Retrospective Rapid Health Impact Assessment of the Liverpool Healthy Homes Programme.

Report authored by:-

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Thanks go to all those who participated in the workshop.

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A special thanks goes to Chris Price for his continued support and input into this HIA.

Finally, big thanks go to Phil Hatcher, who commissioned this Health Impact Assessment, for his on-going support and commitment to this report.
Health Impact Assessment is defined as:-

‘A combination of procedures methods and tools by which a project, programme, policy or legislative proposal may be judged for its potential effects on the health of a population and the distribution of these effects within it.’

Health Impact Assessment (HIA) is a globally recognised assessment tool designed to aid the decision makers on supporting their strategies, policies or programmes, to be healthy, in order to improve health and reduce health inequalities.

This HIA on the Liverpool Healthy Homes Programme, was commissioned by Phil Hatcher Business Manager (Healthy Homes), Liverpool City Council.

The purpose of this HIA is to examine likely health impacts - positive or negative - of the Healthy Home Programme, offering an independent, systematic and robust analysis of the likely impacts of the implementation of the Programme on the population of Liverpool as well as supporting the decision makers.

It aims to focus on the wider determinants of health as identified in the social model of care and not the medical health impacts.

This HIA will be undertaken as a retrospective rapid HIA. This report will also describe the scope of the HIA, including methods and process, the data collected and the evidence defined from this data.

The assessment part of the report brings together a range of evidence, including a literature review, policy analysis, a localised demographic profile and the outcome of a focus group. Upon gathering all this evidence, common strategic health determinants were identified and themed, along with the associated health impacts. These were then analysed and a set of recommendations proposed.

The following recommendations are advised:-

**Recommendation 1** - The Programme should be sustained.

**Recommendation 2** - A review is undertaken of the partners.

**Recommendation 3** - A working group be established to develop further ways of engaging with those who may be socially isolated.

**Recommendation 4** – The Intervention Criteria currently used are continually renewed.

**Recommendation 5** – A HIA is undertaken on the Winter Warmth Programme.

**Recommendation 6** – Ensure further work is undertaken to determine the issue surrounding overcrowding in Liverpool.

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1European Centre for Health Policy, Gothenburg 1999
Executive Summary - The Liverpool Healthy Homes Programme Health Impact Assessment

The Liverpool Healthy Homes Programme Health Impact Assessment

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The Liverpool Healthy Homes Programme Health Impact Assessment

1.1 Introduction

This Health Impact Assessment (HIA) was undertaken on the Liverpool Healthy Homes Programme through the Liverpool HIA Capacity Building Project. The HIA was overseen, researched and authored by the HIA Research Fellow, Sophie Grinnell.

1.2 Liverpool, Housing and the Healthy Homes Programme

Liverpool has a unique history reaching as far back to medieval times as a thriving port with booming population numbers. However, from the 20th Century the City suffered major housing shortages which created overcrowding and slum housing. This was addressed by the Council constructing large numbers of houses.

During the Second World War, Liverpool endured a huge housing loss, with almost 10,000 being destroyed. To solve this housing crisis, swaths of houses were demolished and replaced with high rise blocks of flats.

At this time there was also a drive to construct new communities using pre-fabricated construction methods. These houses tended to be small, offering no choice for larger or extended families. These communities were later demolished, again destroying communities and leaving residents without or with restricted access to health services, such as dentists and doctors.

Liverpool now finds itself needing to upgrade and refurbish much of its accommodation for the residents of Liverpool.

The Liverpool Healthy Homes Programme was initiated to combat a number of issues arising from housing and was based on the Housing Health and Safety Rating System (HHSRS), a new system for assessing housing conditions and enforcing housing standards. The HHSRS, introduced under the 2004 Housing Act is a ‘risk-based tool which was devised to help local authorities identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings.’

The HHSRS assesses across 29 categories of housing hazard such as damp, mould personal safety and a range of falls, with each hazard having a weighting which determines whether dwellings are overall category 1 (serious) or category 2 (other).
1.3 Aim of the Health Impact Assessment

The aim of this HIA was to identify the health impacts of the Healthy Homes Programme and to ensure that health inequalities are reduced and housing quality is improved over the period of the Programme.

The purpose of this HIA report is to provide a systematic and robust analysis of the Programme in order to support the evaluation of the Programme as well as support future business strategy development.
2.0 Health and Health Impact Assessment

“Health is a state of complete physical, mental and social well-being not just the absence of disease or infirmity.”

As stated in the Ottawa Charter for Health Promotion, good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion is the ‘process which enables people to increase control over, and improve their health.’

2.1 Health Impact Assessment

Health Impact Assessment is a globally recognised tool which is used to systematically assess the health impacts, either positive or negative, of a strategy, policy or programme. HIA is a flexible tool and has a range of approaches as described in Appendix A. HIA also supports decision makers through the decision making process.

HIA also offers the opportunity to ‘potentially prevent negative health effects and maximise the positive health effects.’ It also supports the strengthening of partnership working between organisations.

People's health is affected by a variety of factors, such as individual, social, economic and environmental. These factors are commonly referred to as the social determinants of health. It is these factors that HIA links and examines.

2.2 Social Determinants of Health

Factors such as environment, income, employment, transport, housing, crime and the social and physical condition of local neighbourhoods, all contribute to both good and poor health. These factors are known as the Determinants of Health.

2.3 Social Model of Health

HIA uses the social model of health (Dahlgren and Whitehead). This is shown below (diagram 1). This model is widely recognised and is commonly referred to as ‘The Rainbow.’ This multi-level rainbow model highlights the complex interactions between a range of factors – biological, lifestyle, environmental, social and economic.

The Rainbow offers a framework which supports the identification of potential health impacts within each layer. Identifying these health impacts within this framework can support the most suitable interventions be it a policy, plan or programme depending on within which layer the impact falls, as it helps explore the different interactions between the layers and the determinants.

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4World Health Organisation, 1946
5Ottawa Charter for Health Promotion, 1986
6Health Impact Assessment Toolkit for Cities Document 1, Vision to Action, WHO, 2005
2.4 Health Inequalities and Health Equity

Health inequalities are defined by the World Health Organisation, as differences in health status or in the distribution of health determinants between different population groups.\(^7\)

As stated in a paper ‘A Glossary for Health Inequalities’ (2002), ‘Health inequality is the generic term used to designate differences, variations, and disparities in the health achievements of individuals and groups.’\(^8\)

This paper quotes ‘Most of the health inequalities across social groups such as class and race are unjust because they reflect an unfair distribution of the underlying social determinants of health, for example access to educational opportunities, safe jobs, health care, and the social bases of self-respect.’

2.5 Policy context of Health Inequalities

A number of important reports have been produced over the years concerning the importance of dealing with health inequalities. Key works include the Black Report (1980),\(^9\) the Acheson Report (1998)\(^10\) and more recently the final report of the WHO Commission on the Social Determinants of Health (2008)\(^11\) and the Marmot report ‘Fair Society, Healthy Lives’ (2010)\(^12\).

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\(^8\)A Glossary for Health Inequalities, Journal of Epidemiology, Community Health, 2002, I Kawachi, S, V, Subramanian, N Almeida-Filho (www.jech.bmj.com/content/56/9/647.full)
\(^9\)The Black Report, Black, D, 1980
\(^10\)Independent Inquiry into Inequalities in Health (Acheson Report), Acheson, D, Department of Health, 1998
\(^11\)Closing the Gap in a generation: Health equity through action on the social determinants of health, WHO Commission on Social Determinants, WHO, 2008
\(^12\)Fair Society Healthy Lives (Marmot Review), Marmot, M, Department of Health, 2010
3.0 The Liverpool Healthy Homes Programme

3.1 Introduction

This section of the HIA report presents the why, what and how about this unique Liverpool Healthy Homes Programme.

3.2 Decent Homes and Health and the Housing, Health and Safety Rating System

3.2.1 Decent Homes

‘The Decent Homes Programme’ was launched in 2000 with a remit to ‘bring all social housing into decent condition by 2010, with most of their improvement taking place in deprived areas, and increase the proportion of private housing in decent condition occupied by vulnerable groups.’

The Decent Homes Programme was set up to support those primarily living in private rented accommodation. Those living in social rented accommodation would be supported by their registered landlord, although this initiative initially excluded those living in their own private homes.

In the 2002 Spending Review, this drive for better housing conditions was widened to include all vulnerable households in the private sector.13

A Health Impact Assessment undertaken by the Building Research Establishment (BRE) Trust in 2010 has established the cost of poor housing to the National Health Service (NHS) is in excess of £600 million a year.14

3.2.2 Defining a Decent Home

A Decent Home is described as:-

‘One that is wind and weather tight, warm and has modern facilities.’15

A nationwide survey in 1996, English House Condition Survey, reported over 1.5 million UK dwellings did not meet the Fitness Standard with 14.2% of households living in poor conditions. These figures were unchanged from the same survey undertaken in 1991.

The English House Condition Survey is a national survey undertaken every five years to assess the overall condition of the housing stock. It was initiated in 1967 and was used to create a benchmark from which to inform housing renewal policies. It was used until 2001. This survey highlighted a number of issues and concerns given to

13The Decent Homes Programme, Environmental Change, Institute, University of Oxford, Darby, S, 2005
14The real cost of poor housing, BRE Trust, Davidson, M et al, 2010
15Office of the Deputy Prime Minister, 2004
whether these issues were likely to create inequalities. These concerns included adequate thermal comfort, and disrepair. Also apparent were a number of vulnerable population groups who were considered most at risk, including the elderly, the very young and those who suffer from a long-term illness.

Guidance by NICE (National Institute for Health & Clinical Excellence), ‘Housing and public health: a review of reviews of interventions for improving health,’ an evidence briefing, 2005, supports this thinking by stating that the ‘likelihood of these groups may have most exposure to many hazards in the home, due to the amount of time spent indoors.’

The Fitness Standard was originally introduced in 1919, by the then Ministry of Health. It was a legal standard where housing conditions were measured. It was based on a ‘bricks and mortar’ approach rather than the impact of the occupants. Stated in the 1985 Housing Act, (as amended), ‘A dwelling-house is deemed fit for habitation unless it fails to meet one or more specified criteria, and for that reason is not suitable for occupation.’ These criteria include:-

- Structural stability,
- Serious disrepair,
- Dampness,
- Adequate provisions for lighting, ventilation and heating,
- Wholesome water supply and
- Facilities for food preparation.

With the fitness standard having received some criticism the Housing, Health and Safety Rating System (HHSRS) was commissioned and brought into use by the Department of Environment, Transport and Regions (DETR) in 2000. This now appears to be the most commonly used and best system in use. This system has the benefit of ‘grading the dwelling conditions on the basis of the likelihood and consequences of a hazard occurrence.’

The HHSRS is based on the underlying principle that ‘A dwelling, including the structure, the means of access, any associated outbuildings and garden, yard and / or other amenity space, should provide a safe and healthy environment for the occupants and any visitors,’ and in order to satisfy the above principle:-

- a dwelling should be free from unnecessary and avoidable hazards; and
- where hazards are necessary or unavoidable, they should be made as safe as reasonably possible.

The Rating system has been devised to assess potential hazards on their severity from minor harm to major risk and even death, where the higher the score the higher the risk.

The Rating System is calculated on a risk basis thus acknowledging that all dwellings contain hazards. Each hazard can be scored as well as being associated to a particular population. So for example, a missing spindle on a staircase could be a hazard to a young child.

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16Housing and public health: a review of reviews of interventions for improving health’, an evidence briefing, NICE, 2005
17Housing Act, 1985 (as amended)
The scoring uses a formula as well as considering the likelihood over a twelve month period and the occurrence which could then cause harm to vulnerable people or persons, with the likelihood given as a ratio, for example 1 in 10.

Four Classes of Harm have also been developed with occurrences being categorised based on the perceived severity. Examples of risk for each class are bulleted below:
- Class I includes death or permanent paralysis,
- Class II includes loss of a limb, or severe chronic confusion or fever,
- Class III includes severe stress, loss of finger or severe concussion,
- Class IV includes slight concussion, moderate cuts or regular coughs and colds.

HHSRS Guidance has developed a list of 29 hazards potentially found in the home. These range from extremes of temperature (hot and cold), a range of falls (on stairs, on the levels, between levels), hot surfaces and materials, damp and mould growth, carbon monoxide and electrical hazards.  

An evidence summary report produced ‘The Real Cost of Poor Housing’ by the Building Research Establishment (BRE), 2010, collated a range of evidence relating to the links between housing and health.

This extensive report clearly demonstrated the importance of the Acheson Report, and the annual Health Surveys for England (produced by the Department of Health) as official publications for highlighting the issues and links between housing and health.

With growing momentum in the UK, in particular, a number of conferences have been organised, such as the Warwick University ‘Unhealthy Housing’ Conference as well as seminars and events assembled by the WHO.

This momentum led to a study commissioned by the Office of the Deputy Prime Minister (ODMP) in 2003, which examined the health and safety of occupiers in homes. This resulted in a list of 29 hazards, split into four categories, (physiological, psychological, infection and safety) being created which could be ‘attributable to housing design and / or condition.’ This table is shown below:

<table>
<thead>
<tr>
<th>Physiological</th>
<th>Psychological</th>
<th>Infection</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Damp &amp; Mould Growth.</td>
<td>Overcrowding and space.</td>
<td>Domestic Hygiene etc.</td>
<td>Falls in baths etc.</td>
</tr>
</tbody>
</table>

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19 [www.eastmidlandsdash.org.uk/docs/HHSRS-Overview.pdf](http://www.eastmidlandsdash.org.uk/docs/HHSRS-Overview.pdf)
20 ‘The Real Cost of Poor Housing,’ Building Research Establishment, 2010
21 Independent Inquiry into Inequalities in Health (Acheson Report), Acheson, D, Department of Health, 1998
22 Explanatory Fact Sheet on the HHSRS alongside the publication of the Housing Bill – Consultation on draft legislation, ODMP, 2003
7. Radiation.
8. Un-combusted fuel.
9. Volatile organic compounds.

