Prospective Desk-Top Health Impact Assessment of the Liverpool Selective Landlord Licensing Scheme 2014.

Report authored by:-

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Acknowledgements

Many thanks go to Phil Hatcher, Programme Manager (Healthy Homes), for commissioning this piece of research and to Iain Crawford, Housing Project Officer Licensing, who actively took on the task of being involved in the HIA.

Many thanks go to Francesca Bailey for proof reading 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.

**Purpose of the HIA.**

The purpose of this HIA is to examine likely health impacts - positive or negative - of the Liverpool Selective Landlord Licensing Scheme by offering an independent, systematic and robust analysis of the likely impacts of the implementation of the scheme, 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 is undertaken as a *Prospective Desk-top HIA*. This report will describe the scope of the HIA, including methods and process, the data collected and the evidence defined by this data.

The assessment section of the report brings together a range of evidence, including a literature review, policy analysis and a localised demographic profile. Based on the evidence collected a set of recommendations are proposed.

The following recommendations are advised:-

**Recommendation 1**  
Develop and Deliver a Communication and Media Strategy with a Focus on the Social Determinants of Health.

**Recommendation 2**  
Promote a Tenants Network

**Recommendation 3**  
Promote a Landlords Network

**Recommendation 4**  
Develop a ‘Scheme’ Evaluation Tool.

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1 European Centre for Health Policy, Gothenburg 1999
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1.0 The Liverpool Selective Landlord Licensing Scheme

1.1 Introduction

This Health Impact Assessment (HIA) was undertaken on the proposed Liverpool Selective Landlord Licensing Scheme (referred to as the Scheme) through the Liverpool HIA Capacity Building Project. The HIA was overseen, researched and authored by HIA Research Fellow, Sophie Grinnell.

1.2 The Aim and Purpose of the Liverpool Selective Landlord Licensing Scheme

The Liverpool Selective Landlord Licensing Scheme has the aim to:

‘Drive up standards in the growing Private Rented Sector within its housing market.’

With the objectives to:

- The licence conditions will improve standards of tenancy management.
- Citywide licensing will create a level playing field promoting an understanding among residents about what they can reasonably expect from their landlord.
- Poor landlords will be isolated and therefore easier to identify.
- Licensing will promote greater confidence in the rental market and improve demand.
- The Council will be better placed to engage positively with landlords to tackle low demand and neighbourhood blight.

1.3 Background to Selective Landlord Licensing Schemes

The Housing Act, 2004, introduced the ‘selective licensing of private landlords scheme’ within the local housing authority’s area.

The idea behind this scheme is ‘intended to address the impact of poor quality landlords and anti-social tenants’ with a primary focus on tackling areas with low housing demand.

Areas deemed to be of low demand housing are often shown by high vacancy rates, rapid turnover, short or absent waiting lists and low, or falling house prices and can occur across all housing tenures.

The evidence strongly suggests that there is a significant pattern of neighbourhood dissatisfaction which corresponds to areas from which people are moving away and where housing demand is low.

Low demand areas are often also associated with negative stereotyping of an area – this stereotyping can lower residents ‘quality of life.’ Other issues highlighted by a report by the Joseph Rowntree Foundation conclude that in these areas people often move frequently and then with the tag of being bad tenants or disruptive but often they are the ones fleeing from harassment or other such issues.

Clarification of ‘Areas of Low Demand Housing’

Local authorities apply for areas for selective licensing which are subject to areas of low demand for housing or suffer from anti-social behaviour.
This report also highlights concerns raised over having a strong sense of community, which in the main is seen as a positive impact. However, it can create problems if people find it difficult to integrate into such communities and who then may move to different areas creating areas of low demand.

These areas of low demand have also given private landlords the opportunity to purchase properties, with many of these landlords being stated as unprofessional or ‘rogue’ landlords.

A number of studies have been undertaken to identify reasons why areas fall into low demand housing and have summarised that whilst there are a number of reasons, from houses being boarded up and being unable to sell, to changes in the employment, economic and demographic make-up. These studies have uncovered ‘critical factors driving actual abandonment’ and include:-

- History and reputation of an area which deters newcomers,
- The decayed environment, especially where there are boarded-up and abandoned homes and other buildings,
- Easy access to better housing in better neighbourhoods,
- Management problems facing local authorities and
- The gradual breakdown of social stability leading to anti-social behaviour, crime and fear.

One driver to get such areas and communities back into full healthy use is due to the demand for housing. Nationally, four million homes are required over the next twenty years, and figures indicate that there is a need for a further 90,000 houses in the rented sector.

