



BRIEFING PAPER TWO

Public health and housing: we can get it right

This paper is one of four briefings on personalisation, public health reform, and the emerging primary and secondary health care landscapes by the Housing LIN. These accompany the recent Chartered Institute of Housing paper, 'Localism: delivering integration across housing health and care', supported by the Housing LIN.

The other briefings in this series are:

Briefing No.1 - Housing support and personalisation: practical advice for the current moment

Briefing No.3 - The new NHS commissioning landscape and its impact on housing and care for older people

Briefing No.4 - Opportunities to Improve Health and Wellbeing: Integrating Secondary and Acute Health Care and Housing in the New NHS

Produced for the Housing Learning & Improvement Network by
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About the Author

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1. The purpose of the briefing

In light of proposed health reforms, specifically the introduction of a new public health service for England within a local government setting, this briefing provides housing commissioners and providers with the information they need to develop the local approach to housing so that it contributes to public health outcomes.

Whilst the Housing LIN audience is primarily interested in the health and wellbeing of older people, this paper is written on the basis that choices made at an earlier stage in life impact on quality of life when people are older. For this reason, the content is concerned with public health and adult life, not just older age.

On the basis that “health is everybody’s business” this briefing does make some reference to health reforms to the NHS, for example the introduction of clinical commissioning groups¹, insofar as they relate to public health. Further information on wider health reforms is provided in the accompanying Housing LIN briefings.

In more detail this paper covers:

- An introduction to public health, key concepts and the main players
- A summary of the main themes of public health reform and what will be different as a result
- Information about public health and housing policy proposals relating to mental health and older people
- A summary of the evidence base for housing and health; health reform is based upon this, amongst other information about the wider determinants of health

Throughout this briefing reference is made to evidence, guidance and information to enable local areas to connect housing and public health more effectively.

Recommendations are also made for local action by housing commissioners and providers. ‘Housing’ includes all professionals working in sector eg, planning policy, environmental health practitioners and not just those who work with individuals who have specific health needs.

¹ The government has accepted a recommendation from the NHS Future Forum, following the ‘listening exercise’, to widen involvement in clinical commissioning from just GPs, to include doctors and nurses, other specialists, users and carers

2. An introduction to public health

It is important that the housing sector has a common understanding of what public health is, where it has come from and what practitioners are interested in. This section presents the public health definition and domains of public health practice, the key concepts that underpin public health activity, and it provides an introduction to the key players in the public health sector (an important source of information and evidence).

2.1 Public health definition and history

The common definition of public health is:

"The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society"

Public health is concerned with the health improvement and protection of groups of people (populations), not individuals – the Faculty of Public Health refer to this as ‘the bigger picture’.

Public health originated in the mid-19th century as social reformers sought to tackle the cause of infectious diseases such as cholera and tuberculosis; poor housing, poor sanitation and overcrowding. Disease was argued to be the main reason for poverty.

Much of what we do in the housing sector was born out of the public health movement. Town planning came from a desire to replace slums with well-designed cities and suburbs, and the Public Health Act 1848 introduced the forerunners of today’s environmental health practitioners. Public health was the responsibility of local authorities until 1974, when most of the public health function was transferred to the NHS (environmental health remained with the local authority)ⁱ. Proposals for reform will see the return of most of this function to the local authority, a welcome return for public health and local government.

2.2 The framework for public health practice

We all have a role to play in public health – ‘health is everybody’s business’; the Marmot Reviewⁱⁱ *Fair Society, Healthy Lives* (this underpins current health reforms) says that housing practitioners are part of the public health workforce.

As public health pulls together people from a wide range of disciplines, three domains in public health practice were developed in 2005 to aid a common understanding of the public health systemⁱⁱⁱ:

- *Health improvement* is concerned with addressing inequalities, the wider determinants of health, for example housing and employment, and lifestyles
- *Improving services* is concerned with effectiveness and efficiency, audit and evaluation, service planning, equity and governance
- *Health protection* is concerned with infectious diseases, chemicals and poisons, radiation, emergency response and environmental health hazards

These three domains are used as the basis for training and qualifications in the public health profession.

2.3 Key concepts in health

It will be useful for those working in housing to understand some of the terminology used in public health so we can communicate what we do in these terms.

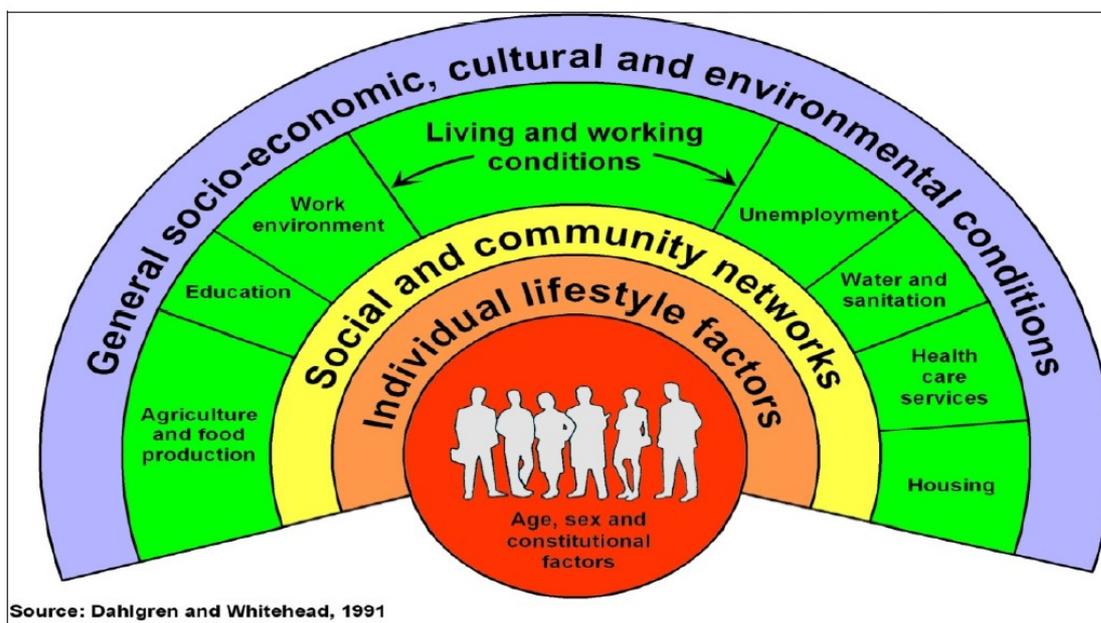
Health inequalities are avoidable inequalities in health between groups of people arising from inequalities within and between societies. Social and economic conditions and their

effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs^{iv}.