- Explosions.
- Structural collapse.

With this drive towards improved housing the government produced a target for all dwellings in the social rented sector to be decent by 2010, but no target for private housing sector. However, there appears to be an assumption that considering the number of residents and therefore occupiers within the private rented sector that including this sector would expect to have a significant impact on health.

3.3 Hazards Associated with Housing and Health

The paper in the American Journal of Public Health, ‘Housing and Health: Time Again for Public Health Action’ (Krieger and Higgins), 2002, brought together a broad but solid understanding of housing and health. Although some is based on American housing and health concerns it does highlight similar issues faced in the UK.

Exploring housing as a determinant of health the aforementioned paper presents a useful summary of the health concerns associated with poor housing. For the purposes of this HIA, it has been tabulated with a summary narrative alongside each health concern.

Table 2 Summary of Health Issues Associated with Poor Housing

<table>
<thead>
<tr>
<th>Health Concern</th>
<th>Summary Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases</td>
<td></td>
</tr>
<tr>
<td>Infectious</td>
<td>These can occur if there is unsatisfactory or lack of safe drinking water, inadequate food storage, diseases brought about by disease vectors (for example insects and rats). Tuberculosis (TB), is associated with overcrowding, as are respiratory infections.</td>
</tr>
<tr>
<td>Chronic</td>
<td>Damp, cold and mouldy houses have a huge negative impact on health with associated impacts such as: asthma and other chronic respiratory symptoms. Water intrusion is also a major contributor to creating dampness which can lead to the respiratory health impacts, internal moisture and lack of ventilation can also have adverse health effects. Damp can also be a breeding ground for mites, roaches and moulds which can impact on respiratory health. Poor, old and dusty floor coverings especially carpets can also have negative impacts on allergic and respiratory illnesses. There is some evidence that links indoor temperature and cardiovascular disease, if the temperature is outside of the determined range. Exposure to passive indoor smoke, toxic substances along with poor ventilation can exacerbate asthma and / or respiratory symptoms. Elevated levels of carbon monoxide can lead to headaches and even death. Other factors in poor housing such as exposure to lead, asbestos and radon can cause diseases such as neurodevelopment and</td>
</tr>
</tbody>
</table>
Injuries

Injuries that can occur in poorly designed homes can include burns and falls, exposed heating sources, unprotected windows, poor staircases with inadequate lighting, plus injuries from fires.

Childhood Development and Nutrition

Evidence of the impacts of poor housing on the young have shown a link to poor nutrition, with relatively costly housing forcing low-income families to spend less on food.

Mental Health

It is recognised that poor and inadequate housing may also have a negative impact on mental health. Excessive indoor temperatures have been associated with irritability and social intolerance, as opposed to damp, moulidy and cold indoor temperatures which may be linked to anxiety and depression.

Overcrowding has impacts on psychological distress – in one study this was particularly relevant to single women aged between 25 - 45.

Social isolation is a further factor of inadequate housing where occupants do not want to invite others to their homes. High rise blocks of flats may also create situations of social isolation due to lack of social / common spaces.

3.4 Historical Housing Context for Liverpool

Liverpool has a unique history from as far back as medieval times when it was a thriving port with booming population groups. However, from the 20th century the City suffered major housing shortage which in turn led to overcrowding and slum housing. This problem was solved with the Council contracting the construction of vast numbers of new homes to be built.

During the Second World War, Liverpool endured a huge housing loss, with almost 10,000 houses being destroyed. The City solved this housing shortage problem by demolishing the war torn houses and replacing them with high-rise blocks of flats.

At this time there was also an incentive to create new communities and homes were built using pre-fabricated construction methods. These houses tended to be small and offered no choice, particularly for larger or extended families. These communities were also later demolished which also demolished communities. This also led to residents being left without access or restricted access to health services such as dentists and doctors.

Liverpool now finds itself in need of upgrading and refurbishing much of its accommodation for the residents of Liverpool.

3.5 Liverpool Healthy Homes Programme

The Liverpool Healthy Homes Programme was a targeted approach to improve housing conditions in line with the Governments Decent Homes initiative. The Liverpool Programme aimed not only to improve housing conditions but also to improve health and reduce health inequalities.
3.6 Delivery of the Liverpool Healthy Homes Programme

The Healthy Homes Programme (the Programme) focused on the top 10 hazards of the 29 as described within the Housing Health Safety Rating System identified by the Liverpool Healthy Homes Environmental Health Team and are shown in table 3.

**Table 3 Top Ten Hazards Identified by Liverpool Healthy Homes Environmental Health team (April 2009 – July 2013)**

<table>
<thead>
<tr>
<th>Number</th>
<th>Hazard Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Excess cold</td>
</tr>
<tr>
<td>2)</td>
<td>Fire</td>
</tr>
<tr>
<td>3)</td>
<td>Damp and mould</td>
</tr>
<tr>
<td>4)</td>
<td>Fall stairs</td>
</tr>
<tr>
<td>5)</td>
<td>Personal hygiene sanitation &amp; drainage</td>
</tr>
<tr>
<td>6)</td>
<td>Fall level surface</td>
</tr>
<tr>
<td>7)</td>
<td>Fall between levels</td>
</tr>
<tr>
<td>8)</td>
<td>Electrical hazard</td>
</tr>
<tr>
<td>9)</td>
<td>Food safety</td>
</tr>
<tr>
<td>10)</td>
<td>Entry by intruders</td>
</tr>
</tbody>
</table>

Once these were assimilated a multifaceted partnership delivery approach was developed. Once key deprived areas had been identified and location visits undertaken, teams of ‘on-the-ground’ Healthy Homes Advocates visit each property offering every occupant the opportunity to fill in a Single Application Process survey form.

This form asks multiple questions to determine housing conditions and also includes lifestyle questions, which determines any housing disrepair or health issue. Once completed, if necessary, the forms are inputted into the referral system.

Diagram two below, highlights the delivery process of the Programme.

**Diagram 2 Healthy Homes Programme Delivery Process**
As part of the initial planning to establish which areas the Healthy Homes Programme should target and in which order, a ranking system was introduced specifically designed and created for this Programme’s purpose.

### 3.6.1 Liverpool Healthy Homes Programme Index

A broad range of data sets were identified in order to develop a Liverpool ranking system. Using a ranking system would allow a systematic and consistent approach in which to visit areas of Liverpool, with the most deprived areas and therefore potentially the most vulnerable, being visited first and so forth.

The data sets identified and chosen included four out of the seven from the Index of Multiple Deprivation (IMD), along with other data sets relating to the 10 hazards used within the Programme.

The IMD is a score ascertained at national level to aggregate a single deprivation score, by combining a number of indicators which are chosen to bring together a range of economic, social and housing issues, for each small area in England.

This allows each area to be ranked according to their level of deprivation. The index has also been produced at Lower Super Output Area level (LSOA). A Lower Super Output Area is essentially a geographical hierarchy, all of which are of a consistent and similar in population size. There is an LSOA for each postcode in England.

A number of authors over the past 25 years have cited ‘Deprivation is considered to be a multi-dimensional problem, encompassing a range of domains such as financial, health, education, services or crime’ (Townsend, 1987; Whitehead and Dahlgren, 1991; Venkatapuram and Marmot, 2009).

Overall the IMD has eight domains: Income, Employment, Health, Education & Training, Access/barriers to services, Living Environment/Services, Physical Environment and Crime. The table below provides a brief overview of the IMD domains chosen for the Programme.

#### Table 4 Healthy Homes Programme Indices of Multiple Deprivation Domains Used

<table>
<thead>
<tr>
<th>Domain</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income deprivation</td>
<td>The proportion of the population experiencing income deprivation in an area. This domain also includes an Index of Income Deprivation affecting children and an Index of Income Deprivation Affecting Older People.</td>
</tr>
<tr>
<td>Health deprivation</td>
<td>This identifies areas with relatively high rates of people who die prematurely or whose quality of life is impaired by poor health or who are disabled, across the whole population.</td>
</tr>
<tr>
<td>Barriers to housing &amp; services</td>
<td>The indicators fall into 2 sub domains – ‘geographical barriers' which relates to the distance to key services and ‘wider barriers’ which includes issues relating to access to housing, such as affordability and overcrowding.</td>
</tr>
<tr>
<td>Living environment</td>
<td>This domain comprises 2 sub domains – the ‘indoors' living environment which measures the quality of</td>
</tr>
</tbody>
</table>

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21Index of Multiple Deprivation, www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/
22www.connectingforhealth.nhs.uk/datastandards
23UK indices of multiple deprivation - a way to make comparisons across constituent countries easier, 2012, Office for National Statistics
Those not included are:- Employment, Education & Training, Physical Environment and Crime.

Other data sets used within the Healthy Homes Programme but are not one of the seven IMD domains include:

- **Tenure**
  - Private rent - figures arrived at from private rented percentages taken from the 2001 census.
  - Registered Social Landlords (RSLs) density – density of RSLs property determined as a percentage.

- **Health**
  - Emergency hospital admission – ratio per 1,000 population of emergency hospital admission episodes between 2007 -2009.
  - Residence for hospital admissions for falls.

- **Poverty and Crime**
  - 2008 residential burglary rate.
  - 2008 Housing benefit rate.
  - Fuel poverty (a household is deemed to be in fuel poverty if in order to maintain a satisfactory heating regime….it would be required to spend more than 10% of its income on all household fuel use).  

### 3.6.2 The following table describes each stage of the Programme delivery.

**Table 5 Description of the Liverpool Healthy Homes Programme Delivery Mechanism**

<table>
<thead>
<tr>
<th>Stages</th>
<th>Process Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1 - Planning</strong>&lt;br&gt;As described above</td>
<td>Liverpool Location Index</td>
</tr>
<tr>
<td><strong>Stage 2 - Pre-survey</strong></td>
<td>Pre-survey Process to gain local intelligence of social and environmental aspects of each area, including some community engagement. Vacant properties listed, graffiti, anti-social behaviour issues. Population groups, for example ethnic minority groups. Pre-Survey Notification – letters explaining the Programme are sent to all households before the Advocates visit the area. Pre-survey checks – using generated street lists to ascertain vacant properties, likelihood of aggressive tenants or households where the Advocates were likely to be refused.</td>
</tr>
<tr>
<td><strong>Stage 3 - Intervention</strong></td>
<td>Each household is offered the opportunity to have the specifically designed 4 part Single Assessment Process filled in for them. It covers a number of questions concerning the condition of the property and a number of health related questions. On completion of the forms the occupant is required to sign a...</td>
</tr>
</tbody>
</table>

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declaration essentially giving permission for any referrals to be undertaken.

**Stage 4 - Referrals**

Information is gathered from residents around property condition and residents health and wellbeing. Advocates make referrals for the following:

- **Property Condition**
  - Type of heating
  - Condition of heating
  - Damp and mould growth
  - Insulation
  - Safety and hygiene

- **Health and Wellbeing**
  - Income maximisation
  - NHS services
  - Lifestyle
  - Employment/education and training
  - Fuel debt

**Stage five - 28 day call backs**

A 28 day call back is in operation to ensure relevant referrals have been activated and carried out. This is done through the business support team who are in contact with the occupant from each residency who filled in a SAP form. Follow ups will occur if it is found that any referrals have not been activated.

**Stage six – Post-survey**

A post survey is undertaken for evaluation and analysis purposes on a monthly basis. Range of data is collected including properties visited, number of surveys completed, referrals made, types of illness and property defects.

**Stage seven- Landlord coordination**

Liaising with landlords to promote the health effects of poor housing and to encourage self-regulation. This will also include the repairs reporting mechanism which is an expeditious process of reporting and responding to housing repairs without recourse to enforcement.

Appreciating the social capital of landlords by encouraging them to provide services beyond bricks and mortar, such as advising tenants about their local doctors and dentist surgeries.

**Stage eight- Additional Actions**

This final stage is aimed at ensuring there is a reactive response to any in-bound referrals that are made to the Programme. These can originate from any of the partner organisations such as doctors, hospitals or directly from residents who may have missed the survey.

In order to support the intervention of a range of hazards, a number of associated projects, such as Winter Survival Programme run alongside the main Healthy Home Programme.
With a focus on improving the health and well-being of residents and occupants of those living in the private rented sector, a decision was undertaken to work with Registered Providers, who also could have properties which are in poor condition and whose residents could have health and well-being issues.

In order to facilitate this partnership working the Programme has a Landlord Coordinator, whose role is to develop strong working relationships whilst raising the profile between health and housing.

### 3.7 Health Promotion Programmes

A number of adjacent health promotion programmes are run alongside the main Programme, supported by social marketing.

#### 3.7.1 Winter Survival Programme

The Winter Survival Programme was initiated in response to the number of excess winter deaths in Liverpool. A Winter Survival event is held annually in November where free gifts such as hats, scarves and gloves are given out. These are offered to vulnerable people along with advice about how to keep warm in winter / colder months. Over 76,000 leaflets have been sent out with flu vaccination letters.