There are a number of similarities of this scheme as with others such as Houses in Multiple Occupation (HMOs). HMOs provide accommodation to a range of tenants, often who are vulnerable, across Local Authorities in England. This accommodation can often vary in standards and often in obligations but is seen as an option for those with limited housing options. A house is classed as a HMO if there are at least three tenants living there forming more than one household and there are shared bathroom and kitchen facilities. In 2010 it was reported that there were between 236,000 and 379,000 HMOs in England.\(^2\)

Mandatory landlord licensing was introduced in 2004 for HMOs. The scheme works by making sure that all private landlords obtain a license for each property they own. Failure to do so or if they do not achieve ‘acceptable management standards’ can be subject to enforcement action being taken against them by the Local Authority, which can include fines or worst case scenario, being removed from the control of the management of the property or properties.

The licensing scheme is linked to the Government anti-social behaviour agenda. Whilst this tends to occur in areas with low demand housing it is not just these areas that suffer and therefore the scheme will be available to all areas in order to tackle anti-social behaviour.\(^3\)

An evaluation of the impact of the HMO licensing scheme was undertaken by the BRE (Building Research Establishment) in 2010. A summary of issues is shown below:-

- The private rented sector is a complex and diverse area of housing. There also appears to be good top end rental properties to meet the needs of young professionals.
- There is a dominance of small portfolio landlords.
- There are a certain amount of inexperienced landlords, often forming part of the

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\(^2\) Private Renting www.gov.uk

\(^3\) Adviser Magazine November/December Edition, 2005
‘middle’ PRS where standards are neither very good nor very bad.

- Landlords with larger portfolios were often more professional and business focused.
- Indications are that areas with poor housing stock, normally pre 1919 Victorian terraced housing, often had a concentration of private rented stock occupied by the poorest households, where conditions and management was also poor.
- PRS, which saw high numbers of migrant workers, saw different issues such as overcrowding and inappropriate housing.\(^4\)

Summary of the issues from the evaluation of the HMOs licensing scheme include:-

- Accommodation standards can vary,
- The majority of Local Authorities (83%) had received applications for mandatory licences,
- There is concern relating to the number of landlords not having applied for a licence,
- Fees and potential discounts differed between Local Authorities,
- Over 50% of Local Authorities reported a positive effect from the licensing. This included ‘physical condition of properties, the quality of management and the quality of accommodation,’ indicating a positive change.\(^5\)

A Health Impact Assessment undertaken on the Leeds Landlord Accreditation Scheme – a voluntary scheme which landlords are encouraged to join. This scheme aims to encourage good standards of privately rented accommodation. The HIA found:-

- The properties of those whose landlords were engaged in the scheme were in better condition and tenants experiencing better health,
- Generally tenants are unaware of the scheme,
- Very few properties in areas of deprivation are covered by the scheme.\(^6\)

### 1.4 Housing and the Private Rented Sector

Housing and its impact on health have been acknowledged and understood for over 100 years. Poor housing has been the cause of many infectious diseases due to poor quality construction, inadequate infrastructure and overcrowding. Currently, England is suffering from a major housing crisis, driven primarily by the lack of affordable housing. With a growing, and aging population, the way forward to eliminate this crisis is to ensure enough decent quality housing to meet different and rising needs.\(^7\)

Housing tenure can be defined as the ‘legal status under which people have the right to occupy their accommodation.’

The most common forms of tenure are:-

- Home ownership – which includes those homes mortgaged or owned outright and
- Rented – which includes both social rented housing and private rented housing.\(^8\)

\(^4\) Evaluation of the Impact of HMO Licensing and Selective Licensing, Communities and Local Government, BRE, 2010
\(^5\) Evaluation of the Impact of HMO Licensing and Selective Licensing, Communities and Local Government, BRE, 2010
\(^6\) Health Impact Assessment of the Leeds Landlord Accreditation Scheme, Swift, J. D., Dolman, M, 2007
\(^8\) Housing Tenure, Shelter, 2009
Social rented housing is often owned, provided and managed by housing associations (who are independent and not-for-profit organisations) or Local Authorities, and often with lower affordable rents and on a secure basis to those who are most in need, based on an allocation scheme, or struggling with their housing costs.9

The Private Rented Housing sector has been in decline for some years but is now starting to improve and is seen as part of the solution to the housing market.10 The Private Rented Sector (PRS) offers flexible tenures and can meet a wide range of housing needs.11