There is a *social gradient in health*. Those living in the most deprived neighbourhoods die earlier and spend more time in ill health than those living in the least deprived neighbourhoods. Such health inequalities are determined by social and environmental inequalities; those living in the most deprived neighbourhood are more exposed to environmental conditions, which negatively affect health.

Life expectancy and disability-free life expectancy are affected by a wide range of factors, including the home and neighbourhood environment. The Marmot review concluded that these factors – *social and economic determinants of health* – must be addressed if we are to overcome health inequalities. Dahlgren and Whitehead's model is commonly used to show the wider determinants of health.

Figure 1 The determinants of health



Public health seeks to apply '*proportionate universalism*' in its interventions, an approach advocated by the Marmot Review and earlier research. Interventions should be proportional to the social gradient. Focussing on population-wide interventions alone is likely to result in widening inequalities as more advantaged populations take up opportunities, whilst focussing on very disadvantaged groups is likely to miss the bulk of the problem – these groups are often too small to make a difference.

2.4 The main players

The Faculty of Public Health (www.fph.org.uk) was established in 1972 and sets UK standards for public health training and has an advocacy role. It aims to:

- promote, for public benefit, advances in public health
- maintain the highest possible standards of public health practice and competence
- give authoritative guidance and advocate on public health issues

The UK Public Health Association or UKPHA (www.ukpha.org.uk) was formed by the coming together of three organisations in 1999 to unite the public health movement in the UK. A multidisciplinary membership organisation it seeks to promote the development of healthy

public policy at all levels of government and across all sectors and acts as an information platform and aim to support those working in public health both professionally and in a voluntary capacity.

The Royal Society for Public Health or RSPH (www.rsph.org.uk) was formed in October 2008 with the merger of the Royal Society of Health (RSH) and the Royal Institute of Public Health (RIPH). A membership organisation with over 6,000 members (open to anyone working in the area of public health) it provides qualifications and conferences and plays an advocacy role.

The Association of Directors of Public Health (www.adph.org.uk) is the representative body for Directors of Public Health (DsPH). It aims to improve and protect the health of the population through collating and presenting the views of DsPH; influencing legislation and policy; facilitating a support network for DsPH; identifying their development needs; and supporting the development of comprehensive, equitable public health policies. There has been an Association for Directors of Public Health or their equivalent for more than 150 years (the current form has been in place since 1989).

The Chartered Institute of Environmental Health (www.cieh.org) was established in 1883 (reflecting its origins in public health) and sets standards, accredits and provides courses and qualifications and provides information, evidence and policy advice. It aims to enhance health through improved physical environment, social environment, lifestyles within a framework of sustainable development.

The NHS Confederation (www.nhsconfed.org) also has a perspective on public health that is interesting to follow given that clinicians will have a greater role in public health when reforms are in place.

3. Public health reform

3.1 What public health reform is aiming to achieve

The government wants to *“improve and protect the nation’s health and to improve the health of the poorest, fastest”*. The role of public health is most succinctly described by the proposed public health outcomes framework^v:

- Domain 1 – Health protection and resilience: protecting people from major health emergencies and serious harm to health
- Domain 2 – Tackling the wider determinants of ill health: addressing factors that affect health and wellbeing
- Domain 3 – Health improvement: positively promoting the adoption of ‘healthy’ lifestyles
- Domain 4 – Prevention of ill health: reducing the number of people living with preventable ill health
- Domain 5 – Healthy life expectancy and preventable mortality: preventing people from dying prematurely.

The public health framework links to those for the NHS and social care, enabling commissioners and providers to come together where input from a number of areas is needed to achieve success.

The public health white paper, *Healthy Lives, Healthy People*^{vi}, presents an approach to public health that recognises different stages in people’s lives (as recommended by the Marmot review):

1. Starting well – the focus is on pregnant women, infants and parenting, particularly maternal mental health, smoking and obesity, and relationships
2. Developing well – the focus is on children and young people, particularly accidents, risk taking related to drugs, alcohol and STIs and mental health
3. Living well – the focus is on adult lifestyles and factors such as smoking, obesity, mental health, alcohol and drug use
4. Working well – the focus is on reducing working-age ill-health, particularly mental ill-health
5. Ageing well – the focus is on the ageing population, particularly mental and physical wellbeing to prevent dementia, depression, accidents and deaths from the cold

These stages are reflected in supporting policy eg, the child poverty strategy emphasises the public health role in ‘starting well’, whilst the mental health strategy (discussed later) refers to all stages.

Recommendations

1. The housing sector needs to consider its role in relation to each of the five public health outcome domains, and related outcomes in the NHS and social care frameworks, if it expects to engage health partners in a dialogue about working together. This is an exercise that would be usefully undertaken at a local level, perhaps through a strategic housing partnership, with elected members and health colleagues, with reference to existing publications on the subject such as the National Housing Federation’s *‘Invest in Housing: Invest in Health’*^{vii}. The approach being taken in south Essex through their *Commission of Enquiry into Co-operation between housing, health and adult social care*^{viii} might also be useful to consider.
2. Considering housing’s role in relation to each of the life stages will be helpful to working with health partners and is likely to reveal areas for improvement, for example, can we offer more or something better at the ‘living’ and ‘working well’ stages in life to prevent ill-health at a later stage? Again, a useful approach would be to explore this as a partnership at a local level, making sure that representatives from across the housing sector ie, strategy and policy, spatial planning, environmental health, and service delivery, are involved. (The Housing LIN welcomes any examples of such partnership working for future case studies)

3.2 The main themes of public health reform

The proposed reforms to achieve these outcomes are described in the public health white paper, *Healthy Lives, Healthy People*. This is intended to build on principles established in the *NHS White Paper Equity and Excellence: Liberating the NHS*^{ix} and in the *Vision for Adult Social Care: Capable Communities and Active Citizens*^x. The *Health and Social Care Bill*^{xi} includes the legislative changes required to enable reform. Amendments have been made to reform proposals, primarily in relation to primary care, following the government’s ‘listening exercise’. These are found in *Government response to the NHS Future Forum report*^{xii}. Together these documents reflect that the government expects to see the following changes.