#### 3.7.2 Child Safety at Home Campaign

This campaign was developed in 2011 to target reduction of accidents to children in the home, with a focus on primary school age groups. Accidents occurring in the home, range from burns and scalds to poisoning. This campaign is delivered using a drama group who visit primary and junior schools, targeted at the most deprived areas within Liverpool.

#### 3.7.3 GP Surgeries

Working with GP Surgeries has resulted in a two-way process for referrals between the surgeries and the Healthy Homes team. Patients are identified through an alert system on the GP practices computer system which links health conditions patients may have developed due to substandard housing. The patient is questioned about their housing condition by the GP and a referral to Healthy Homes is then made if appropriate. In addition to this the Health Promotions team visit over 30 surgeries a month and converse with patients in the waiting rooms. Patients are able to fill in a referral form in the waiting room with the Health Promotions staff and will receive a visit from an advocate at their property if appropriate.

### 3.8 Partnerships

A wide and varied range of partners are involved in the programme and cover aspects from practical housing and financial support to specific intervention programmes such as Roy Castles Fag Ends. The diagram below shows the partners involved.
3.9 Healthy Homes Progress – A Summary

Between March 2009 and July 2013 the programme has:

- Visited 107 Super Output Areas;
- Knocked on the doors of 82,400 properties;
- Spoken to over 27,000 residents and as a result have completed nearly 17,000 surveys;
- Those homes were occupied by 37,452 residents and this has led to 22,247 referrals to partners;
- Carried out 4,569 Housing Health & Safety Rating System inspections, identifying and addressing 3,366 category 1 hazards;
- This has generated over £4.5m investment from Private Landlords;
- We have also received 1351 inbound referrals from partners to assist them meet the housing, fuel poverty and energy efficiency needs of their patients / clients;
- Regularly attend 33 GP surgeries to engage with waiting patients with plans to extending this and
- Implemented a pilot GP referral system into GP surgeries enabling them to make direct referrals to the Healthy Homes Programme.
4.0 Assessment of the Programme

4.1 Health Impact Assessment Methodology

Further detail of the HIA Methodology used can be found in Appendix B.

4.1.1 Screening

The Programme was screened using the Liverpool Screening Tool. The purpose behind screening the Programme had two immediate aims, firstly to identify if a HIA was required and secondly, if a HIA was required, then what type.

A three stage process, the screening of the Programme was undertaken by the Steering Group, people identified for the purposes of this HIA. The Steering Group has the responsibility for supporting and guiding the HIA as it is carried out. For this HIA members for the Steering Group were identified by the HHP Management Team. Members of the Steering Group were from all sectors of the HHP Team.

The first stage of the screening process develops an understanding and builds a picture of the Programme being assessed, such as contact details of those involved, date of screening, whether the Programme is new or existing, links to other Strategies and the area of Liverpool that the Programme will affect.

The second part of the screening process asks five questions with yes, no or unknown answers. Once all five questions have been completed if yes or unknown has been answered to questions 1, 2 and 3 then a HIA must be undertaken.

The final part of the screening process is to develop the scope, or blueprint of the HIA, and is only completed if a HIA is required. It allows the aim and objectives for the HIA to be developed, along with other ‘practical housekeeping’ questions, such as what type of HIA, implementation of the recommendations and any further skill training required for the HIA.

The completed screening tool for the Programme can be found in Appendix C.

Table 6, shows the initial health impacts identified through the screening process for this HIA.

<table>
<thead>
<tr>
<th>Table 6 Health Impacts Identified through the Screening Process</th>
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<tbody>
<tr>
<td>• Fuel poverty</td>
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<tr>
<td>• Increased rent</td>
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<tr>
<td>• Mental health and well-being</td>
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<tr>
<td>• Budgetary/financial restrictions on the Programme.</td>
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4.1.2 Scoping

The aim and objectives for the HIA were also developed at the beginning of the HIA process, with the final version being agreed by the steering group. This allowed for some ownership of the HIA for those directly involved.
Aim

To identify the health impacts of the Healthy Homes Programme and to ensure that health inequalities are reduced and housing quality is improved over the period of the Programme.

The purpose of this HIA report is to provide a systematic and robust analysis of the Programme in order to support the evaluation of the Programme as well as support future business strategy development.

Objectives - The following objectives were identified to achieve the aim of the HIA:-

- **Objective 1**: Engage with primary stakeholders at a participatory workshop to determine any gaps in service delivery any health impacts these may have on the target groups.
- **Objective 2**: Identify any target groups which have/may be missed through the Programme Service Level Agreement and any potential health impacts from this.
- **Objective 3** – To develop a set of evidenced based recommendations which will aim to reduce health inequalities in Liverpool.
- **Objective 4** – Identify any other key areas of the Programme and highlight the potential health impacts either positive or negative of these areas.
- **Objective 5** – Collect and analyse the evidence gathered to support or negate the previously identify health impacts.
- **Objective 6** – Develop a set of recommendations.

4.1.3 Identification of Health Impacts

A number of methods have been employed to bring together the identification of potential health impacts that occur through poor housing. These included:-

- a literature review (see section 5),
- a policy analysis (see Appendix D),
- localised profiles (see Appendix E) and
- a stakeholder workshop (see Appendix F).

4.1.4 Impact Analysis and Characterisation

All the health impacts identified from the above methods were manually analysed through a ‘theme analysis.’ Simply, the most common themes / health impacts identified through the above process – now referred to as strategic determinants were further evidenced. Further to this specific population groups likely to be affected were identified.

Upon completion of the evidence gathering all the information was collated in order to identify common themes running through each method of evidence gathering.

These strategic determinants were then characterised using a pre-determined and commonly used set of criteria.

4.1.5 Conclusion and Recommendations

The HIA is concluded and a set of evidence based recommendations developed using all the above information and based, where possible, on the health impacts identified.
5.0 Evidence Gathering

This stage of the report summarises the different information types gathered for the purpose of this HIA. This will include a literature review, policy analysis, localised profile and detail of the HIA workshop.

5.1 Literature Review

This section of the HIA report provides a brief literature review on housing and health.

The literature review is an essential part of the evidence gathering and is important ‘in order to explore the field of work’ to enable an understanding of the topic area under review and provides a historical background.28

For clarity, in this HIA the literature / evidence review for this HIA is two-fold (providing initial understanding of housing and health and secondly to support evidence for specific health impacts) and examines a range of literature from a number of sources.

Literature / evidence can be collected from a number of different sources:-

- Primary Literature – individual research published in peer reviewed journals,
- Secondary Literature – reviews (e.g. systematic, review of reviews), published in academic press,
- Grey Literature – anything not reported in peer reviewed journals, magazine articles.

The initial literature review was conducted in order to explore the area of housing as a determinant of health, in broad terms. It examined the historical and legislative background to housing, highlighting a number of potential health impacts.

This section of the literature review also examined the links between public health and housing, developed a narrative of decent homes, explored what is meant by the term 'vulnerable' and included an understanding about mental health.

Most of the evidence found and examined / used within this report came from using combinations of the following key words:-

**Key Words:** housing; health impacts; determinant of health; mental health; vulnerable people.

The literature review included secondary and grey literature and used sources such as the World Health Organisation (WHO), British Medical Journals, Chartered Institute of Environmental Health and the SCIE (Social Care, Institute for Excellence).

It explores housing as a determinant of health, the barriers to why there appear to be inequalities in housing and subsequent wider health impacts that these may have on

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28The Literature Review, Ridley, D, 2010
different populations. It will also briefly examine if some population groups are more vulnerable than others. The historical context of housing and changes in legislation will also be summarised.

5.1.1 Housing, Health and Inequalities

Housing, health and their potential inequalities have been on the agenda, particularly the public health agenda, for the last 30+ years. But it would appear that there are still inequalities surrounding housing and health.

The literature creates a commentary of a strong and growing body of evidence recognising the impact on health that poor housing conditions can have to occupiers and in particular certain vulnerable population groups such as the young or the elderly.

Historical evidence suggests that there have been significant improvements to health that emerged from poor health due to urbanisation and poor quality housing and a lack of infrastructure.

The impact of health from poor housing was first seen in 1842, when Edwin Chadwick recognised the link between the conditions people were living in and their health. In the early 1800s Chadwick was charged with the undertaking of an inquiry to ascertain the living conditions of people in Britain. He investigated and believed that clean, ventilated and sanitary conditions would ‘make people healthier and therefore less dependent on welfare.’ Along with Dr Thomas Southwood, this report ‘The Sanitary Conditions of the Labouring Population’ in 1842, led to the first Public Health Act being passed in 1848.

Even then, this report mentioned the gap in average life expectancy in Liverpool. For ‘gentry it was 35 years compared with only 15 years for labourers and servants.’ From then, it became accepted that many of the improved health gains, have come from public health drives, most markedly clean water and sanitation.

Although there has been an improvement in the health of the population, health inequalities have continued to happen and even increase. The Black Report, in the 1980s, brought to the fore the links between health and social class, and saw decent housing as a necessity for improved health.

Although well recognised, the links between housing and health are complex. The causal / connecting factors and dimensions of housing, neighbourhood environment and health often co-exist with other forms of deprivation such as low income, unemployment, poor education and social isolation. This complexity therefore makes it difficult to assess the health impacts that occur due to housing conditions.

The implications of poor housing and working conditions were well documented as far back in the 1800’s, for example, with Friedrich Engels book ‘The Condition of the

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29 Brought to Life, Exploring the History of Medicine, www.sciencemuseum.org.uk/broughttolife/people/edwinchadwick.aspx
31 The Black Report, Black, D, 1980
32 A Select Review of Literature on the Relationship between Housing and Health, Scottish Government Communities Analytical Paper, 2010
Working Class in England’ in 1844. He examined ‘mortality and municipal records to calculate the ratio of the living to the dead,’ this concluded that the survival ratio was higher for those living in the ‘best houses in the best streets’.

### 5.1.2 Housing as a Determinant of Health

It is important to understand housing as a determinant of health and what the implications to health are, specifically if housing is of poor quality.

There have long since been historical indications of how poor housing manifests itself on those living in poor environments. As already stated, many public health epidemics were prevented once housing standards and supporting infrastructure had been improved.

Significant amounts of research has been undertaken around housing and the impacts on health, as housing is considered to be one of the most important factors to human life.

In wider recognition of the importance of housing on health the Universal Declaration of Human Rights offered the following statement:-

> ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care.’

One of the key messages to come out of the literature is that due to the complex interactions between housing and health it is difficult to prove. The literature seems to take the view that ‘bad housing damages your health’ but equally determines that this may not be that easy to prove, thus possibly creating inequalities and potentially even more so for those who are more vulnerable than others.

Cited in the book, ‘Tackling Inequalities in Health, An Agenda for Action,’ Goldblatt states this difficulty ‘So that those who live in poor quality housing, in deprived areas, may also not enjoy as good health as those living in decent houses’ and may have reduced life expectancy.’ This recognises that there are likely to be other disadvantages that these people face so determining that it is solely housing is difficult.

Following the British Medical Association (BMA) interest into health inequalities they state that ‘poor housing has been identified as a major factor that contributes to and may exacerbate these inequalities.’

A research paper for the Chartered Institute of Environmental Health, in 2006, ‘Housing as a health determinant: is there consensus that public health partnership are a way forward?’ also stresses the complex interactions between housing conditions and mental ill health.

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33 The Condition of the Working Class in England, Engels F, 1845
34 The Universal Declaration of Human Rights, 1948
Emerging from this paper is the importance of both the internal and external environments. Referencing the indoor factors includes aspects such as cold and damp and poor internal structures with the external factors being the quality of the neighbourhood, levels of deprivation and social cohesion.\(^\text{38}\)


Therefore, by creating decent homes and improved environments it would appear that health can be improved and as such, in 2004, the Government initiated a national drive to improve existing housing and create decent new housing.

2004 saw the Government define a decent home by meeting the following four criteria:

- It meets the current statutory minimum standard for housing,
- It is in a reasonable state of repair,
- It has reasonably modern facilities and services,
- It provides a reasonable degree of thermal comfort.\(^\text{40}\)

This Government report continues by indicating that there are other links with poor housing to other types of deprivation, examples being, poor education, unemployment and social isolation. As such, all or many of these factors compounded together can make it difficult to determine the overall health impact of housing conditions especially poor housing conditions.

### 5.1.3 Housing Tenure

The literature also indicated that there was some evidence relating to potential health impacts and housing tenure.

Tenure is the legal conditions under which people live in their dwellings.\(^\text{41}\) People can occupy homes by either renting or being owner occupied. Owner occupiers are most often owned with a mortgage, or on occasion without a mortgage. If renting, this can be either privately or through a public landlord.

Home ownership has been shown to have improved health for those occupiers. However, whilst home ownership can offer some security and control it can at times create less health promoting impacts, for example if a home owner falls behind with

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\(^{38}\) Housing as a health determinant: is there consensus that public health partnerships are a way forward? Stewart, J, Ruston, A and Clayton, J. Chartered Institute of Environmental Health, 2006

\(^{39}\) A New Commitment to Neighbourhood Renewal: National Strategy Action Plan, Social Exclusion Unit, 2001

\(^{40}\) A decent home: definition and guidance, Department for Communities and Local Government, 2004

\(^{41}\) Housing standards: a glossary of housing and health, Howden-Chapman, P, J Epidemiol Community Health, 2004;(58:162-168)
mortgage payments, this could lead to an increase in insecurity and poorer mental health.\textsuperscript{38}

Housing and specifically the quality of housing / accommodation is accepted as a determinant of health but consideration of the importance and somewhat reality that the quality of the accommodation is related to income.\textsuperscript{33}

A paper by Evans, Wells and Moch, in 2003, cited in ‘A Select Review of Literature on the Relationship between Housing and Health,’ determined that poor quality is especially relevant with studies undertaken on housing type, in particular high rise and multi-dwelling accommodation, where it has been evidenced that these types of accommodation can be detrimental to psychological well-being in particular for mothers with young children.\textsuperscript{44}

A study started in 2009 in Scotland, had the aim to explore the effects of regeneration on those living in high-rises which were in predominantly social renting neighbourhoods and the relationship to health and well-being.\textsuperscript{45} Although not completed to date, early findings suggest that mental health is generally poorer for those who reside in high-rise accommodation. Also emerging is that risk taking health behaviours, such as smoking, are also more significant when compared to those who live in other types of flatted accommodation and other housing mainly within the social rented sector.