Although part of the solution for the housing market the nature of this section of the market can be difficult. Often there are poor quality homes, the areas are also of poor quality with tenures unmanaged and unstable for tenants. It is often seen as the ‘third’ option behind owner occupation and social renting.12

Now, through the 2004 Housing Act, the Landlord Selective Landlord Licensing Scheme aims to bring about mandatory change which will require all private landlords to have a licence by ‘addressing the impact of poor quality private landlords and anti-social tenants,’ primarily in identified areas of low demand housing.13

### 1.5 Background to Liverpool’s Selective Landlord Licensing Scheme

Currently Liverpool operates a voluntary landlord accreditation scheme, CLASS which gives public recognition for being a good landlord. This scheme, which is free, is for private landlords and is voluntary with no obligation to join. Being accredited by this current scheme will promote them as a good and suitable landlord to their prospective tenants.

The proposed Selective Landlord Licensing Scheme (the ‘Scheme’) plans to work with local landlords within the growing Private Rented Housing Sector to ensure good quality housing, which is managed to a high standard. This scheme has been brought to the fore as the City Council has concerns about the number of landlords that ‘rent properties which fail to meet satisfactory standards of tenancy and property management.’ It is proposed that each licence will last for five years.

Liverpool has seen a significant increase in the size of the Public Rental Sector over the last ten years, with the number of private households renting increased from 23,243 (in 2001) to 48,290 (2011).

Liverpool finds itself with continuing areas of low demand housing (areas which have become ‘no-go’ areas and ‘unpopular neighbourhoods’14) which, together with the growing PRS are contributory factors having negative impacts on the housing market, which is exhibiting vulnerability in terms of vacant properties, low house prices and depressed rental values.

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10 The Private Rented Sector: its contribution and potential, Rugg, J, Rhodes, D. Centre for Housing Policy, University of York, 2008
12 The Private Rented Sector: its contribution and potential, Rugg, J, Rhodes, D. Centre for Housing Policy, University of York, 2008
13 Selective Licensing of Privately Rented Housing, House of Commons, W, Wilson, 2013
The recently produced Liverpool Housing Strategy\textsuperscript{15} sets out a co-ordinated approach that places investment in housing at the heart of Liverpool’s future economic prosperity, which includes a, ‘vibrant and well managed’ PRS. This will have a vital role in meeting a number of the strategic housing priorities which include improved housing conditions, better access and choice for residents, home energy efficiency and reducing the number of empty homes.

The scheme intends to engage and work with local landlords who are already in place with the landlord accreditation scheme (CLASS) and the Private Landlord Forum, building on this commitment with a Ten Point Pledge. A comprehensive City wide licensing scheme will drive ‘a consistent level of property management among all private landlords.’

1.5.1 Conditions of the Liverpool Licensing Scheme

- **Mandatory Conditions:**
  - All occupiers provided with a tenancy agreement detailing the terms relating to their rental property,
  - Licence holder to ensure correct certification for gas installations and all electrical equipment tested,
  - Smoke alarms installed along with necessary firefighting equipment,
  - Licence holder to ensure all furniture supplied is safe and conforms to current fire safety legislation,
  - Licence holder should be a ‘fit and proper person’ as specified in the Housing Act, 2004,
  - References are required from potential tenants and it is the responsibility of the Licence holder to ensure these are obtained.

- **Further to the above conditions the following are included:**
  - Tenancy agreements will include a clause relating to anti-social behaviour
  - The licence holder will be responsible to ensure any remedial work is undertaken at the start of a tenancy, this will include dealing with any pest problems,
  - Property inspections are carried out every six months,
  - The license holder will not allow overcrowding (as far as possible),
  - Licence holder must be a UK resident,
  - The licence holder to ensure exterior features of any houses are kept in good repair,
  - Adequate internal facilities are provided (for example bathroom and kitchens),
  - Tenancy agreement packs are provided,
  - Licence holder should inform the licensing team of any changes to the licence holder (for example change of address, telephone number).

1.6 Delivery of the Liverpool Selective Licensing Scheme

If the scheme is approved in Liverpool, it will be delivered by the Housing Department, supported by other departments within the City Council, and external partners such as fire and police services.

It is envisaged that there will be an initial 3-6 month start up time for landlords to get their licenses, after which it will be a requirement for all landlords to have their licenses. Compliance visits to those without licenses at this point will be undertaken on a targeted approach. Enforcement will be carried out for those it is deemed necessary.