A more efficient and effective health service

Although there is a real term increase in spending, the health sector is still expected to achieve billions of pounds in savings to reinvest in other activities (this is the focus on the government’s QIPP^{xiii} programme: Quality, Innovation, Productivity and Prevention – pronounced ‘quip’). This reflects the government’s number one priority – to reduce the deficit in a ‘fair and responsible way’. In practice, this is resulting in efficiency savings and some

redundancies from the Department of Health, PCTs and Strategic Health Authorities, in advance of new commissioning arrangements being finalised, such as GP consortia. There is a danger that experience and expertise will be lost from the sector. Existing PCT public health teams are also expected to change, with reductions likely.

The government's model is for action to be based on robust evidence of needs, enabling targeted interventions. The Health and Social Care Bill strengthens the existing 2007 statutory requirement to produce a Joint Strategic Needs Assessment (JSNA): an assessment intended to provide a comprehensive picture of the health and wellbeing needs of the population. The revised duty will require commissioners to apply the JSNA, informing a new statutory Joint Health and Wellbeing Strategy and all local commissioning, including public health. The government, in its response to the NHS Future Forum, has strengthened the requirement for NHS commissioning to pay attention to the JSNA and joint health and wellbeing strategy, with Boards now expected to be involved in the process of developing clinical commissioning plans. This is expected to enable more effective, joint and integrated, commissioning.

Local Government Improvement and Development (LGID²) has provided a best practice guide on JSNAs. This guidance and a new report by the Chartered Institute of Housing^{xiv}, supported by the Housing LIN, advocates for a link between the assessment and housing intelligence – a shared understanding is more likely to inform effective joint approaches to reducing inequalities and improving outcomes. It recommends that the JSNA should help inform local housing commissioning.

It is worth noting that the use of evidence of need is not new in public health, where need is assessed alongside the cost and benefits of interventions. Health economics is a core part of public health qualifications, with opportunities for practitioners to specialise in this field. For the housing sector this presents a challenge to working with public health commissioners – it's not enough for us to know there is a problem: we also need to know that it will be worth taking action to address it ie, what savings and benefits will be delivered?

Recommendations

3. Commissioning in the housing sector is under-developed when compared to health and social care sectors, with skills and expertise developing only under the Supporting People programme. With reduced capacity and capability in both local government and health it would make sense for local areas to explore opportunities to bring commissioning resources together, considering approaches to integration already in development eg, LB Hammersmith and Fulham^{xv}.
4. Housing commissioners, with provider partners, should work with health colleagues to develop sources of intelligence that are capable of informing all forms of local commissioning, beginning with the Joint Strategic Needs Assessment and local assessments of housing need and demand.
5. Housing commissioners and providers should work together to establish a local evidence base of 'what works' and the potential savings that can be achieved through housing interventions, for use in discussion with health colleagues. There are national sources of evidence (see later section) and tools that can be applied locally, for example the CIEH's Housing Health and Safety Rating System cost calculator^{xvi} and Foundation's Future HIA connecting with health and care^{xvii} report. It is likely however that the housing sector will need to revisit its approach to performance management and evaluation in order to develop the evidence further. The LGID's Measuring impact in health improvement An accessible guide for health practitioners^{xviii} will also be useful to those working in housing.

² Local Government Improvement and Development www.idea.gov.uk

Individuals and communities should be supported to become confident and capable of getting involved in shaping services in their local area (and possibly delivering services too), to take informed decisions about their own lives and to be able to hold other decision makers to account. The government's response to the NHS Future Forum report strengthened the role of the public and users, requiring the new Health and Wellbeing Boards to involve them in developing their health and wellbeing strategy and introducing an explicit requirement that local HealthWatch membership is representative of different users, including carers.

The government's model is to take a less intrusive approach to people's health, applying behavioural intelligence to understand how to change people's behaviour with less intervention from the state. This approach is based on the Nuffield Council of Bioethics' Ladder of Interventions (www.nuffieldbioethics.org). Action will range from 'do nothing' in circumstances where behaviour trends are minor and fizzle out to 'eliminating choice' in circumstances to unacceptable hazard or risk, for example making seatbelts compulsory. The provision of information and advice is the second stage on the ladder; health reforms assume that more emphasis will be placed on this.

Eliminate choice
Restrict choice
Guide choice by disincentives
Guide choice by incentives
Guide choice by changing the default policy
Enable choice
Provide information

Nuffield Council of Bioethics' Ladder of Interventions

Information and advice provision is expected to play a greater role. An NHS strategy for information and advice will be published in Autumn 2011. In the meantime the government has recently confirmed that it will continue to fund FirstStop^{xix} (an independent, free service offering advice and information for older people, their families and carers). An interim report of an evaluation of this scheme is available^{xx}, with a final report expected in June 2011: this may provide useful recommendations for local commissioners and providers.

Accountability arrangements for public health decisions are not yet finalised. With public health responsibility returning (in the main) to local government the intention is that individuals will be able to hold their democratically elected members to account.

Recommendations

6. Localism, Big Society, personalisation are also themes in housing reform. There will be merit in considering how the health and housing sectors can come together locally to support individuals and communities to take control and make informed choices, particularly as the housing sector has a good track record in engagement and empowerment. A 2010 report produced by Leeds Metropolitan University, *Engaging the public in delivering health improvement*^{xxi}, provides some useful suggestions for action to enable the public to take on new roles in public health, whilst the South Essex Commission of Enquiry mentioned under recommendation 1 also looked at a public engagement campaign.
7. Jointly commissioning information and advice provision is an area for local discussion with health and social care colleagues. There's a danger that local resources – including the voluntary and community sector – will be uncoordinated, and that the public will be overwhelmed and/or receive conflicting information and advice. It would be useful to refer to HACT's Fit for Living Network *position statement on information*

and advice^{xxii} which advocates for integrated, independent and trustworthy services, and describes the ideal situation and the challenges to overcome. Reference to the First Stop evaluation previously mentioned, and an evaluation of Care and Repair's earlier housing options initiative^{xxiii} would also be useful.

8. It is also worth considering the application of the 'Ladder of Interventions' in housing terms, particularly as reduced public spending, housing and welfare reform require changes in behaviour if they are to be successful: people will need to make different choices in relation to their housing circumstances and we should consider which interventions will be the most effective in enabling this. For example, an older homeowner may need to consider the use of their own assets eg, equity in their home, to fund repairs or adaptations, whilst some households eg, those under-occupying a home in receipt of housing benefit, will need to consider downsizing if income is insufficient to meet their current housing costs. How people will respond to these changes is something that concerns everyone in the housing sector, and there are clear health implications too, for example a house move may cause stress and anxiety for a vulnerable household, disconnecting them from social networks and access to services and amenities. The recent report of qualitative findings^{xxiv} commissioned as part of the Dilnot Commission on Funding of Care and Support^{xxv} considers attitudes towards planning and preparing for the future and provides useful insight for housing and health sectors.