A number of ‘key stressors’ were evidenced by Evans, these included insecurity and tenure concerns, difficulties with landlords and repairs, frequent relocations, limited control over social interactions and the stigma of poor housing.\textsuperscript{46}

5.1.4 Studies of Housing Improvement / Interventions and Health

From a brief literature search it would appear that there have been a number of studies undertaken which have assessed the health impacts from housing improvements programmes. Of immediate relevance to this HIA, was an ‘HIA of housing improvements: incorporating research evidence,’ 2003. This review of the studies related in the main to housing conditions and home accident prevention. Certain elements were excluded, such as radon, lead and carbon monoxide as measures were, and remain in place, to protect residents from these hazards.

Key messages from this review include:-

- Of the studies assessed in terms of general well-being, 14 were found to have changes in health, 10 were found to have some improvements and 5 found no differences, whilst some showed mixed effects. The measures included self-reported well-being, activity symptoms or illness episodes.
Three studies of re-housing and community regeneration reported adverse impacts on general health and one study showed age standardised mortality rates increased except for infants, five years after rehousing from a slum area.47

5.1.5 Mental Health and Housing

Although there is no single definition of Mental Health used, the one that appears to be most common is the one defined by the Health Education Authority in 1997:-

‘Mental health is the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others’ dignity and worth.’

Whilst the above quote is a positive definition of mental health it is not so easy to define poor mental health and the wide range of conditions that come under the mental health umbrella. These conditions include depression / sadness through to severe psychotic diagnoses.

The evidence and recognition of the importance of mental health and well-being and its impact on inequalities on health is growing and recognising ‘the importance of mental health and well-being is directly and indirectly related at every human level to human responses to inequalities.’

A four factor framework has been identified in relation to mental health and well-being:-

- **Enhancing control** e.g. opportunities for decision making, independence, autonomy, influence, self-help, job control, choice and levels of democracy,
- **Increasing resilience and community assets** e.g. hopefulness, optimism, life satisfaction, trust & safety, social networks, social support, public spaces, accessible services,
- **Facilitating participation** e.g. valued roles, sense of belonging, getting involved, decision-making, collective action, voting and other forms of civic engagement,
- **Promoting inclusion** e.g. positive identities, tolerance & cohesion, practical support, challenging discrimination, tackling inequalities.

A research paper carried out in 2002 by the Chartered Institute of Environmental Health (CIEH), points out that over the years there has been a significant amount of research on the ‘physiological outcomes of health and housing’ which illustrates issues associated with poor housing such as accidents, asthma and type of house that may present risk to the occupants health.51

This paper also examines the impact of poor housing on mental health whilst recognising that until recently there had been ‘very little comprehensive research on the psychological effects of poor housing….on mental well-being.’

[48]Health Education Authority, 1997
[51]Poor Housing and Mental Health in the United Kingdom: Changing the Focus for Intervention, Chartered Institute of Environmental Health, 2002
By collating and examining the research the CIEH highlighted what did exist on the relationships and links between housing, in particular poor housing, and mental health. Importantly it also provides the evidence which 'supports the view that provision of poor housing exacerbates mental health illnesses of those housed in such accommodation.'

A paper by Robinson and Adams in 2008, cited in a Scottish Government Analytical Paper, established there was a considerable amount of research and evidence that had explored the links between housing stress and mental well-being. It reported on a case study which concluded with ‘a gradient in mental health state by housing tenure, from less stress amongst homeowners without mortgages, to most stress amongst renters.’

A number of reports show the importance to health, including mental health and well-being, of the area they live in. A paper (and cited in the CIEH paper, 2002), by Frank and Mustard in 1994, indicated some of the likely health impacts were dependent on an area. When environment is mentioned it includes social, environment and economic environment, ‘one’s immediate social and economic environment and the way that this environment interacts with one’s psychological resources and coping skills, shapes health much more strongly than the medical model would suggest.’

With regards to both physical and mental health, the report does suggest that improved and ‘enhanced’ environments can provide a ‘perceived buffer’ to the negative impacts of health. Aspects that may appear to have an impact on health could include self-esteem, control or ‘standing in society.’

The CIEH paper also reports on the relationship between the ‘type, condition or location of housing, with unemployment or low fixed income and health.’ The report suggests that ‘type, condition or location of housing, with unemployment or low fixed income and health’ is shown by having a lack of choice, whereby people have to rent poor and low quality accommodation in deprived areas and that this accommodation does not create the ‘perceived buffer’ as described above.

Overall, the evidence appears to show that the impact on mental health and well-being from poor quality housing is as important as the physical impacts of health.

5.1.6 Vulnerable People

But who is ‘deemed’ to be vulnerable? Coming from the Latin word vulnerare, meaning ‘to wound’ it is deemed to encompass those people who are ‘exposed to the possibility of being attacked or harmed, either physically or emotionally.’

The paper by Mechanic and Tanner in 2007, ‘Vulnerable People, Groups, And Populations: Societal View,’ references the complexities of those who are vulnerable and that vulnerability can arise from a number of difficulties or situations such as:-

- developmental problems,
- personal incapacities,
disadvantaged social status,
- inadequacy of interpersonal networks and supports,
- degraded neighbourhoods and environments and
- the complex interactions of these factors over the life course.  

5.1.7 Public Health and Housing

The impacts on health from housing, either good or bad, positive or negative have been around for many years. From the days of urban industrialisation health, housing and planning came to the fore and in many ways merged.

As urban areas developed quickly populated, due to the industrial movement, it became urgent to build houses rapidly. Whilst the numbers of houses were constructed quickly, they were built without the necessary infrastructure such as sewers.

From 1875 a number of Acts of Parliament were passed that focused on such issues as overcrowding. In fact, the first Town Planning Etc Act &c in 1909, heavily considered the expanse of back to back housing and their contribution to poor health within the urban population.

Further legislation followed which covered the approval of housing design and later the clearance of slums.

This period in time also saw the Garden City Movement, led by Ebenezer Howard, which saw the drive to 'green' towns and cities. This movement eventually led to the New Towns Act, 1946.

Public Health is at the fore of helping and supporting people and communities to stay healthy and is defined as:

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

Public Health has a broad remit and covers areas such as nutrition, obesity, smoking, drugs and substance misuse and alcohol, as well as sexual health, pregnancy and children’s health.

During the literature review two further areas of concern were also highlighted - fuel poverty (including details on excess winter deaths) and accidents, falls and injuries, both described in more detail below.

5.1.8 Fuel Poverty and Excess Winter Deaths

Fuel poverty is recognised as a major health concern. In 2009, data shows that across England of the 4 million fuel poor households, about 3.2 million are those considered to be vulnerable households. These can include not just the elderly but

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57 en.wikipedia.org/wiki/Garden_city_movement
58 Sir Donald Acheson, 1988
those with children, households where someone is disabled or who has a long-term illness.\textsuperscript{59}

A report ‘The Health Impacts of Cold Homes and Fuel Poverty’ in 2011 stated that in 2008, 18\% of households in the UK were estimated to be living in fuel poverty.\textsuperscript{60}

Fuel poverty is defined as ‘the need for a household to spend over 10\% of its income on fuel to maintain adequate domestic thermal comfort.’\textsuperscript{61} Fuel poverty arises from a combination of three major factors:- low income, fuel costs and energy efficiency. The diagram below shows the fuel poverty diagram.\textsuperscript{62}

\textit{Diagram 4 Fuel Poverty Diagram}

The potential or likely impacts on health from living in cold homes are widely acknowledged. The WHO recommends indoor temperatures - 21 degrees in living rooms and 18 degrees for bedrooms.\textsuperscript{63}

There is wide recognition that living in cold conditions can lead to poor health and a risk of poor health.\textsuperscript{64}

The Public Health White Paper, 2010, stated that 35,000 deaths in the previous year, 2008 / 2009, could have been prevented through warmer homes.\textsuperscript{65}

According to the literature there are links between fuel poverty and excess winter deaths. As cited in this review, Boardman states the health link with fuel poverty is that ‘if people are unable to achieve affordable warmth and are sitting in a cold home, then this is detrimental to their health.’\textsuperscript{66}

It is estimated that around 40,000 more deaths per year occur between December to March than at any other time of the year. It is accepted that a proportion of these may be attributable to other seasonal illnesses, such as influenza, although it appears that two thirds are attributable to the cold and are classed as winter deaths.

\textsuperscript{59}www.poverty.org.uk/80/index.shtml
\textsuperscript{60}The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
\textsuperscript{61}The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
\textsuperscript{62}Decent Homes Impact Study: The effects of Secure Warm Modern Homes in Nottingham, Jones, A, 2012
\textsuperscript{63}The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
\textsuperscript{64}The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
\textsuperscript{65}Healthy lives, healthy people: our strategy for public health in England, Public Health White Paper, Department of Health, 2010
\textsuperscript{66}Fuel Poverty & Excess Winter Mortality, Fewtrell, L, EPSRC, 2012
\textsuperscript{www.regionalvisions.ac.uk}
Research shows that Britain has a higher rate of winter deaths than the colder Scandinavian countries which have harsher winters. This can be explained to some degree by the quality and conditions of the housing stock.

A poverty briefing paper highlights the relationship between housing quality, socio-economic status and excess winter death mortality which provided some interesting factors which were related to specific health impacts. For example:

- The age of property was found to have a strong association with excess winter deaths due to cardiovascular disease.
- Some investigation of the determinants of indoor temperature found a clear gradient of decline in temperature from higher to lower socio-economic groups.
- A strong correlation has been determined between the risk of fuel poverty and the likelihood of emergency admissions to hospital for respiratory problems, particularly with the elderly.67

5.1.9 Accidents Falls and Injuries – Unintentional Accidents

A report into accidents, undertaken by Liverpool John Moores University, was commissioned by Liverpool Primary Care Trust in 2009 and explored the impacts of unintentional injuries. The report states that in 2007, in England and Wales, there were over 11,000 deaths due to unintentional injury. Also reported were over 600,000 hospital admissions as well as those that were treated in ‘walk-in’ clinics and General Practitioners surgeries. These injuries can often lead to longer term treatment (follow-up care), can leave long term disabilities which can in turn lead to wider health impacts such as loss of mobility which can have an impact on mental health. 68

Injuries can be intentional (attack) or unintentional such as falls or burns. Population groups identified as most at risk of unintentional injury are the elderly and children, especially boys when they have a lower socio-economic status.

It was estimated by the Department of Health in 2002, that disability from an injury is ‘a considerably greater burden of potential health life-years lost than from cancer, or heart disease and stroke.’69

Unintentional accidents injury deaths are divided into categories, those involving vehicle accidents and those which occur in the home. Other categories include accidents in the workplace, leisure accidents and those where it is unclear.

It is estimated that of all accidents that occur, 45% occur within the home and that all accidents are in the top 10 causes of death for all age groups.70 Evidence also suggests that the number of accidents in the home is higher than accidents occurring at work or in road traffic accidents.

68Liverpool Unintentional Injury Prevention Audit, Trauma and Injury Intelligence, Centre for Public Health, John Moores University, Hungerford, D et al, 2009
69Liverpool Unintentional Injury Prevention Audit, Trauma and Injury Intelligence, Centre for Public Health, John Moores University, Hungerford, D et al, 2009
Data suggests that over a third of all adult accidents occur in the home whilst one million children (young people), under the age of 15 years attend accident and emergency departments due to accidents in the home. Injury rates for children in the lowest social class appear to be three times more likely to be involved in a home accident, than those in higher social class.

Older people are also at risk of having an accident in the home, with almost 1,500 deaths per year occurring from a fall to those who are 65 years and above.

Domestic fires also result in a high number of deaths and injuries. Research shows that domestic fires are more prevalent in low income households with children and where smoking occurs.

The quality of indoor environment is also recognised as an important factor. Poor internal environments and structural deviance can create risks for accidents, trips and falls within the home.

5.10 Overcrowding

According to a report by Shelter in 2005, ‘Full house? How overcrowded housing affects families,’ more than half a million households across the country still live in overcrowded conditions, as assessed by the much used Government’s Bedroom Standard measure. The definition of overcrowding is seen as outdated having not been changed or updated since 1935 and its first use in Victorian times.

Under the apparently outdated definition of statutory overcrowding, children under the age of 12 months old are not counted as members of a household and those aged between 1 year and 10 years of age are only counted as half a person. When counting number of rooms lounges and large kitchens are counted as adequate to sleep in.

According to the literature it would appear there are three main methods (each having its own pros and cons) used to measure overcrowding:

- The bedroom standard,
- Number of persons per room and
- Occupancy rating.

The bedroom standard, used most commonly, does consider ‘reasonable levels of bedroom-sharing in accordance with modern living.’

Overcrowded housing can have a number of impacts on those living in these overcrowded conditions. These can include:

- Impact on mental well-being including stress, depression and anxiety,
- Sleep deprivation,
- Lack of privacy,
- Impact of family life and relationships,
- Lack of storage space also has the potential to lead to accidents and
- The importance of having some decent outside space.