\textsuperscript{15} Liverpool Housing Strategy 2013-2016 www.liverpool.gov.uk
The expected cost per license and this was put out to consultation was £500 per licence – this being based on a paper system. However, this would likely change once an on-line system goes live.

1.7 Aim of the Health Impact Assessment

The aim of this HIA is to identify the likely health impacts of the Liverpool Selective Landlord Licensing Scheme based on two research questions:-

1. Does low demand housing areas impact on people’s health?
2. Will the licensing scheme have positive or negative impacts on people’s health?

The purpose of this HIA report is to provide a systematic and robust analysis of the Scheme in order to support the consultation of the Scheme being undertaken by the City Council.
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."\(^{16}\)

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.’\(^{17}\)

2.1 Health Impact Assessment

HIA 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.\(^{18}\)

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.

See Appendix A for further detail of HIA and HIA methodology.

\(^{16}\) World Health Organisation, 1946
\(^{17}\) Ottawa Charter for Health Promotion, 1986
\(^{18}\) Health Impact Assessment Toolkit for Cities Document 1, Vision to Action, WHO, 2005
3.0 Assessment of the Scheme

3.1 Health Impact Assessment Methodology

3.1.1 Screening

The Scheme was screened using the Liverpool Screening Tool. The purpose behind screening the Scheme 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 Scheme was undertaken by HIA Research Fellow/facilitator and Iain Crawford, Liverpool City Council Housing Project Officer Licensing.

The first stage of the screening process develops an understanding and builds a picture of the Scheme being assessed.

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 develops 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 Scheme can be found in Appendix B.

Table 1, shows the initial health impacts identified through the screening process for this HIA.

<table>
<thead>
<tr>
<th>Health Impacts Identified through the Screening Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Decent Homes</td>
</tr>
<tr>
<td>• Improved neighbourhoods</td>
</tr>
<tr>
<td>• Increased Rents</td>
</tr>
<tr>
<td>• Improve Confidence for occupants</td>
</tr>
<tr>
<td>• Overcrowding (+ and -)</td>
</tr>
<tr>
<td>• Possibility of homelessness</td>
</tr>
</tbody>
</table>

3.1.2 Scoping

The aim and objectives for the HIA were also developed at the beginning of the HIA process, allowing for some ownership of the HIA for those directly involved.

<table>
<thead>
<tr>
<th>Aim:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To identify the positive and negatives health impacts of the</td>
</tr>
<tr>
<td>Selective Landlord Licensing Scheme.</td>
</tr>
</tbody>
</table>

The purpose of this HIA report is to provide a systematic and robust analysis of the Scheme in order to support the consultation of the Scheme being undertaken by the City Council.

<table>
<thead>
<tr>
<th>Objectives - The following objectives were identified to achieve the aim of the HIA:-</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Objective 1:- Collate and assess relevant literature review;</td>
</tr>
<tr>
<td>• Objective 2:- Identify any target/vulnerable populations who may be at particular risk</td>
</tr>
<tr>
<td>from the implementation of the scheme.</td>
</tr>
<tr>
<td>• Objective 3 – Undertake a brief policy analysis;</td>
</tr>
<tr>
<td>• Objective 4 – Identify, assess and analyse health impacts;</td>
</tr>
<tr>
<td>• Objective 5 – Develop a set of evidence-based recommendations,</td>
</tr>
<tr>
<td>• Objective 6 – Undertake a HIA Process Evaluation.</td>
</tr>
</tbody>
</table>
3.1.3 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 Appendix C),
- a policy analysis (see Appendix D),
- localised profiles (see Appendix E).

3.1.4 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.

3.1.5 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.
4.0 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 and localised profile.

4.1 Literature Review

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

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.19

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.

**Key Words:** housing, tenure, landlords, rental, welfare and benefits, built environment and mental health.

The literature review included secondary and grey literature and used sources such as the World Health Organisation (WHO) and British Medical Journals.

It explores housing as a determinant of health; the differences and potential impacts of housing tenures, the impacts of housing and the built environment and the impacts on mental health and well-being. Where possible, vulnerable populations or those groups which are ‘easy to miss’ will be identified. The full literature review can be found in Appendix C.

4.2 Policy Analysis

The policy analysis examines a range of policies, national and local strategies, relating to cycling and physical activity. The policy analysis will help identify where in the wider context the policies ‘sit.’ Examples of the policies analysed include:- Housing Act, 2004, Fuel Poverty Strategy and Decent Homes. The full policy analysis can be found in Appendix D.