A sustainable and resilient economy

To enable greater choice a diverse market of providers is needed. To achieve savings a more competitive market is required. Health and social care reforms seek to achieve a different market place. The public sector will not be the 'default' provider of services in the future, supporting the government's ambition to rebalance the economy across sectors.

In public health, the introduction of a new ring-fenced public health budget for local authorities is intended to encourage innovation in commissioning: a proportion of the budget will be payable as a reward for progress on specific public health outcomes. The health premium, driven by a formula, has been subject to consultation and it remains an area of concern for local government and the health sector: it's not yet clear how areas with the greatest inequalities to address will fare.

The ring fenced budget is intended to enable authorities to procure services from a wide range of providers and incentivise and reward those organisations for improving health and wellbeing outcomes and tackling inequalities (payment by results).

The government is also keen for the voluntary, community and social enterprise sector organisations to play a part, not just in terms of providing services but also in enabling community capacity and expertise to contribute to health prevention, for example through volunteering, peer support, befriending and social networks. The imminent Open Public Services White Paper (expected July 2011) is expected to elaborate on the market place.

Finally, the Marmot review estimated that the inequality of illness costs the economy between £56bn and £60.5bn a year in lost productivity, lost taxes, increased welfare and benefits payments, and health costs of treating ill-health. Health reforms are expected to contribute to reducing this cost, particularly through enabling local areas to lead on public health matters.

Recommendations

9. Consideration to the provider market is an area for development in local housing commissioning and it would make sense to consider whether commissioning expertise can be shared with health, building on any commissioning expertise developed through housing support commissioning as a result of the Supporting People programme (for district authorities this expertise will be at the county council level). Examples of positive practice in Supporting People included support to voluntary and community sector organisations to enable them to develop, compete and deliver outcomes for a competitive price. HACT's evaluation of whether this approach is sustainable (Sustaining diversity through collaborative tendering^{xxvi}) is a useful reference point and it advocates for improvements in commissioning approaches
10. Local housing commissioners could explore how to make the most of the wider contribution the sector has to offer improvements in both health and economic outcomes, working with health partners and providers. A good example of a joint approach can be found in Thanet, Kent where the local authority is working with the PCT amongst others to address significant socio-economic disadvantage through a range of interventions that include housing regeneration, tackling low skills and worklessness and addressing significant health inequalities. Housing service providers also have much to offer the economy^{xxvii}, from being major employers in local areas and nationally, with considerable purchasing power, to providing services to tenants and customers to enable them to access skills and employment opportunities. Making the link between housing, health and the economy will be important if the housing sector wishes to attract government attention (The case for investing in London's affordable housing^{xxviii})

3.3 What the new commissioning 'architecture' will look like

At the moment, Primary Care Trusts are responsible for commissioning public health services. Reforms bring the abolition of PCTs and the introduction of a new public health service, with commissioning undertaken by three organisations working together (these are based on proposals for consultation³):

- Upper tier and unitary local authorities will commission public health services, through Health and Wellbeing Boards. From April 2013, there will be a new public health duty requiring steps to improve the health of their population to be taken.

The same local authorities will employ a Director for Public Health (DPH) (employment will be joint with Public Health England). The DPH will play an integral role in promoting joint working, and advocating for the public's health, and will provide an annual report on the health of the local population.

The proposed local authority public health commissioning areas include seasonal mortality, accidental injury prevention, public mental health, drug and alcohol misuse, physical activity, health at work, prevention and early presentation, community safety and violence, social exclusion and children's public health from 5 to 19 years (the NHS commissioning board will be responsible for under 5s).

- Public Health England (PHE) will directly fund and commission some services eg, national campaigns on nutrition or infectious disease; directly provide some services for example the functions currently carried out by the Health Protection Agency; and

³ Proposals for which organisation should commission public health activity has recently been consulted on: Healthy lives, healthy people: consultation on the funding and commissioning routes for public health, www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122916

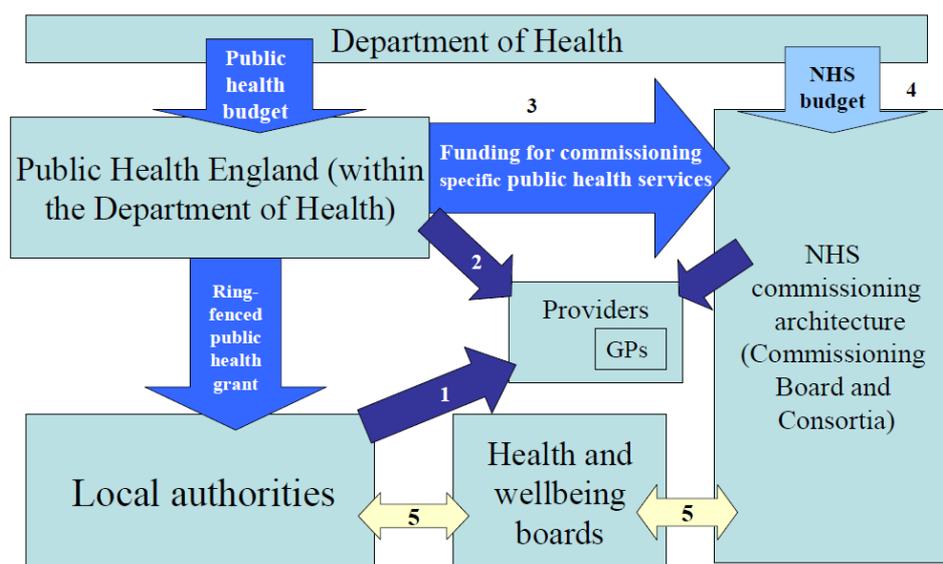
directly provide some activity which will be exercised locally, for example via the local networks of Public Health England Health Protection Units.

PHE will be accountable to the Secretary of State for Health, with a mission to achieve measurable improvements in public health outcomes, provide effective protection from public health threats and to 'inspire, challenge and commission' partners from all sectors.

- The NHS Commissioning Board will be asked by Public Health England to take responsibility for commissioning some public health interventions or services funded from the public health budget (primarily population interventions such as screening programmes); it is assumed that the Board will ask clinical commissioning groups to undertake this role locally, as far as possible.

Public health work integral to primary care provision will continue to be funded from within the overall resources used by the NHS Commissioning Board, for example health checks by GPs, preventative services provided by dentists under their NHS contracts etc. NHS commissioning will be informed by public health expertise from the local DPH and PHE, and through the provision of intelligence and data on population health issues.