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71 Housing and public health: a review of reviews of interventions for improving health Evidence briefing, NICE, Taske et al, 2005
www.nice.org.uk/nicemedia/pdf/housing_MAIN%20FINAL.pdf
The report by Shelter, provided a ‘snapshot’ of the impacts of living in overcrowded conditions, although data collected was London based, as this is where overcrowding is at its most serious.

The results of the Shelter report states that Black and Minority Ethnic (BME) groups are twice as likely to be affected by overcrowding as white British families.  

5.2 Policy Analysis

The policy analysis examines a range of policies National and local strategies and policies relating to advocacy and health. The policy analysis will help identify where in the wider context the policies ‘sit.’ Examples of the policies analysed include: The Way Forward for Housing, \textsuperscript{73} The Fuel Poverty Strategy \textsuperscript{74} and the Housing Act, 2004. The full policy analysis can be found in Appendix D.

5.3 Profile

A City wide demographic profile was generated, bringing together a wide range of data sets to represent the health of the local population in its widest context. The data profile comes from a range of available data sets including the 2012 Liverpool Joint Strategic Needs Assessment (JSNA), the Association of Public Health Observatories and data collected by the Healthy Homes Team. The profile can be found in Appendix E.

5.4 Qualitative Evidence Used in this HIA

A half day workshop was arranged with a range of representatives including service providers, service users and external partners.

The HIA workshop was undertaken on Wednesday 13\textsuperscript{th} July 2011 at the Isla Gladstone venue in Stanley Park. It was held as part of a wider Healthy Homes Programme (HHP) stakeholder event.

All detail from the workshop was written up by the HIA facilitator as they were written down on each post-it note. Full details of the workshop can be found in Appendix F.

\textsuperscript{73} The Way Forward for Housing, Department for Environment, Transport, Regions, 2000
\textsuperscript{74} Fuel Poverty Strategy, Department of Energy and Climate Change, 2001
6.0 Theme Analysis

6.1 Introduction

Undertaking a manual theme analysis enables all the health impacts to be identified. These were then split into health impacts and strategic determinants. The most common of these identified throughout the whole of the HIA process then had further research on them to identify specific health impacts.

NB - Mental health was a consistent theme throughout all the health impacts identified.

6.1.1 Theme Analysis Results

All the health impacts identified throughout each stage of the HIA have been tabulated in order of process, HIA Screening, literature review and the HIA workshop.

The results of the theme analysis are shown in tables 7 and 8 on the following pages. The ‘most common’ and recurring themes were prioritised as the most important for the purposes of this HIA.

Identified population groups are tabulated in table 9.
<table>
<thead>
<tr>
<th>Screening</th>
<th>Literature Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fuel Poverty.</td>
<td>• Self-esteem (linked to Mental Health).</td>
</tr>
<tr>
<td>• Increased rent if works undertaken.</td>
<td>• Control and empowerment.</td>
</tr>
<tr>
<td>• Mental health and well-being.</td>
<td>• Social isolation (-ve) / social cohesion (+ve).</td>
</tr>
<tr>
<td>• Budgetary restrictions of the Healthy Homes Programme.</td>
<td>• Internal / External environments.</td>
</tr>
<tr>
<td></td>
<td>• Improved neighbourhoods improve social isolation.</td>
</tr>
<tr>
<td></td>
<td>• Void properties lead to poor neighbourhoods (fly tipping etc).</td>
</tr>
<tr>
<td></td>
<td>• Poor housing conditions.</td>
</tr>
<tr>
<td></td>
<td>• Income – lower income evidence suggest those who have a lower income are likely</td>
</tr>
<tr>
<td></td>
<td>to live in poorer quality accommodation.</td>
</tr>
<tr>
<td></td>
<td>• Poor education.</td>
</tr>
<tr>
<td></td>
<td>• Unemployment.</td>
</tr>
<tr>
<td></td>
<td>• Health impacts identified:</td>
</tr>
<tr>
<td></td>
<td>• Control,</td>
</tr>
<tr>
<td></td>
<td>• Self esteem</td>
</tr>
<tr>
<td></td>
<td>• Overcrowding,</td>
</tr>
<tr>
<td></td>
<td>• Respiratory diseases.</td>
</tr>
</tbody>
</table>
For the purposes of this report symbols used mean - ve = negative and + ve = positive.
The numbers in brackets are the number of times an issue / health impact was raised.
Post-it notes were written exactly as they had been written in the workshop.

**Table 8 Summary of Health Impacts as Identified through the HIA Workshop**

<table>
<thead>
<tr>
<th>The Programme</th>
<th>H&amp;S issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Vulnerable groups directly approached (delivery process of the Programme) / Contact with vulnerable people/isolated groups.</td>
<td>• Fire precautions, home fire checks, holistic approach to saving lives, referral to partner agencies [Safe and Sound, healthy initiative].</td>
</tr>
<tr>
<td>• People who may slip through the net can get picked up through the Programme (+ ve).</td>
<td>• Windows fitted with safety locks (+ ve)</td>
</tr>
<tr>
<td>• Point of contact within community.</td>
<td>• Legislation checks.</td>
</tr>
<tr>
<td>• Locations of areas visited, (e.g. not seen much HHP activity in South Liverpool). Postal districts.</td>
<td>• Disabled walk-in shower, stair lift, support provided (+ ve).</td>
</tr>
<tr>
<td>• Programme – proactive face to face.</td>
<td>• Listing all repairs needed may lead to increased expectations (but only Cat 1 &amp; 2 undertaken).</td>
</tr>
<tr>
<td>• Landlord accreditation – good.</td>
<td>• Handyman person.</td>
</tr>
<tr>
<td>• Up-take of activities (2) (opportunities for connecting, learning, giving, being active, taking notice).</td>
<td>• Partnership links – other organisations CAB, Homestart, Age Concern, Careline, employment etc</td>
</tr>
<tr>
<td>• Bogus callers.</td>
<td></td>
</tr>
<tr>
<td>• The elderly who may be asset rich but cash poor. (3)</td>
<td></td>
</tr>
<tr>
<td>• Limited / few facilities (locally).</td>
<td></td>
</tr>
<tr>
<td>• Cold (lukewarm calling).</td>
<td></td>
</tr>
<tr>
<td>• Number of properties people not in /out at work during the day (- ve).</td>
<td></td>
</tr>
<tr>
<td>• When HHP is in an SOA, the partners are there as well, increase response time to referrals (+ ve).</td>
<td></td>
</tr>
<tr>
<td>• People requesting that action is not taken.</td>
<td></td>
</tr>
<tr>
<td>• Not linking with important services e.g. neighbourhoods all RSLs (- ve).</td>
<td></td>
</tr>
<tr>
<td>• Improve links with GP &amp; commissioning.</td>
<td></td>
</tr>
<tr>
<td>• Reactive not proactive. Should be highlighting projected friends e.g. fuel poverty (-ve).</td>
<td></td>
</tr>
<tr>
<td>• Not joined up with neighbourhoods, elected members.</td>
<td></td>
</tr>
</tbody>
</table>

Other

- Addicts – provision for.
- Children’s centres:-
  - Language enrichment,
  - Parent/child bonding,
  - Confidence building.
- slow response from referrals / referrals processes to other agencies can cause necessary stress/confusion.
- Families living in more affluent areas may have their needs overlooked (eg due to stigma, domestic violence, PND, depression, mental illness, drugs/alcohol misuse).
- Safeguarding.
- Good response to referrals (+ve).
- Landlords only interested in receiving the rent – no apparent interest in the tenants needs. (-ve) (2)
- Programme supports mediation between landlords.
- Maximising income.
- More training required (-ve).

<table>
<thead>
<tr>
<th>Health impacts identified through the HIA process</th>
<th>Negative Housing issues as identified through the workshop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social isolation (8) (example - disabled person unable to leave house).</td>
<td>Damp,</td>
</tr>
<tr>
<td><strong>Access:</strong></td>
<td>Overcrowding (2),</td>
</tr>
<tr>
<td>o to housing maintenance services that react to need.</td>
<td>Cleanliness,</td>
</tr>
<tr>
<td>o to local community amenities/ networks. (older people may gain more independence). (+ve)</td>
<td>Lack education – healthy lifestyles (3),</td>
</tr>
<tr>
<td>o to other services. (+ve)</td>
<td>Drug/alcohol misuse,</td>
</tr>
<tr>
<td>o services – barrier with potential cuts to services (-ve) (3).</td>
<td>Antisocial behaviour,</td>
</tr>
<tr>
<td></td>
<td>Child protection issues,</td>
</tr>
<tr>
<td></td>
<td>Respiratory illness,</td>
</tr>
<tr>
<td></td>
<td>Poor decoration (poor state of mind MH),</td>
</tr>
<tr>
<td></td>
<td>Accidents (falls),</td>
</tr>
<tr>
<td></td>
<td>Improved insulation, reduced bills, improved health, comfy environment (2),</td>
</tr>
<tr>
<td></td>
<td>Substandard kitchens /bathrooms – infestation, lack food storage space, damaged work surfaces,</td>
</tr>
<tr>
<td></td>
<td>Lack of acoustic insulation – lack enjoyment, noise – aggression, can’t play TV or music, tension stress.</td>
</tr>
<tr>
<td>Overcrowding (4) cultural considerations.</td>
<td></td>
</tr>
<tr>
<td>Good mental health (2) / poor mental health.</td>
<td></td>
</tr>
<tr>
<td>Feeling of powerless.</td>
<td></td>
</tr>
<tr>
<td>Mental health &amp; well-being. (3)</td>
<td></td>
</tr>
<tr>
<td>Confidence.</td>
<td></td>
</tr>
<tr>
<td>High self-esteem.</td>
<td></td>
</tr>
<tr>
<td>Poor self-esteem / depression.</td>
<td></td>
</tr>
<tr>
<td>Emotional well-being (2) [comfortable in own home able enabling them to achieve +ve social and economical well-being].</td>
<td></td>
</tr>
<tr>
<td>Stress.</td>
<td></td>
</tr>
<tr>
<td>Pride - (2) (+ &amp; - to MH) / Lack of pride in home due to low self-</td>
<td></td>
</tr>
</tbody>
</table>
- Esteem, lost job etc
- Communication –
  - Not enough newsletters to partners (2),
  - Not feeding key findings to local partners,
  - Voice for people with poor awareness of local activities,
  - Between partners improves people’s lives,
  - Assumption everyone has a knowledge / understanding of their own health, unaware of the dangers e.g. ecoli.
- Physical health / exercise.
- Family networks – better future individuals and communities.
- Community spirit.
Table 9 Vulnerable Groups Identified Through the HIA Process

- BME (bi-lingual advocate Polish, Somali, Asian, Chinese. [reluctance to attend health services as certain cultures believe if you are going to get it then you are going to get it].
- Older people (special advocate), Unemployed, Single parents, 0 – 6
- Young people (harassment by youths, hypersensitivity to normal youthful behaviour)
- 55+
- Adults with MH issues
- People whose first language isn’t English (2)
- Those hard of hearing
- People with long-term conditions
- Disharmony between long term residents and short term residents (eg students).
- Multiple occupancy
- People from migrant communities living in poor conditions because rents are high.

Other comments in relation to vulnerable population groups
- Racial tension.
- More targeted to certain vulnerable groups (asylum seekers, refugees, homeless).

The following strategic determinants were prioritised at the most common through the HIA process.

Most ‘common’ Strategic Determinants Identified:-

- Social Isolation,
- Mental health,
- Education, including health literacy,
- Environment (internal and external),
- Overcrowding.
7.0 Impact Analysis

7.1 Introduction

Using the ‘hierarchy of evidence’ (as described below), specific health impacts were identified for each of the strategic determinants and analysed for its impact based on the strength of evidence.

The following four tables indicate potential health impacts and relevant evidence for each of the strategic determinants. Specific population groups also potentially at ‘risk’ from each of the strategic determinants have been included where identified through the literature and research. Mental health was a concurrent theme across each strategic determinant.

A pre-described hierarchy of evidence was examined against each piece of research explored to provide consistency.

Hierarchy of Evidence

Level I - Reviews of (systematic) reviews or meta analyses
Level II - Systematic reviews; reviews of several HIAs
Level III - Single studies or HIAs
Level IV - Expert witnesses (key informants)
Level V - Stakeholders

For clarity, each identified strategic determinant has been tabulated below.

Table 10

<table>
<thead>
<tr>
<th>Strategic Determinant - Social Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health impacts</strong>: sleeplessness, clotted arteries – link to cardiovascular disease; depression, loss of identity, self-esteem, sense of powerlessness, lack of independence, stress, mental health, difficulty accessing range of services, quality of life.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key messages from the evidence</strong>:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women, especially single women with or without children experience social isolation.</td>
</tr>
<tr>
<td>Single women, financial implications, unable to fund going out, pay for babysitter for example.</td>
</tr>
<tr>
<td>Single women find themselves isolated as they don’t have children.</td>
</tr>
<tr>
<td>Older Single women find themselves isolated as they don’t have children.</td>
</tr>
<tr>
<td>Prevention of social isolation better than cure.</td>
</tr>
<tr>
<td>Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strength of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>III</td>
</tr>
<tr>
<td>III</td>
</tr>
</tbody>
</table>

75Living in isolation: Women’s experiences of poverty and exclusion, Reid C and Ponic P, 2004
76Living in isolation: Women’s experiences of poverty and exclusion, Reid C and Ponic P, 2004
- A chapter (post 2006) highlights various issues relating to social isolation:
  - own space is as important and valuable as social interaction,
  - ‘Belonging’ is a multi-dimensional social construct of related to persons, places or things and is fundamental to personality and social well-being,
  - Apartness or aloneness often described as solitude may also be part of the concept of social isolation,
  - Social isolation may be voluntary or involuntary.