4.3 Profile

A City wide snapshot 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 number of available data sets (Liverpool Joint Needs Assessment, Liverpool Housing Strategy and Liverpool’s City Safe Annual Report). The full profile can be found in Appendix E.

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19The Literature Review, Ridley, D, 2010
5.0 Theme Analysis

5.1 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.

5.2 Theme Analysis Results

The main themes identified through the research questions are broken down and the health impacts identified for each theme ‘counted’ through each process of the HIA – screening, policy analysis and literature review.

The research questions were broken down to focus on their main elements on which to undertake the manual theme analysis.

Research questions:

1. Does low demand housing impact on people’s health?
2. Will the scheme have an impact on people’s health?

Main elements:-

- Decent Homes,
- Anti-social Behaviour,
- Empty Homes,
- Built Environment,
- Landlord, Management and Tenants.

The results of the theme analysis are shown in table 2 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 also shown below.

Note For the purposes of this report symbols used mean - ve = negative and + ve = positive.

<table>
<thead>
<tr>
<th>Health Impacts</th>
<th>Screening</th>
<th>Literature Review</th>
<th>Policy Analysis</th>
<th>Tally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcrowding</td>
<td>1 (+ve) 1 (-ve)</td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Housing H&amp;S concerns</td>
<td>2</td>
<td>3</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Impacts of fuel poverty</td>
<td>1 1</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>ASB</td>
<td>1</td>
<td>5 1 6</td>
<td>3</td>
<td>9 12 3</td>
</tr>
<tr>
<td>Quality of life</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense Community/pride</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved neighbourhoods</td>
<td></td>
<td>1 1 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including Built Environment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empty Homes</td>
<td>2</td>
<td></td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

Table 2 Health Impacts as Identified through the HIA Screening Process, Literature Review and Policy Analysis
• Social Isolation, social cohesion
• Poverty (access, stress, opportunities)
• Homelessness
• Increased rental
• Tenancies (security/lack repairs)
• Improved housing
  o confidence
• Life expectancy
• General Health Impacts
  o Mental Health – (throughout)
  o Self-esteem
  o Control
  o Choice

<table>
<thead>
<tr>
<th>Health Impacts</th>
<th>Narrative</th>
<th>Strength of Evidence**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Life</td>
<td>Examples - sleep disturbance choice, self-esteem, control, confidence, life expectancy, empowerment, social functioning.</td>
<td>Historically focused on and measured on society and the conditions with which people have a decent standard of living. More recently broader elements of quality of life are being explored. Relationships – quality of people’s social, family and interpersonal relationship. Economy – people’s spending power, employment and potential for growth and development. Environment and Infrastructure – how pleasant is the built environment. Health in broadest sense – access to services and if home, work and environments are safe and secure. Security – levels of crime, people feel safe in their homes. Governance – democracy, fairness and freedom of expression and equality.</td>
</tr>
</tbody>
</table>

Most ‘common’ Strategic Determinants Identified:-
• Built Environment,
• Anti-social behaviour,
• Fuel poverty,
• Empty Homes.

Table 3 Priority Health Impacts as identified through the above Strategic Determinants and theme analysis

<table>
<thead>
<tr>
<th>Health Impacts</th>
<th>Narrative</th>
<th>Strength of Evidence**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>General Health Impacts</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

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


Prospective Desk-Top Health Impact Assessment
Liverpool’s Selective Landlord Scheme
### Quality of Life (QOL)

- Difficult to specify due to the complex and multi-dimensional aspects often including physical, social, psychological and spiritual factors, as well as being people and person focused.

### Social Isolation

**Examples** - 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.

- Women, especially single women with or without children experience social isolation.
- Single women, financial implications, unable to fund going out, pay for babysitter for example.
- Single women find themselves isolated as they don’t have children.
- Older single women find themselves isolated as they don’t have children.
- Prevention of social isolation better than cure.
- Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income.
- 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.

### Mental Health

- Has been considered throughout the HIA process and within the recommendations.

