH INDEX (0-100)	Equal variances assumed	.192	.662	-.781	236	.436	-4.6423	5.9436	-16.3516	7.0669
	Equal variances not assumed			-.695	11.920	.500	-4.6423	6.6781	-19.2036	9.9189
SF-36 ENERGY/VITALITY (0-100)	Equal variances assumed	.250	.618	-.440	236	.660	-2.9609	6.7314	-16.2222	10.3003
	Equal variances not assumed			-.471	12.396	.646	-2.9609	6.2924	-16.6225	10.7006
SF-36 PAIN INDEX (0-100)	Equal variances assumed	2.986	.085	.855	245	.393	6.9180	8.0921	-9.0209	22.8570
	Equal variances not assumed			1.123	16.046	.278	6.9180	6.1614	-6.1406	19.9767
SF-36 GENERAL HEALTH PERCEPTIONS (0-100)	Equal variances assumed	.388	.534	.779	237	.437	5.3811	6.9049	-8.2217	18.9838
	Equal variances not assumed			.701	11.938	.497	5.3811	7.6764	-11.3540	22.1162
SF-36 HEALTH TRANSITION (0-100)	Equal variances assumed	.022	.881	.683	245	.495	3.51778	5.15296	-6.63197	13.66753
	Equal variances not assumed			.611	14.245	.551	3.51778	5.75546	-8.80654	15.84210