**Identified population groups:**
- Women,
- The elderly – expected aging population in Liverpool,
- Refugees,
- Those with mental health problems.

<table>
<thead>
<tr>
<th><strong>Strategic Determinant - Education</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health impacts:</strong> choice (particularly regarding risky lifestyle behaviour), sleep disorder impacts negatively on attainment, social engagement and participation, skills to access other services and facilities, experience years of good health, mental health and well-being, lower life expectancy, increased risk of death from lung cancer, stroke, cardiovascular disease and infectious diseases.</td>
</tr>
<tr>
<td><strong>Health impacts of health literacy:</strong> choice, empowerment, decision making, communication, low up-take of preventative services and reduced compliance with treatment, potential increased hospital admissions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key messages from the evidence:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Education can affect health in different ways at different stages of the life cycle. Level of education has been shown to have greater impact on mental health in younger age groups and physical functioning in older people.</td>
</tr>
<tr>
<td>- Research suggests that a good education can lead to increased good health.</td>
</tr>
<tr>
<td>- Associations between education and mortality are not new.</td>
</tr>
<tr>
<td>- Evidence indicates that there is a strong link between health and the determinants of health (such as health behaviours including risk behaviours and preventative service use).</td>
</tr>
<tr>
<td>- Low health literacy is very common.</td>
</tr>
<tr>
<td>- Health literacy can be defined as ‘the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.’</td>
</tr>
</tbody>
</table>

---

78 Preventing loneliness and social isolation: interventions and outcomes, Windle K, Francis J and Coomber C, Social Care Institute for Excellence (SCIE), (no date)
79 Chronic illness : impact and interventions,( Chapter 5), Social Isolation, Biordi, D and Nicholson, N, (www.jblearning.com/samples/076375126X/LARSEN_CH05_PTR.pdf)
83 Health information for patients: time to look beyond patient information leaflets, Colledge, A et al, jrsm.rsmjournals.com/content/101/9/447, 2008
84 National Network of Libraries of Medicine, Glassman, P, (website undated)
Health literacy is not just the ability to read but encompasses a much wider spectrum such as listening, and decision making skills and the ability to apply these skills.\textsuperscript{85}

Patients should have access to information delivered in the way they want it, with their information needs discussed during contact with health professionals.\textsuperscript{86}

Identified population groups –
- Older adults,
- People with lower socioeconomic status,
- Ethnic minority groups,
- People with long-term illness or disability,
- Population groups where English isn’t the first language,
- Cultural groups.

\begin{table}
\centering
\begin{tabular}{|p{1\textwidth}|}
\hline
\textbf{Strategic Determinant - Environment} (this is a generic word being used to describe internal and external environments [civic pride]).
\hline
\textbf{Health impacts:} -social relationships may be affected, stress, depression, range of medical health impacts such as heart disease, cancer, respiratory disease and injuries.
Indoor air quality – respiratory diseases.
Noise – sleep deprivation, depression, range of respiratory disease.
\textbf{Externally} – restricted play space can lead to mental health issues and behavioural problems, increased mortality, increase in blood pressure, community cohesion and social networks, depression and fear of perception of crime.
\hline
\textbf{Key messages from the literature:-}
- The evidence suggests that the burden of illness is likely to be greatest in lower socioeconomic groups and minority/vulnerable populations.\textsuperscript{87}
- The design of homes, schools, hospitals and other buildings can impact directly and indirectly on health.\textsuperscript{88}
- Evidence shows that the young and older population groups most likely to be affected as they are more at risk of economic hardship and lack of money to improve or maintain homes.\textsuperscript{89}
- Homeownership is often used as an indicator to reflect improved health, but the evidence suggests that there maybe some factors that may influence this such as difficulty in paying mortgage – could create negative impacts on health especially mental health.\textsuperscript{90}
\hline
\textbf{Identified population groups:}
- Ethnic minority groups,
- Those deemed to live in deprived areas,
- Older population,
- Younger population,
\hline
\end{tabular}
\caption{Table 12}
\end{table}

\textsuperscript{85} National Network of Libraries of Medicine, Glassman, P, (website undated)
\textsuperscript{86} National Network of Libraries of Medicine, Glassman, P, (website undated)
\textsuperscript{87} Dwelling Disparities: How Poor Housing Leads to Poor Health, Environ Health Perspective, Hood, E, 2005
\textsuperscript{88} Health Impacts of the Built Environment, Institute of Public Health in Ireland, Lavin T, Higgins C, Metcalfe O and Jordan A, 2006
\texttt{www.publichealth.ie/.../Health_Impacts_of_the_Built_Environment}
\textsuperscript{89} Independent Inquiry into Inequalities in Health (Acheson Report), Acheson, D, Department of Health, 1998
\textsuperscript{90} Health Impacts of the Built Environment, Institute of Public Health in Ireland, Lavin T, Higgins C, Metcalfe O and Jordan A, 2006
\texttt{www.publichealth.ie/.../Health_Impacts_of_the_Built_Environment}
Those living in older homes.

Specific to health literacy:
- Landlords,
- Partners to the HHP.

Table 13

**Strategic Determinant - Overcrowding**

<table>
<thead>
<tr>
<th>Health impacts:</th>
<th>Strength of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>mental health and stress, childhood TB, respiratory problems which are linked to loss of sleep, restricted physical activity and missed school, meningitis, increased risk of coronary heart disease in later life, almost half childhood accidents are associated with physical conditions in the home particular to domestic fires, links between overcrowding and cognitive development, depression especially for those in high-rise accommodation and respiratory health problems can be exacerbated by tobacco smoke.</td>
<td></td>
</tr>
</tbody>
</table>

**Key messages from the literature:-**
- A review concluded that there is a diverse nature of terminology in relation to overcrowding. No one definition is used regarding overcrowding and crowding. Some evidence relating to overcrowding considers the adequacy of personal space and for crowding 'objective measure of number of people per room in a dwelling,' which can also vary.
- Research relating to the impacts of overcrowding on mental health is less researched than on the physical impacts of overcrowding.
- People who may have poor health may have difficulty holding down or securing employment thus unable to afford suitable / appropriate accommodation and subsequently may end up living in overcrowded accommodation, likewise for people who are ill and who may require care and support from their families.
- There is a small amount of evidence on overcrowding and aspects of health on both adults and children. There is some evidence that overcrowding in childhood affects certain aspects of adult health.
- There is some limited evidence attributed to overcrowding and adult mortality rates particularly in woman.
- There does not appear to be any evidence exploring the impact of education from overcrowding on different ethnic groups.
- Research shows that there is limited evidence highlighting that individual perception between overcrowding on their health and well-being.
- There is inconclusive evidence surrounding overcrowding and accidents in the home. There is evidence of a relationship but its strength is unclear and that other factors such as social class and housing tenure appear to be more strongly associated with accidents in the home.
- There is no strong evidence of studies which measured the impact of interventions to reduce overcrowding with health improvements.
- There is limited evidence that poor housing and overcrowding can have an impact on crime rates.  

**Identified population groups:**
- Children,
- Unemployed or on incapacity benefit,
- Those with long term illnesses,
- Ethnic minority groups,
- Woman,
- Those in high rise accommodation.

---

91 The Impact of Overcrowding on Health & Education: A Review of Evidence and Literature, ODPM, 2004
8.0 Characterisation

The final part of the HIA process is to use all the evidence in order to characterise each strategic health determinant.

The characterisation criteria, (shown below in table 14), is used to ensure a structured approach to this stage of the HIA process. This criteria has been used since HIAs inception in Liverpool, back in the late 1990’s, as developed in the Merseyside Guidelines.92

<table>
<thead>
<tr>
<th>Table 14 Characterisation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health impacts</td>
</tr>
<tr>
<td>Direction of change</td>
</tr>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>Likelihood of impact</td>
</tr>
<tr>
<td>Latency</td>
</tr>
</tbody>
</table>

Speculative = may or may not happen; no direct evidence to support,  
Possible = more likely to happen than not; direct evidence but from limited sources,  
Probable = very likely to happen; direct strong evidence from a range of data sources collected using different methods,  
Definite = will happen; overwhelming, strong evidence from a range of data sources collected using different methods.

To characterise each strategic determinant the following question was asked for each one. The results are shown in table 15.

‘what influence will the Programme have on…(for example social isolation)?’ will the impact be a positive or negative?’

<table>
<thead>
<tr>
<th>Table 15 Characterisation of the Strategic Determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
</tr>
<tr>
<td>Social isolation</td>
</tr>
<tr>
<td>Environment (internal &amp; external)</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Overcrowding</td>
</tr>
</tbody>
</table>

9.0 Conclusion

9.1 Conclusion

The analysis of the evidence indicates that the Programme is having a positive effect on the health of the people in Liverpool whose houses are in poor condition, has improved.

However, the findings of the HIA have identified areas where a more focused approach is likely to have improved the health and well-being of residents of Liverpool.

9.2 HIA Process

In order to learn what worked and maybe didn’t work as well a brief ‘evaluation’ was undertaken by the researcher. The areas examined included the Brief of the HIA, the data collection and then used the SMART analogy to look at the wider aspects of the HIA.

The Brief – initially for this HIA the brief was straightforward, however, as the HIA progressed and through further discussions, it revealed a strong evaluation element of the Programme, which was agreed to be necessary to enable the HIA to support strategic planning.

The importance and necessity of this widening brief created a more complex piece of research.

Literature and Data Collection – given the broad remit of the HIA a substantial amount of literature was examined. In terms of data, particularly profile data - this proved to be a lengthy task as, whilst a substantial amount is collated, it is collected in differing formats and for different purposes.

The HIA was completed although the timescales were difficult to manage for a number of reasons including uncertainty over HIA Project funding and getting everyone to meetings, especially in current climate of organisational restructures.
**10.0 Recommendations**

In view of the aims of the HIA and the following evidenced recommendations are being recommended.

**Recommendation 1 - The Programme should be sustained.**

**Rationale**

In view of the established evidence supporting the positive association between decent housing and good health, there is a strong basis for a reliable prediction that the Healthy Homes Programme will achieve improved health for those residents living in substandard housing within Liverpool.

The collection of hard data around the health of individuals as a result of the Healthy Homes Programme was never part of the original remit of this Health Impact Assessment.

This continuation of the Healthy Homes Programme is supported by the tremendous progress that has been made, the potential long term savings to the NHS and the wider partners.

**Recommendation 2 - A review is undertaken of the partners.**

**Rationale**

In view most common health impacts identified through this HIA, it is recommended that an audit is undertaken of current partners involved in the Healthy Homes Programme. This will ensure that:

- a) the most effective partners to work in conjunction with the Programme are involved and
- b) provide a gap analysis of Partners, as the Programme has and is evolving to ensure the most relevant ones are included.

**Recommendation 3 – A working group be established to develop further ways of engaging with those who may be socially isolated.**

**Rationale**

It is recommended that a working group be developed to explore ways of engaging with those who may be socially isolated, for example giving radios to people who live on their own.

It is also recommended that partnership working with the Advocacy Rights Hub should be more focused as they host the Liverpool Family Services Directory which has a wide range of activities, clubs and organisations.

**Recommendation 4 – The Intervention Criteria currently used are continually renewed.**

**Rationale**

It is recommended that the Intervention Criteria is examined and refreshed to be more specific, based on the health impacts that have been identified.
The original criteria used was a good way to capture those most in need in large areas of Liverpool but using a more focused criteria will hopefully enable the Programme to engage with those who are hard to reach.

**Recommendation 5 – A Health Impact Assessment is undertaken on the Winter Warmth Programme.**

**Rationale**
It is recommended that a HIA is undertaken on the Winter Warmth Programme to ensure all vulnerable population groups are identified, especially if there are groups at risk within groups.

**Recommendation 6 – More work is undertaken to determine the issue of overcrowding in Liverpool.**

**Rationale**
As overcrowding has emerged as an issue whilst researching this HIA, perhaps consideration should be given to a more specific piece of research.

It is possible that different cultures may have differing perceptions of this subject.
A – Health Impact Assessment

Health Impact Assessment (HIA) is a globally recognised tool which is used to assess the health impacts, either positive or negative, of a strategy, policy or programme. HIA is a flexible tool and has a range of approaches as described below.

HIA also offers the opportunity to ‘potentially prevent negative health effects and maximise the positive health effects.’ It also supports the strengthening of partnership working between organisations.

People’s health is affected by a variety of factors, such as individual, social, economic and environmental. These factors are commonly referred to as the social determinants of health. It is these factors that HIA links and examines.

There are a range of options of the type and depths of HIA. The decision of which type and to what depth will be influenced by a number of scoping questions such as:-
- time,
- resources and
- HIA skills,
- along with the ‘type’ and the ‘when’ to undertake a HIA.

Types of HIA:-
- *Desk-top HIA* - Undertaken with limited resources, unlikely to include any community participation.
- *Rapid HIA* - Includes a broader evidence search and some community participation. Still undertaken with some constraints (such as limited resources and time).
- *Comprehensive HIA* - More in-depth and carried out over a longer period of time.

The “when” is an important factor to consider and will be determined by what stage the strategy, proposal or programme is at.