Figure 2 The proposed flow of the public health budget⁴ from the Department of Health across the system



Extract from: *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health* (Department of Health, 2010)

NB this will be updated to reflect clinical commissioning groups in place of GP consortia

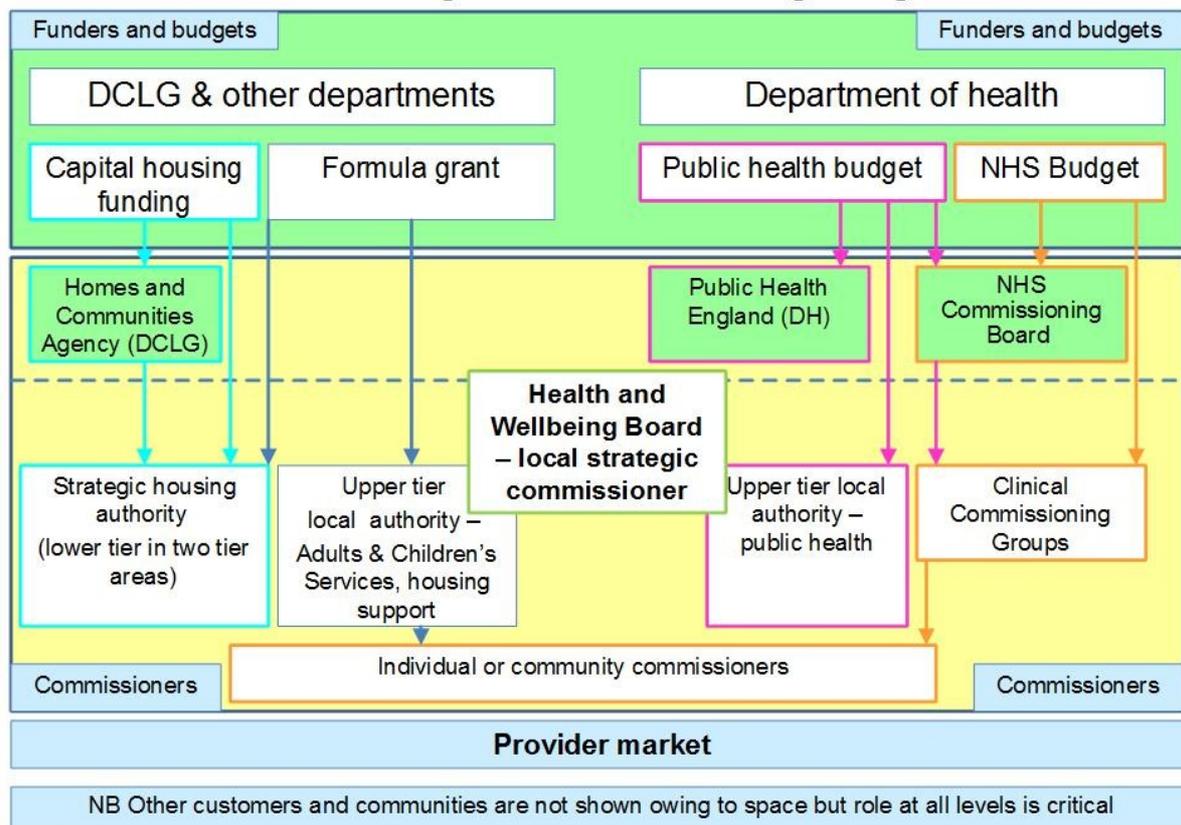
The joint, statutory, health and wellbeing strategy, to be developed by the health and wellbeing boards with regard to the joint strategic needs assessment, will be the framework for commissioning plans for public health, the NHS and social care, and any other services that the board agrees are relevant, for example housing.

⁴ Other sources of funding for local authority public health roles is not included here eg, health protection, housing, leisure; local authorities are free to integrate this funding locally

Recommendations

11. New organisations, roles and responsibilities in health require new or revised relationships with housing. Local housing commissioners and providers should together consider how they can take a co-ordinated approach to engaging the health sector locally, starting with the Health and Wellbeing Board and Director of Public Health. Agreeing a local communication and engagement plan and/or protocol (two-way) with the health sector (including clinical commissioning groups) would be a useful exercise, particularly as reform is still underway and it is useful for the housing sector to understand what this means locally, and to contribute relevant information and support. There's a real risk that, in our desire to make our voice heard, the housing sector will inundate health with information about what we have to offer and requests for meetings. This will not be appreciated at a time when resources are stretched, and when individuals are facing cultural change, for example GPs have just had responsibility for their patients and not for the health of the local area, whilst elected members and clinical commissioners have not had cause to come together in the past.

Health and housing – future commissioning arrangements



3.4 The public health and housing role in outcomes for populations

This section looks at the government's policy proposals for specific populations, where this has been published, focussing on the role of public health and the housing sector contribution to public health outcomes.

Mental health

The Public Health White Paper emphasises the need to improve mental wellbeing and prevent mental ill-health throughout life, not just physical health. Public mental health will be one of the commissioning responsibilities for the local authority. The expectations are that prevention and early intervention will:

- Improve educational attainment, behaviour and self-esteem for children and young people
- Reduce absences from work
- Reduce re-offending behaviour
- Reduce rapid declines in the health and wellbeing of older people (and dependency)

The government's strategy, *No health without mental health*^{xxix} and the supporting document *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*^{xxx} describe six specific outcomes and how these will be achieved. National implementation will be overseen by the Cabinet sub-Committee on Public Health, and mental health will be a key priority for Public Health England (PHE is expected to support local authorities to make public mental health part of public health). The new local health and wellbeing boards and directors of public health are also expected to treat mental health as a priority.

Public health is particularly expected to play a role achieving three of the six objectives (outcomes):

- **More people will have good mental health:** public health is expected to play a considerable role in improving mental wellbeing and preventing mental ill-health, at different stages of life, ranging universal public health and early years education programmes at a neighbourhood and local authority level, focussing particularly on disadvantaged families, to 'ageing well' programmes for people as they get older.
- **More people with mental health problems will recover:** public health will have a role in improving the wider environment (the determinants) to enable recovery, for example the home, employment etc,
- **More people with mental health problems will have good physical health:** public health will tackle the contributory factors to poor physical health for people with a mental health problem, such as smoking.