**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

**Identified population groups:**

- Women – especially in relation to social isolation,
- The elderly – expected aging population in Liverpool,
- Refugees,

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<table>
<thead>
<tr>
<th>Quality of Life (QOL)</th>
<th>Social Isolation</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- difficult to specify due to the complex and multi-dimensional aspects often including physical, social, psychological and spiritual factors, as well as being people and person focused.</td>
<td>- Women, especially single women with or without children experience social isolation.</td>
<td>- Has been considered throughout the HIA process and within the recommendations.</td>
</tr>
<tr>
<td>- Single women, financial implications, unable to fund going out, pay for babysitter for example.</td>
<td>- Single women find themselves isolated as they don’t have children.</td>
<td>- Prevention of social isolation better than cure.</td>
</tr>
<tr>
<td>- Single women find themselves isolated as they don’t have children.</td>
<td>- Older single women find themselves isolated as they don’t have children.</td>
<td>- Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income.</td>
</tr>
<tr>
<td>- A chapter (post 2006) highlights various issues relating to social isolation:</td>
<td>- Prevention of social isolation better than cure.</td>
<td>- Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income.</td>
</tr>
<tr>
<td>- Own space is as important and valuable as social interaction,’</td>
<td>- ‘Belonging’ is a multi-dimensional social construct of related to persons, places or things and is fundamental to personality and social well-being,</td>
<td>- Apartness or aloneness often described as solitude may also be part of the concept of social isolation,</td>
</tr>
<tr>
<td>- Apartness or aloneness often described as solitude may also be part of the concept of social isolation,</td>
<td>- Social isolation may be voluntary or involuntary.</td>
<td></td>
</tr>
</tbody>
</table>

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21 Health-related Quality of Life: A discussion of the concept, its use and measurement, World Bank, Bowling, A, 1999

22 Systematic review of health-related quality of life models, Hanna, K et al, Health and Quality of Life Outcomes, 2012

23 Living in isolation: Women’s experiences of poverty and exclusion, Reid C and Ponic P, 2004

24 Living in isolation: Women’s experiences of poverty and exclusion, Reid C and Ponic P, 2004


26 Preventing Loneliness and social isolation: interventions and outcomes, Windle K, Francis J and Coomer C, Social Care Institute for Excellence (SCIE), (no date)

• Those with mental health issues,
• Those with a higher risk to becoming homeless,
• Single families,
• Those on low incomes.
• Children,
• People with learning disabilities.
6.0 Conclusion and Recommendations

6.1 Conclusion

Given Liverpool has areas of low demand, high levels of empty homes, and is one of the country’s most deprived areas and in response to the research questions posed within this HIA it would seem that initiating the Selective Licensing Scheme would be beneficial.

Responding to solve areas in low demand is likely to improve people’s health. However, there is a risk that due to the complexities and nature of the PRS there could be some significant negative impacts.

Positively, by instigating this scheme, those in the rented sector are more likely to be able to live in decent homes, within decent neighbourhoods but the potential negative impacts could include:

- If landlords own multiple homes which would lead to a high licence fee this could lead to properties being left empty – which could increase degradation of the areas and increase anti-social behaviour.
- Issues concerning insecure tenancies, which may be exacerbated with the licence fee – for example, what happens to the tenants if a landlord is found to be in breach of licence conditions, could the licence fee prevent money being spent on the properties themselves?
- Possible danger of targeting the ‘good’ landlords, how are the rogue and hidden landlords going to be managed and found?

6.2 Recommendations

**Recommendation 1 – Develop and Deliver a Communication and Media Strategy with a Focus on the Social Determinants of Health.**

**Rationale**
As part of the proposed scheme a licensing team should be established, within which it is recommended there will be a targeted marketing campaign focusing on the landlords, tenants and residents.

It is advised, to support the campaign work of this team, that by adding a specific section with a focus on the social determinants of health and links to housing that will impact on tenants, landlords and local communities will benefit those targeted to help understanding.

**Recommended Responsible Key Person or Team for Implementation** – TBC

**Recommendation 2 – Tenants Network**

**Rationale**
Undertake a number of a tenant focused focus groups and through these build and support a tenant’s network. This could support the proposed scheme and highlight the positives. It is also likely to be a forum with which to address concerns, issues and local health impacts.

**Recommended Responsible Key Person or Team for Implementation** – TBA but it is suggested inclusion of relevant LCC staff and tenants.

**Recommendation 3 – Landlords Network**

**Rationale**
Developing a landlord’s network within the Scheme could support the implementation of the
scheme and address any concerns. It will be important to 'keep on board' the landlords who are managing their properties appropriately whilst trying to find and work with those who may not be so proactive in managing properties and offering decent homes for their tenants.

**Recommended Responsible Key Person or Team for Implementation** – TBA but it is suggested inclusion of relevant LCC staff and landlords.

### Rationale

In response to all the aspects highlighted with the literature review and evidence the Scheme is more than just ensuring decent homes and fit-for-purpose properties. The evidence strongly suggests that the built environment is equally as important. In order to ensure the Scheme captures all relevant elements it is strongly advised to develop an evaluation tool that will be initiated at the commencement of the Scheme implementation and continues over the whole period of the Schemes initial course.