‘When’ to undertake a HIA:-
- *Prospective HIA* - Conducted before a proposal is implemented
- *Retrospective HIA* - Conducted after proposal implementation
- *Concurrent HIA* - Conducted during proposal implementation.
B – Health Impact Assessment Methodology

This chapter gives an overview of the generic methodology that has been used for this HIA. A brief explanation has been provided for each stage of the HIA process.

Figure 1 A generic HIA methodology (Abrahams et al, 2004)

Screening
This first stage initially assesses any likely health impacts that could occur with the implementation of a strategy, policy or programme and determine if a HIA is required. Generic screening will ensure a systematic approach to strategies, policies or programmes selected for a more in-depth HIA. It also requires the creation of a Steering Group ensuring there is a body that will take responsibility for the HIA.

A number of immediate considerations can be identified at this stage:-
- Understanding of the proposal,
- Likely health impact (either positive or negative),
- Capacity and resources required to complete the HIA,
- Limitations,
- Determination of the type of HIA to be undertaken (Desk-top, Rapid or Comprehensive).
Scoping

Completing the scope will set the blueprint of the HIA. The Steering Group will take responsibility for agreeing the Terms of Reference for the HIA. This will then enable the HIA to be guided. Aspects to be considered and involved within the Terms of Reference include: timescale, geographical boundaries, those to be involved in the HIA process (either as stakeholder or key informant) and dates (where possible dates of meetings decided). The scope will ensure the HIA kept on schedule and with meetings minuted and any barriers, difficulties or limitations that appear through the HIA process can be dealt with swiftly.

Literature Review

This stage involves the collation of a body of knowledge or key evidence and the systematic analysis of the potential impacts, their significance, the population groups likely to be most affected and the strength of evidence for these impacts.

A literature review should be undertaken to source robust evidence which supports or negates the potential health impacts that are identified firstly at the screening stage and then throughout the HIA process.

A literature review should still be regarded as part of the evidence gathering but some may be viewed separately for its initial purpose of setting the scene.

Evidence Gathering

Both qualitative and quantitative evidence can be used within HIAs. Anecdotal evidence within a HIA is as important and can often add to local health impacts that a policy, programme or project may have on local population groups.

Quantitative evidence for HIAs can usually be in the form of stakeholder workshops or smaller focus groups. Other methods of collating this ‘data’ can be collected through a range of other different methods such as questionnaires and Delphi studies or case studies, for example.

Qualitative evidence for HIAs usually consists of the following:-

Policy Analysis

A comprehensive policy analysis should be undertaken in order to set the context. National and local strategies and policies are examined for their relation to health in its widest context.

Profile (Community Profile)

The purpose of creating a community profile allows a localised picture to be created.

The broader the data collected is better – so not only specific health data collected but data that is broader in its relation to health, for example those who find themselves in fuel poverty, those in receipt of school dinners.

The data collected will be invaluable when identifying a range of factors relating to populations / communities such as size of population, age and gender structure, health status, educational attainment and lifestyle factors.

Data collected can be sourced from a number of data sets and if necessary can be
compared to National data.

Undertaking the profile can also help identify vulnerable population groups that may be affected that have been overlooked or missed.

Collating the Health Impacts

Once all the health impacts have been identified through the process described above, a theme analysis is usually undertaken or a consensus workshop to identify the priority, or most ‘common’ health impacts that could have an impact on health (either positively or negatively).

NB The literature review is part of the evidence gathering process but is carried out during the early stage of the HIA process to help develop topic / subject areas, backgrounds and new areas which may emerge.

Impact Analysis

As part of the impact analysis stage it may be that a more specific evidence search is required, for example, many on-going HIAs highlight social isolation as a main health impact, so further searches of the literature around this theme may be required.

Characterisation of the Impacts Identified

Characterising the impacts looks at certain characteristics such as direction of change (+ or -), the likelihood of the impact and given the evidence, when the impact could occur. The detail is shown in table 16 and description below along with an example of social isolation (table 17).

<table>
<thead>
<tr>
<th>Health impacts</th>
<th>The health determinants affected and the subsequent effect on health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direction of change</strong></td>
<td>Health gain (+) or health loss (-);</td>
</tr>
<tr>
<td><strong>Scale</strong></td>
<td>The severity (mortality, morbidity and well-being) and magnitude, where possible (size/proportion of the population affected)</td>
</tr>
<tr>
<td><strong>Likelihood of impact</strong></td>
<td>Definite, probable, possible or speculative based on the strength of the evidence and the number of sources</td>
</tr>
<tr>
<td><strong>Latency</strong></td>
<td>When the impact may occur</td>
</tr>
</tbody>
</table>

Speculative = may or may not happen; no direct evidence to support
Possible = more likely to happen than not; direct evidence but from limited sources;
Probable = very likely to happen; direct strong evidence from a range of data sources collected using different methods
Definite = will happen; overwhelming, strong evidence from a range of data sources collected using different methods.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Direction</th>
<th>Likelihood</th>
<th>Latency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td>+</td>
<td>Probable</td>
<td>Unknown (U/K)</td>
</tr>
</tbody>
</table>

Conclusion and Recommendations

The HIA report concludes with a set of evidenced based recommendations which, whilst SMART, should ensure they achieve the aim of the HIA.
C – Completed HIA Screening Pro-Forma for the Healthy Homes Programme

<table>
<thead>
<tr>
<th>Section A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Title of Strategy/Policy/Project (herein referred to as the Strategy)</td>
</tr>
<tr>
<td>Rapid Health Impact Assessment of the Liverpool Healthy Homes Programme</td>
</tr>
<tr>
<td>B) Date of screening - 10th June 2011</td>
</tr>
<tr>
<td>C) Name and contact details of policy proponent - Phil Hatcher (<a href="mailto:Phil.Hatcher@liverpool.gov.uk">Phil.Hatcher@liverpool.gov.uk</a>)</td>
</tr>
<tr>
<td>D) Is the Strategy new or existing (please underline as appropriate)</td>
</tr>
<tr>
<td>E) Is the Strategy of Liverpool Primary Care Trust/City Council/External (e.g. community) (please underline as appropriate).</td>
</tr>
<tr>
<td>F) Which Directorate/Portfolio does the Strategy ‘sit’ within (e.g Housing and Neighbourhoods) – Environment</td>
</tr>
<tr>
<td>G) Is the Strategy statutory? Yes/No (please underline as appropriate).</td>
</tr>
<tr>
<td>H) If yes where does it come from? N/A</td>
</tr>
<tr>
<td>I) Are there links to existing or proposed strategies? – Yes – see below</td>
</tr>
<tr>
<td>Housing strategy, Accident Prevention Strategy, Infant Mortality Strategy.</td>
</tr>
<tr>
<td>J) What is the purpose &amp; or aim of the Strategy? What is the rationale behind the Strategy (what is it trying to achieve, what are the Proposals expectations)? – to reduce health inequalities through Housing Improvement Programme.</td>
</tr>
<tr>
<td>K) At what stage is the Strategy at:- Scope/Draft/Review Stage/Final/Other (please underline appropriate stage)</td>
</tr>
<tr>
<td>L) What area/s is the Proposal intended to affect (be implemented) (please underline as appropriate)</td>
</tr>
<tr>
<td>• City Wide – Focusing on Specific Super Output Areas</td>
</tr>
<tr>
<td>• City &amp; North</td>
</tr>
<tr>
<td>• Alt Valley</td>
</tr>
<tr>
<td>• Liverpool East</td>
</tr>
<tr>
<td>• South Central</td>
</tr>
<tr>
<td>• South Liverpool</td>
</tr>
<tr>
<td>• Other – please specify.</td>
</tr>
</tbody>
</table>
**Section B** - Please answer the following screening questions to identify any known effects on health with the implementation of the Strategy.\(^{93}\)

<table>
<thead>
<tr>
<th>Screening Question</th>
<th>Yes/No/Unknown (Y/N/UK)</th>
<th>Justification/Description of likely health impact (– or +) (notes for all answers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Will the proposal have any positive impacts on the determinants of health?</td>
<td>Yes</td>
<td>Addressing fuel poverty will have a positive impact.</td>
</tr>
<tr>
<td>(b) Will the proposal have any negative impacts on the determinants of health?</td>
<td>Yes</td>
<td>Consideration of the negative impact of re-housing on mental well-being for people. Consideration of the negative impact of reduced accessibility to services. Concern that the Programme leads to landlords increasing property rents.</td>
</tr>
<tr>
<td>Include the impact on mental health wellbeing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Question 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any population groups likely to be affected by the Strategy (either positively or negatively)?</td>
<td>Yes</td>
<td>Landlords could be affected through enforcement Tenants in houses surveyed could see improvements to housing</td>
</tr>
<tr>
<td><strong>Question 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are any of the negative impacts avoidable and therefore unfair?</td>
<td>Yes</td>
<td>Finances restrict the project size</td>
</tr>
<tr>
<td><strong>Question 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any community concern/s over the Strategy?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Question 5</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any limitations (e.g. evidence base, profile data) from a HIA or Programme perspective?</td>
<td>Yes</td>
<td>It is difficult to measure direct outcomes due to other influencing factors and timescales it could take to make an impact</td>
</tr>
</tbody>
</table>

If answer yes or unknown to questions 1b, 2 or 3 then a HIA must be undertaken. Health impact assessment **Yes** / No (please underline as appropriate).\

Section C - This section enables the remit/blue print of the HIA to be developed.

1. Date HIA to be finished? 29th July 2011.

2. Name and contact details of those to be invited to the Strategy HIA Steering Group (suggest no more than 10); other people can be included as key informants:-
   - Phil Hatcher (phil.hatcher@liverpool.gov.uk)
   - Ian Watson (ian.watson@liverpool.gov.uk)
   - Chris Price (Chris.price@liverpoolpct.nhs.uk)
   - Hussein Khan (Hussein.khan@liverpool.gov.uk)
   - Trish Thomas (trish.thomas@liverpool.gov.uk)
   - Anju Rooney (anju.rooney@liverpool.gov.uk)
   - Kate Waller (kate.waller@liverpool.gov.uk)
   - Emma Maloney (Emma.maloney@liverpool.gov.uk)
   - Jane Nugent (jane.nugent@liverpool.gov.uk)
   - Ben Connolly (ben.connolly@liverpool.gov.uk)

3. Type of HIA to be undertaken (Bold as appropriate)

<table>
<thead>
<tr>
<th>Desk-top</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid</td>
<td>Concurrent</td>
</tr>
<tr>
<td></td>
<td>Retrospective</td>
</tr>
</tbody>
</table>

4. Are there any budgetary requirements/issues for undertaking the HIA (e.g. printing, venue hire etc)? if yes please give details. - Not budgetary but there needs to be some stakeholder involvement.

5. Reporting of HIA. To be sent to Responsible Director and HIA Officer plus Relevant committee/s – please list:
   - 2020 Stakeholder group
   - Commissioners
   - Other stakeholders
   - LCC Director and Assistant Director

   With proposal to relevant Board – please list:
   - Health and Well-being Board.

6. How will the recommendations be implemented (e.g. inserted into action plan, fed into new Proposal). Recommendations will be used alongside the Healthy Homes Business Plan.

7. Who will be responsible for undertaking the implementation of the recommendations? Phil Hatcher.

8. Are there any training/up-skilling requirements to carry out this HIA?*94
   - 2 hour briefing session – Yes / No
   - ½ day awareness raising of HIA – Yes / No
   - 1 day HIA training course (10am till 4pm) – Yes / No
   - Would the HIA benefit being undertaken by an Action Learning Set (ALS) – Yes / No

9. Dissemination of HIA - TBC

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*94 Those involved In the HIA required no further up-skilling as the HIA was undertaken by the HIA Researcher.
## D – Policy Analysis

<table>
<thead>
<tr>
<th>Strategy/policy</th>
<th>Date</th>
<th>Lead Agency</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every Child Matters.</td>
<td>2003</td>
<td>Department for Education</td>
<td>Security, family life, danger, risk, non-separation of services, educational failure, anti-social behaviour, ill health.</td>
</tr>
<tr>
<td>Liverpool Sustainable Community Strategy ‘Liverpool 2024 A thriving International City.’</td>
<td>2010</td>
<td>Liverpool First</td>
<td>Transport, employment, housing, environment, crime and community cohesion.</td>
</tr>
<tr>
<td>Decent Homes.</td>
<td>2010</td>
<td>National Audit Office</td>
<td>Housing conditions, decent standard, funding (sustainability of funding), quality if housing management increased tenant involvement, empowerment and control, vulnerable households.</td>
</tr>
<tr>
<td>Neighbourhood Renewal Strategy.</td>
<td>2001</td>
<td>Cabinet Office</td>
<td>Unemployment, educational failure, crime, social exclusion, literacy and numeracy, housing &amp; physical fabric of</td>
</tr>
<tr>
<td>Document Title</td>
<td>Year</td>
<td>Author/Department</td>
<td>Key Points</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>------</td>
<td>---------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Choosing Health White Paper.</td>
<td>2004</td>
<td>Department of Health</td>
<td>Health inequalities, lifestyle choices e.g. smoking, obesity and improved mental health &amp; well-being.</td>
</tr>
<tr>
<td>The Way Forward for Housing.</td>
<td>2000</td>
<td>Department for Environment, Transport, Regions</td>
<td>Quality, choice, control, better homes and services, independence, protection of the vulnerable, social inclusion, improved housing standards, fuel poverty.</td>
</tr>
<tr>
<td>Lifetime Homes, Lifetime Neighbourhoods, A National Strategy for Housing in an Aging Society.</td>
<td>2008</td>
<td>Communities and Local Environment</td>
<td>Inclusiveness, neighbourhoods &amp; communities, access to facilities, civic pride, improved housing quality and housing options.</td>
</tr>
<tr>
<td>NHS White Paper.</td>
<td>2011</td>
<td>Department of Health</td>
<td>Access to information, control, choice.</td>
</tr>
<tr>
<td>The Joint Strategic Framework for Public Health: 2009-12.</td>
<td>2012</td>
<td>Liverpool PCT</td>
<td>‘Mental Health is everyone’s business.’ An integrated framework for mental health and well-being for Liverpool that recognises that mental health is a whole population issue.</td>
</tr>
</tbody>
</table>
E - Community Profile

Liverpool Specific Profile Data

This section of the HIA brings together a range population data for Liverpool, primarily using the Liverpool Joint Strategic Needs Assessment (JSNA) 2010 and the more recent JSNA 2012. Data is ‘topped up’ with data from previously compiled data from recent HIAs undertaken in Liverpool and Liverpool Annual Monitoring Report, along with any data already obtained and collected by the Healthy Homes team.