The strategy also describes a number of housing-sector related contributions to these outcomes:

- Home visiting and improved home safety contribute to prevention for children and their parents
- Young homeless people are at particular risk of developing mental ill-health and targeted activity is needed
- Volunteering and informal and community education programmes improve mental wellbeing, particularly for groups such as homeless people
- Warm homes initiatives support mental wellbeing for older people
- Access to programmes and education in, or close to, the home is important

The government will publish a series of public mental health reviews of the evidence for preventing mental illness and promoting mental health in 2011 which should provide more ideas to inform links between public health and housing activity. In the meantime a report produced by Local Government Improvement and Development and the Department of Health, and researched and written by the new economics foundation, *The Role of Local Government in Promoting Wellbeing*^{xxxv}, provides some examples of the housing sector contribution. The report also highlights that housing is one of ‘the most important levers for wellbeing’, that preventable health problems impact on the cost of providing housing, and that housing is in local government control⁵.

Recommendations

12. In the majority of local areas the primary housing contribution to mental health is likely to be the provision of housing support (recent reports have been produced by the National Housing Federation and University of York^{xxxii}) and homelessness services to people with a mental health problem. However, there is clearly a greater role for the housing sector to play and locally commissioners and providers should be looking at how this can be enabled effectively, thinking about the mental health and wellbeing of the wider population.

Although the National Mental Health Development Unit ended earlier this year, the resources it developed are still intended to support the government’s plans. The website (www.nmhdu.org.uk) provides a useful source of guidance and supporting tools, for example the Mental Wellbeing Checklist^{xxxiii}. The NHS Confederation’s report Public mental health and well-being – the local perspective^{xxxiv} also provides useful evidence and case studies, as does Liverpool’s Public Health Observatory report on Wellness Services: Evidence based review and examples of good practice^{xxxv}

Older people

Public health is expected to play a major leadership role in preventing a decline in health associated with ageing, promoting and enabling active ageing and tackling inequalities. The integration of public health at a local level with social care, transport, leisure, planning and housing is expected to keep people connected (avoiding loneliness and isolation), active, independent and in their own homes, supporting the government’s aim to ‘help elderly people live at home for longer’

Public health is expected to:

- Enable communities and volunteers to help themselves. Gloucestershire Village Agents (www.villageagents.org.uk) is used as an example of volunteers to identify and work with excluded older people, with cost-effective impacts on mental health, falls prevention and home safety^{xxxvi}. DWP will be providing grants to voluntary and community sector groups to carry out this role
- Keep people at home, for example through falls prevention, nutritional advice and using community resources to prevent isolation
- Provide evidence based preventative services such as information and advice or services aimed at minimising disability, deterioration or dependency.

⁵ Strategic housing authorities are lower tier local authorities ie, districts in two tier areas, unitaries and metropolitan boroughs.

A number of housing-sector related contributions have been identified to support 'ageing well':

- Designing neighbourhoods and houses to support people's health, such as Lifetime Homes (this standard remains an important part of the Code for Sustainable Homes).
- Enabling warm homes, for example through the winter fuel allowance and warm homes initiatives (Warm Front until 2012/2013, the Green Deal from 2012 and the new Energy Company Obligation which will focus particularly on the needs of the most vulnerable and on those in hard-to-heat homes)
- Housing support, disabled facilitations and investment in decent homes are expected to enable people to remain living in their own home as they get older

Recommendations

13. Although the increasingly larger older population is not news to the housing sector, there is perhaps still some way to go in terms of planning and provision, particularly as reductions in public sector spending mean there is greater pressure to enable people to remain in their own homes, living independently, using their own resources as far as possible. It's likely that local housing commissioners and providers will already be focusing on these issues but it would be worth reviewing whether this focus is balanced to include households who are not yet in need of housing, social care or health services ie, there remains potential for them to be enabled to meet their own needs. These households will include homeowners (the majority of home owners are older people), who are less likely to be on the radar of public services. Reference has already been made to HACT's Fit for Living Network^{xxxvii} position statement on information and advice provision but statements on the role of housing providers in enabling older low income homeowners to repair and adapt their homes, innovative funding options for older home-owners to repair and adapt their homes are also worth reading.

4. The housing and health connection – the evidence base

Although much has been written about the relationships between housing and health, it is only in recent years that the cost to health arising from housing problems has been researched in any depth⁶, despite recommendations in a 2005 NICE report on the matter^{xxxviii}. Bearing in mind the need to combine evidence of need with the benefits from intervention in making decisions about whether to take action, the housing sector needs to become fluent in the use of evidence such as that presented here.

To understand the links, this section summarises the main relationships and, where available, the associated cost to health and social care of housing issues. It draws on the Marmot Review *Fair Society, Healthy Lives* (the evidence base for the government's health reforms) and other relevant research reviews (these are referred to in the end notes). Another useful starting point for public health evidence is NHS Evidence - National Library for Public Health^{xxxix}: this is due to be updated in 2011. This section also makes reference to additional resources that will enable housing and commissioners to address the challenges.

⁶ This is primarily as a result of the introduction of the Housing Health and Safety Rating System, a new risk assessment tool used to assess potential risks to the health and safety of occupants in residential properties in England and Wales introduced by the Housing Act 2004 (implemented from April 2006), and its use in the English House Condition Survey. The introduction of the Supporting People programme also provided an opportunity to collate evidence of efficiencies through preventative services.