**Recommended Responsible Key Person or Team for Implementation** – TBA

### 6.3 Limitations

The main limitation of this HIA was the complexity of the PRS, the impacts on health and determining the recommendations to ensure health inequalities were improved if this scheme is implemented.

Whilst it would have been ideal to have undertaken some tenant and landlord engagement, due to an already agreed Public Consultation it was decided not to. It was agreed that the HIA would not influence or be involved within the Public Consultation phase to ensure a fully transparent and open process of the HIA. However, it would now seem a valuable exercise to engage in some health impact workshops with both tenants and landlords.
A – Health Impact Assessment and HIA Methodology

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.

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.

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.

Diagram 1: The Rainbow Model

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.\textsuperscript{28}

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.’\textsuperscript{29}

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.’

**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),\textsuperscript{30} the Acheson Report (1998)\textsuperscript{31} and more recently the final report of the WHO Commission on the Social Determinants of Health (2008)\textsuperscript{32} and the Marmot report ‘Fair Society, Healthy Lives’ (2010).\textsuperscript{33}

**When and What Type of HIA?**

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, determined by what stage the proposal 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.

**HIA Methodology**

*Figure 1 Generic HIA Methodology (Abrahams et al, 2004)*

\textsuperscript{28} World Health Organisation Glossary, www.who.int/hia/about/glos/en/index1.html
\textsuperscript{29} 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)
\textsuperscript{30} The Black Report, Black, D, 1980
\textsuperscript{31} Independent Inquiry into Inequalities in Health (Acheson Report), Acheson, D, Department of Health, 1998
\textsuperscript{32} Closing the Gap in a generation: Health equity through action on the social determinants of health, WHO Commission on Social Determinants, WHO, 2008
\textsuperscript{33} Fair Society Healthy Lives (Marmot Review), Marmot, M, Department of Health, 2010
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 is 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 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 the 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 A 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 4 and description below along with an example of social isolation.

**Table 4 Characterisation Criteria**

<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>Direction of change</td>
<td>Health gain (+) or health loss (-);</td>
</tr>
<tr>
<td>Scale</td>
<td>The severity (mortality, morbidity and well-being) and magnitude, where possible (size/proportion of the population affected)</td>
</tr>
<tr>
<td>Likelihood of impact</td>
<td>Definite, probable, possible or speculative based on the strength of the evidence and the number of sources</td>
</tr>
<tr>
<td>Latency</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 5 Example of Characterisation of an Identified Health Impact**

<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, thus improving health and reducing health inequalities.
## B – HIA Screening of the Liverpool Selective Landlord Licensing Scheme

### Screening and Scoping – To determine if an HIA is required.

**Step A - HIA Steering Group Formed – HIA Facilitator and Proposal Proponent**

HIA Facilitator (name/contact details) – Sophie Grinnell (sophie.grinnell@liverpool.ac.uk)
Proposal Proponent (name/contact details) – Iain Crawford (Iain.Crawford@liverpool.gov.uk)

### Section A – Policy Context

| Title of Proposal – Selective Licensing Scheme | HIA Commissioned by Phil Hatcher |
| Date of Screening – 12/12/13 |

#### Rationale of Proposal (please summarise aim and objectives of the Proposal).

The City Council believes that a citywide selective licensing scheme will contribute positively to its strategic aims in relation to Private Rented Sector housing and bring about real improvements in the sector. This will be achieved in the following ways:

- The licence conditions will improve standards of tenancy management.
- Citywide licensing will create a level playing field promoting an understanding among residents about what they can reasonably expect from their landlord.
- Poor landlords will be isolated and therefore easier to identify.
- Licensing will promote greater confidence in the rental market and improve demand.
- The Council will be better placed to engage positively with landlords to tackle low demand and neighbourhood blight.

| 1 | Is the Proposal new or existing | New ☒ | Existing □ |
| 2 | Who does the Proposal belong to? (for example Public Health, Municipality/Local Authority/Community) | LA |
| 3 | Is the Proposal statutory? | Yes ☒ | No □ |
| If no please give details – |
| 4 | Are there links to existing or proposed strategies? | Yes ☒ | No □ |
| If yes please give details – links with wider Housing Strategy |
| 5 | Which Directorate/Portfolio does the Proposal ‘sit’ within? (e.g. Housing, Regeneration, Public Health) – | Community Services |
| 6 | At what stage is the Proposal at? | Refresh □ | Draft ☒ | Consultation □ | Final □ | Other □ |
| Other – please state: |
| 7 | Location of the Proposal to be implemented (for example City Wide, a particular community), please state | Location | City wide |
### Section B - Please answer the following screening questions to identify any known effects on health with the implementation of the Proposal