This will provide a snapshot of the demographics of the population groups, including those who are most vulnerable, and taking into consideration the age groups and expected aging population within Liverpool.

The health and social care priorities as stated in the JSNA for Liverpool are as the previous year, these include:-

- Cancers
- Heart Disease
- Mental health
- Respiratory Diseases
- Impacts of Alcohol
- Health inequalities within Liverpool and between Liverpool and elsewhere

The Health and Well-being Board will focus on the following four priorities:-

- Reducing the impact on child poverty,
- Reducing cancer deaths,
- Reducing the impact of alcohol and
- Improving mental health.

Liverpool and deprivation – context.

Liverpool has a long and well documented history of health inequalities and continues to be the most deprived local authority area in England on the Index of Multiple Deprivation (IMD).95

The IMD is used as the accepted method of measuring deprivation. It combines a number of indicators which cover a range of economic, social and housing issues, into a single deprivation score.96

At Lower Super Output Area’s (LSOA’s) – areas with a population of approximately 1,500 – Liverpool has 29 LSOA’s with 51% of these being in the most deprived 10% in England. This is more than any other local authority in the UK.

Regarding life expectancy boys born in Liverpool today are expected to live three years longer as opposed to 10 years ago, with girls expected to live two years longer.

However, women have the second worst life expectancy in England and Wales at

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95 Annual Report of the Joint Director of Public Health, Liverpool Primary Care Trust, NHS, 2011-2012
79.2 years, as compared to men who are fifth worst in the country at 74.8 years.

Across the city the life expectancy gap is 11 years for men and 8.1 years for women. Mortality rate for deaths from all causes for all ages ranks third worst (nationally) with a rate of 752.7 deaths per 100,000 (2008 / 2010) as compared to the Northwest as 603.1 and England 533.3.

Infant deaths – it is recognised that children from less affluent households are more likely to die before their first birthday. 2008 / 2010 data indicates that Liverpool had 5.2 deaths per 1,000 live births.\textsuperscript{97}
General Liverpool Population

- Liverpool population 445,800 (2012) and is projected to increase to 465,600 by 2033 – an expected increase of 4.4%.
- The city’s population has increased by almost 1% since 2002. Most notable increase in age groups are the 20-24 year age group (a 31% increase) and the 25-29 age group, (46% increase).
- In lower age groups the 0-4 age group has seen an increase, whereas the 5-14 age group has decreased.
- The population is expected to age quite significantly over the next 20 years with the 65+ year’s population projected to increase by a third.
- Liverpool has a small but growing BME population. Currently BME residents account for approximately 9.0% of Liverpool’s overall population.
- During 2011/12 13,226 people received social care from Liverpool City Council, approximately 4% of the adult population of Liverpool, the majority (68%) being people over 65 years. The most common primary need group is Physical Disability (71%) followed by Mental Health, inclusive of dementia, with 16%.

Housing and housing related data

The 2011 Census indicates:

- 46.9% Liverpool households are owner occupiers.
- 27.8% households rent their homes from a social landlord, with 23.4% renting from a private landlord.
- Private renting has doubled between 2001 – 2011 – a fast growing area of rental, growing at 96.3% as compared nationally to a growth rate of 82.1%.
- In terms of social rented housing – more than a quarter of all housing in Liverpool is social housing, and in three wards this is more than half of all housing.
- Geographically, conditions are worst within the City and North Neighbourhood Management Area. Housing conditions within the Registered Social Landlord (RSL) sector are significantly better than equivalent conditions in the private housing sector across all components of the decent homes standard. 6.1% of RSL dwellings exhibit category 1 hazards on the HHSRS compared to 13.1% of dwellings in the private sector. 24.0% of RSL dwellings are non-decent compared to 33.2% of dwellings of the private sector.

(Source: Socio-economic Classification – this has been determined using the Mosaic Public Sector Profiler, this is a postcode classification tool which uses 400 data indicators to classify citizens into 15 broad Groups and a further 69 Types. In summary, this shows 27% of households in Mosaic Group ‘O’, more than 5 times the national proportion. This group is characterised by low income, high unemployment, long-term illness and one parent families. The second largest group is ‘Young, well-educated city dwellers’ highlighting the large young and student population in Liverpool.

Housing – housing conditions – These have improved significantly across the city, shown by comparing the survey of decent homes standards of 2010 against the previous one from 2006. The number of unfit dwellings has reduced from 9,800 to 8,030 (a reduction of 18.1%) and the number of non-decent dwellings has reduced by 28.8% from 63,000 dwellings to 44,855.
- However, there are some concerns over conditions in the private sector with 9,143 dwellings being non-decent, 19,369 having Category 1 Hazards within the HHSRS and 32,578 dwellings failing the repair requirements of the decent home standard.
- Fuel poverty - Liverpool has the worst overall rate in the country at 7.5% (with some wards approaching 50%). According to the Department for Energy and...
Climate Change. Liverpool has just under 1 in 5 households living in fuel poverty (2011). This equates to 19.3% or 37,800 households.

Healthy Homes Programme Data Collection.

- **Priority properties (2012)** - 25,000 properties have been identified in priority need.
- **Poor housing conditions (BRE 2007)** - cause up to 500 deaths and around 5,000 illnesses requiring medical attention each year in Liverpool.
- **Rented properties** (Stock Condition Survey, 2006) - 5,500 contain in the region of 7,500 category 1 hazards.
- **Excess winter deaths** - there are, on average, 242 deaths per year in Liverpool and for each winter death, there are eight emergency hospital admissions.
- **Accidents** within the home account for half of all accidents which is equal to 77 deaths per year in Liverpool. Data collected suggests:
  - Accidents in 2008 were the 6th highest cause of death (154).
  - 4th accident related mortality in the country.
  - 2nd highest accident related hospital admissions in country in 2007 / 08 (8033).
  - 50% of accident mortality was caused by falls in 2008.
  - Hospital admissions for falls higher in most deprived areas.
  - 90% falls causing mortality was in the over 65 years age range in 2007 (522 hip fractures in older people).

Other socio-economic related Liverpool Data

- **Worklessness** – Liverpool’s unemployment rate is two thirds higher than the England rate.
- **Homelessness** – as at the end of July 2011, Liverpool only had 39 statutory homeless people, in temporary accommodation, along with a record low number of rough sleepers.
- **Children living in poverty** – recognising the importance to give every child a good start in life and the impacts this can have on their futures, on average 1 in 5 children in the UK are classified as living below the poverty line, Liverpool has 1 in 3 children living in poverty, 13th highest of all local authorities in the UK, and equating to 30,000 children.
- **Smoking during Pregnancy** – The JSNA makes reference to the likelihood that babies from deprived backgrounds are more likely to be born to mothers who smoke as well as being exposed to second hand smoke. Smoking during pregnancy can cause a host of problems from lower birth weight to perinatal mortality. Although prevalence remains relatively high, Liverpool has reduced the proportion of mothers who smoke by the time of delivery by more than 25% since 2005/6.
- **Breastfeeding** – evidence shows that breastfeeding has positive health benefits, just over half of mothers in Liverpool start breastfeeding as compared to three quarters nationally. This appears to drop at the 6-8 week period to just a quarter of mothers.
- **Childhood Weight** – based on data collected through the National Child Measurement Programme (NCMP), in 2010 obesity rates had risen for boys to 12.5% and for girls to 11.6% - reception class data collection. For Year 6, by 2010 obesity rates for boys and girls had risen to 22.6% and 19.7% respectively.
- **Educational Attainment** – Pupils gaining 5+ GCSEs Grade A – C in Liverpool has risen from 37% (2006) to 60% (2011) an increase of 62%.
- Not in Education, Employment or Training (NEET) – 11.5% of 16-18 year olds in Liverpool are NEET, the third highest in the country.
- **Childhood Accidents** – Emergency Hospital Admissions for accidents to children has risen by almost a quarter between 2004/5-2010/11.
- **Teenage Pregnancies** – Liverpool experiences a higher rate of teenage pregnancies.

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101Liverpool Joint Strategic Needs Assessment (JSNA), Liverpool City Council & Liverpool Primary Care Trust, 2012
conceptions, higher than both regional and national rates, although since 1999 Liverpool has seen an overall reduction.

- **Cancer** – There were 1,374 cancer deaths in Liverpool, 2010.
  o 301 were attributable to lung cancers,
  o 9% were colorectal cancers and
  o 7% breast cancers.

- **Smoking Prevalence** – Liverpool has seen a decrease in smoking prevalence from 35% (2005) to 25.9% (2011).

- **Adult obesity** – data estimates that 22.9% of Liverpool adults are obese.

- **Cancer Screening** –
  o Breast – 2010/11 – 69% of eligible women had screening.
  o Cervical – 2010/11 – 73% of eligible women were screened.

- **Alcohol** –
  o Bing drinking – it is estimated that 22.6% of adults in Liverpool binge drink, compared to the national average of 20.1%.
  o Alcohol Related Hospital Admissions – data for 2010 / 11 shows that Liverpool’s admission rates were slowing and data for 2012 indicates rates are starting to fall. Liverpool is now ranked sixth worst in the Country.
  o Alcohol Related Mortality – alcohol contributes to deaths from Chronic Liver Disease (CLD), analysis of data suggests that between 2006-2010 Liverpool has a directly age standardised mortality rates of 20.94 years per 100,000 of its population, twice the national average.
  o Alcohol Related Crime – analysis suggests that Liverpool has seen a decline in number of alcohol related recorded crime at a rate of 6 per 1,000 (2010/11).
  o Alcohol Related Incapacity Benefit – Liverpool has 540 claimants and is 23rd highest rated in the Country.

- **Mental Health** – for 2010/11, 13.5% of Liverpool patients 18+ years were on the register for depression, equating to the 31st highest in the Country. The prevalence of more serious mental illness was 1.1% (2010/11) as compared to 0.8% for England.
  o Dementia – the proportion of the Liverpool population suffering with dementia is 0.48%, which is the same as national figures. With an expected rise in aging population of over 65+ being diagnosed with dementia is expected to increase to 42% by 2030.
  o Suicide deaths – since 2000 there has been an average number of 25 deaths, lower than national and regional rates, however, there is some concern of the potential impact on mental health due to the current economic downturn.

- **Welfare Reforms** – recent welfare reforms will have a substantial impact on residents in Liverpool. Areas expected to have the most impact include:-
  o Residents will have to pay towards Council Tax,
  o Housing Benefit (Bedroom Tax) – likely to affect 11,600 Liverpool residents,
  o Housing Allowance – likely to affect 65,000 residents in Liverpool.102

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102Wider Determinants; Housing and Homelessness, Liverpool City Council 2013
F – Workshop Summary

A HIA workshop was undertaken on Wednesday 13th July 2011 at the Isla Gladstone venue in Stanley Park. It was held as part of a wider Healthy Homes Programme (HHP) stakeholder event.

Sophie Grinnell (SG) HIA Facilitator gave a brief overview about HIA & what it was. It was explained that this HIA was part of a wide programme across Liverpool to Capacity Build for HIA, looking at all policies, strategies and programmes that are being produced across Liverpool Primary Care Trust (LPCT) and Liverpool City Council (LCC) which is currently funded by LPCT.

A small number of people had heard of HIA & an even smaller number had actually been involved in HIA. This gave some immediate guide as to how to run the rest of the workshop.

Following on from the slides about ‘What HIA is?’ Chris Price (CP), Health & Wellbeing Partnership Manager gave his positive feedback from past experience with undertaking a HIA on the Detached Sports Programme. This gave a valuable insight to being involved in the process. Direct links were made to the Decade of Health & well-being and the Five Ways to well-being.

The stakeholders (listed in appendix), who were already in small groups, were asked to complete tasks 1-3.

**Task 1**

They were asked to consider the health impacts of housing and health, either positive or negative and put each one down individually on a post-it note. They were given approximately 20mins to do this in order to start thinking about the impact of housing on health in its widest sense.

An additional task to this was then to consider any particular population groups that maybe affected by these health impacts.

**Task 2**

In task two the stakeholders were asked to look at what is working well for the programme and what is not working so well. The idea behind this task was to explore if there were any gaps in the programme, particularly from a range of various stakeholders. Again with a consideration to any particular population groups. This task again was given about 20mins.

**Task 3**

A shorter task (approximately 10mins) the groups were asked to identify the three main priority health impacts from their discussions over the previous two tasks.

Upon completion of all three tasks each table fed back one of their three priorities to the rest of the stakeholders.

SG then explained the next steps and how this information would be fed into the HIA along with feeding back the HIA at the next stakeholder event.

Everyone was thanked for their input.
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