4.1 Housing conditions

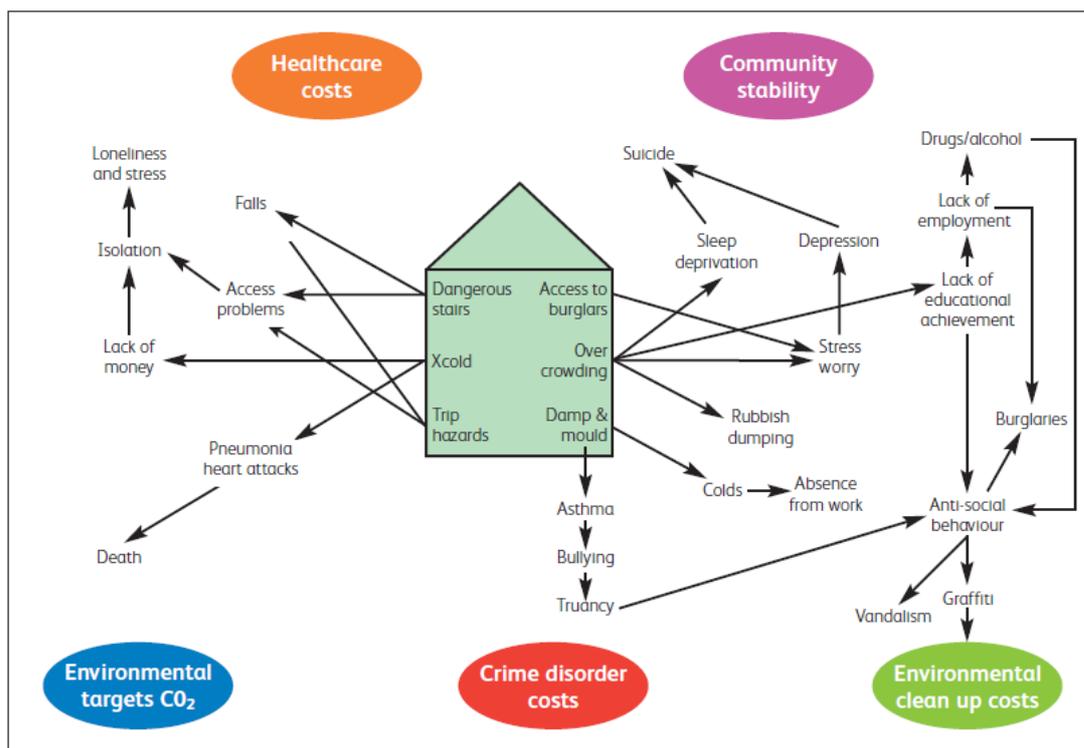
Housing-related hazards that increase the risk of illness include damp, mould, cold, structural defects.

- Cold housing is thought to be the main reason for up to 40,000 additional (excess winter) deaths reported each year between December and March. Cold homes are linked to increased risk of cardio-vascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. Excess winter deaths become significant for those in the 45+ age group, with a marked increase in risk for those over the age of 85. Very young children and those with a disability or long-term illness (households who spend longer in their home) are also disproportionately affected. The BRE estimates that the cost of not improving poor housing⁷ to the average SAP rating to the NHS is £145 million^{xi}
- Being able to afford to keep a warm home, particularly a home that is difficult to heat, is a key factor in the health of older people and workless households. The risk of fuel poverty is higher in rural areas, whilst two-thirds of fuel poor households are owner occupiers. Fuel poverty is expected to increase as energy costs rise. The risk to health of 'energy precariousness'^{xii} (a term reflecting that the main problem is that the home is hard to heat) is considered to be much greater than those recorded by excess winter deaths⁸, as households choose to save energy which increases the risk of accidents, poor air quality and damp.
- Structural defects increase the risk of an accident (such as poor lighting, or lack of stair handrails); 45% of accidents occur in the home and accidents are in the top 10 causes of death for all ages. The majority of injuries to people aged 75 and older occur at home. Unintentional injury is a leading cause of death among children and young people aged 1–14, with one million visits to accident and emergency departments by children every year arising from the injuries in the home^{xiii}. The annual cost to the UK government from falls in those aged 60+ is £1 billion with the average cost of a single hip fracture estimated at £30,000. This is five times the average cost of a major housing adaptation (£6,000) and 100 times the cost of fitting hand and grab rails to prevent falls.
- In 2010, the Building Research Establishment (BRE)^{xiiii} calculated that poor housing cost the NHS at least £600 million per year in England, based on data from the English House Condition Survey, with the total cost to society each year estimated to be greater than £1.5 billion. A 2011 BRE/Shelter Cymru report about housing in Wales concluded that poor housing costs the NHS in Wales £67 million per year, with the total cost to society of poor housing, including factors such as children's poor educational attainment and reduced life chances, estimated at around £168 million a year.
- The private rented sector contains the highest proportion of non-decent homes. Overall, the BRE estimates that it would cost £17.6 billion to achieve 100% decency in the private sector. Lack of investment in homes now may result in increased costs in the future - 80% of current housing will still be in use in 2050

⁷ Poor housing is defined as housing which fails to meet the statutory minimum standard for housing in England, as assessed by the Housing Health and Safety Rating System.

⁸ David Ormandy, professorial fellow at the University of Warwick and Head of the WHO Collaborating Centre for Housing Standards and Health, with Véronique Ezratty of the Medical Studies Department of edf, is working on a paper on 'energy precariousness'

The following diagram from the CIEH summarises the links between the home and health.



Extracted from Good Housing Leads to Good Health, CIEH 2008

Further evidence and resources

- Sheffield Hallam University has undertaken a number of research projects for local authorities and housing providers, ranging from a health impact assessment of Sheffield's housing strategy^{xliv} to the more recent report for Leeds, *A cost-benefit analysis of Leeds Housing Stock, beyond the Housing Health and Safety Rating System*.
- The CIEH's *Good Housing Leads to Good Health: a toolkit for environmental health practitioners*^{xlv} is a useful resource, recently supplemented by a more recent report for the CIEH undertaken by the Building Research Establishment presenting the health costs of cold housing^{xlvi}.
- The Department of Health's Health Inequalities Team produced a 'how to' guide in April 2010, *How to reduce the risk of seasonal excess deaths systematically in vulnerable older people to impact at population level*^{xlvii}. This remains relevant in today's climate of efficiencies and intelligent commissioning.

4.2 Housing in the wider environment

- The environmental elements that have a significant impact on health^{xlviii} are:
 - Outdoor air pollution, particularly for cardio-respiratory mortality and morbidity
 - Open/green space brings direct benefits to physical and mental health and wellbeing
 - Transport in terms of enabling access from home to employment, education, social networks and services (important to reduce isolation and improve opportunities) and in terms of road traffic accidents

- Low levels of social integration, and loneliness, significantly increase mortality. In neighbourhoods that are perceived to be less safe and/or where there are no community facilities there are usually fewer opportunities for integration, for example through volunteering,
- Fear of crime and harassment, and the presence of needles and syringes impact on mental wellbeing^{xlix}. Noise from neighbours also has a negative effect.
- A lack of attention to health and health inequalities in the spatial planning process can lead to unintended and negative consequences. Planning interventions to encourage active travel such as better walking and cycling routes, reducing car speed to improve road safety, and improving public transport (reducing traffic) to reduce air pollution will reduce health inequalities.

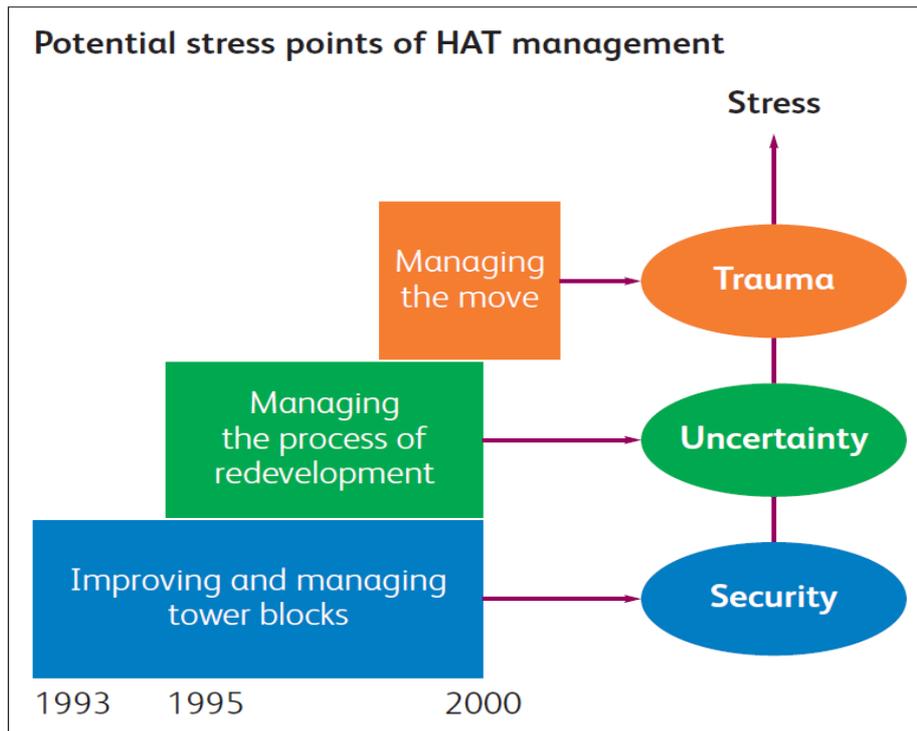
Further evidence and resources

- The Spatial Planning and Health Group (formerly a NICE Programme Development Group) has published *Steps to Healthy Planning: proposals for action*ⁱ. Further evidence is also available from SPAHGⁱⁱ including the research report *Spatial Planning and Health: The cost-effectiveness of integrating health into the planning process*ⁱⁱⁱ produced by NICE PDG and University of the West of England.
- The Hyde Group commissioned the Town and Country Planning Association (TCPA) to develop *Spatial Planning for Health: A guide to embedding the Joint Strategic Needs Assessment in spatial planning*ⁱⁱⁱ to promote the contribution of well-planned developments in achieving long term health and well-being outcomes. It refers to other published guidance and advice and makes recommendations for improvements in aligning planning and health processes.
- The CIEH's 2007 *Commission on Housing Renewal and Public Health*^{iv} report looks specifically at the positive and negative environmental and health impacts of clearance, presenting the arguments for and against clearance and recommending improvements in the strategic approach taken by local authorities. Despite limited opportunity for renewal today recommendations remain relevant to strategic planning for wider geographic areas.

4.3 Security of tenure and tenancy sustainment

- Housing supply affects health, with a considerable number of households living in temporary accommodation and in overcrowded homes
- Lack of security of tenure and short tenancy durations found in the private rented sector may contribute to mental health problems and discourage tenants from taking up home improvement initiatives, reporting problems to a landlord, for fear of being evicted; investing in rented homes.
- Access to housing support and advice and information about income is particularly important to families with young children and for 16 – 25 year-olds
- People who feel that they do not control life circumstances – for example, where they live or the quality of their home - are at risk of mental illness, depression, but they are also at risk of physical illness. The process of changing someone's housing circumstances, for example through the renewal process, can also introduce stress and trauma.

Figure 3



Housing and Health in Liverpool, Sheffield Hallam University

4.4 Households and communities with additional health needs

Many population groups have additional health needs, such as older people, people living with disability or mental illness, ethnic minority groups, homeless households, refugees and asylum seekers, Gypsies and Travellers. Evidence includes:

- Homeless people attend Accident and Emergency five times as frequently as the non-homeless, implying a total of around 53,000 attendances annually by homeless people, costing around £5 million per annum^{iv}.
- Older people are particularly at risk of health problems relating to accidents and cold homes, whilst loneliness and isolation can contribute to dementia and cognitive decline over the age of 65, and also have an impact on likely recovery from illness
- Children living in social housing are at increased risk of multiple disadvantage in adulthood. Children in bad housing are more likely to have mental health problems, such as anxiety and depression, to contract meningitis, have respiratory problems, experience long-term ill health and disability, slow physical growth and delayed cognitive development^{vi}.
- There is a relationship between the population of social housing and health disadvantage; a 'residualisation' effect has resulted in concentrations of disadvantaged groups with higher rates of unemployment, ill health and disability than the average for the rest of the population. This has arisen through a combination of limited housing supply and policy

Further evidence and resources

- The 2007 report *Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence*^{vii} is still regarded as a relevant reference point for evidence of the savings to be gained through adaptations.

5. Conclusions

The length of this briefing and extensive list of references should give an indication of the strength of the connection between housing and health, and how critical it is in the current economic and political climate that the housing sector considers how working with public health can more effectively prevent, and address, health inequalities and improve health outcomes.

Different ways of working are needed. Recommendations and practice examples in this report support the development of more effective, outcomes based and intelligent, local commissioning that builds on existing capacity and expertise in housing, health and social care sectors. Local areas need to take a hard look at their local housing commissioning arrangements and assess whether these will achieve the desired outcomes, in this case health and wellbeing (including economic wellbeing) outcomes. Commissioning isn't new and it isn't rocket science but it will make a difference: health reforms present an opportunity.

About the Housing Learning and Improvement Network

The Housing LIN is the leading professional 'knowledge hub' for over 5,700 housing, health and social care professionals in England. We have strong links with government, trade and professional bodies and leading industry players across the public, private and third sectors. Our aim is to:

- raise the profile about the housing and care needs and aspirations of older people
- act as a champion for the work on housing with care organisations in the sector
- provide latest publications and tools that can support the way you improve, plan, commission, promote and/or deliver your services
- help you to respond to, inform and influence policy and practice developments and what older people say about service quality
- give you access to our national and regional activities, and
- enable you to benefit from the latest ideas, tools and resources in the field to help raise standards.

For further information about the Housing LIN and to access its comprehensive list of on-line resources, visit www.housinglin.org.uk

The Housing LIN welcomes contributions on a range of issues pertinent to Extra Care housing. If there is a subject that you feel should be addressed, please contact us.

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