<table>
<thead>
<tr>
<th>Screening Question</th>
<th>Yes/No/Unknown (Y/N/UK)</th>
<th>Justification/Description of likely health impact (- or +). Add as much detail as you can, rather than just bullet points.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 1 – Identification of Health Impacts</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| (a) Will the Proposal have any **positive** impacts on the determinants of health? | Y                       | • Encourage decent homes for occupiers to live.  
• Removal of H&S dangers.  
• Gas certificates required.  
• Improved confidence for occupants.  
• Improved neighbourhoods.  
• Reduce overcrowding. |
| (b) Will the Proposal have any **negative** impacts on the determinants of health? | Y                       | • Could create rental increase.  
• Potential for homelessness.  
• Overcrowding. |
| **Question 2 – Population Groups**                                                |                         |                                                                                                                  |
| Are there any population groups likely to be affected by the Proposal (either positively or negatively)? | Y                       | Could affect minority groups. |
| **Question 3 – Health Inequity**                                                   |                         |                                                                                                                  |
| Are any of the negative impacts avoidable and therefore unfair?                   | Y                       | Potential rent increase. |
| **Question 4 - Community Concerns**                                               |                         |                                                                                                                  |
| Is there any community concern over the Proposal?                                 | N/K                     | Consultation may show concerns. |
| **Question 5 - Limitations**                                                      |                         |                                                                                                                  |
| Are there any limitations from a HIA or Proposal perspective? (e.g. evidence base, profile) | Y                       | There is a potential issue that landlords may pursue a judicial review for the scheme not to be implemented. |

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34 Health inequalities/inequities are:  
“Systematic, socially produced (and, therefore, avoidable or modifiable), unfair or unjust differences in health determinants or health outcomes between groups with different levels of underlying social advantage/disadvantage.” Health Equity Impact Assessment Project Report, IMPACT, 2010
data)

If the answer is YES or UNKNOWN to questions 1, 2 or 3 then a HIA must be undertaken.
HIA to be undertaken Yes ☒/ No ☐
If NO please proceed to the ‘No HIA required pro forma’ – not included in this HIA

Section C - Scoping Section ‘Developing the HIA’

Date HIA to be completed? January 2014

Step B – Aims and Objectives of the HIA.

Aim of HIA: To identify the positive and negative health impacts of the Selective Licensing Scheme.

The purpose of this HIA report is to provide a systematic and robust analysis of the Scheme in order to support the consultation of the Scheme being undertaken by the City Council.

Objectives of HIA:
- Collate and assess relevant literature review;
- Undertake a brief policy analysis;
- Identify vulnerable population groups;
- Identify, assess and analyse health impacts;
- Develop set of recommendations;
- Undertake HIA Process Evaluation.

Step C – Determine type of HIA to be Undertaken.

(Bold/Circle as appropriate)

<table>
<thead>
<tr>
<th>Type of HIA</th>
<th>‘When to’ HIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk-top</td>
<td>Prospective</td>
</tr>
<tr>
<td>Rapid</td>
<td>Concurrent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Retrospective</td>
</tr>
</tbody>
</table>

Will Community Participation be undertaken as part of the HIA (e.g. Focus Groups/Workshops)
Yes ☐ No ☒

Step D – Associated Risks

The Steering Group should consider if there is likely to be any resource or budgetary risks associated with undertaking the HIA or the implementation of the Proposal, for example staffing resources/skills to undertake the HIA, costs for undertaking focus groups, HIA printing costs (see SN4 HIA skills and training)

State identified associated risks in the box below.
Agreement across partners to generate up-front funding to enable the scheme to start.

Step E – Recommendations

Who will be responsible/oversee the implementation of the recommendations?
To be determined through the HIA process.
How will the implementation of the recommendation be monitored/reported?
As above.

Step F – Dissemination of the HIA

Where will the HIA report be reported to and by whom? (Boards/Committees)
CSLT (Community Services Leadership Team), Councillors and HIA Gateway
Who by? – to be agreed.
C – Literature Review

Housing as a Determinant of Health

It is important to understand housing as a determinant of health and the implications to health, 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. Back in the 1800s many public health epidemics were eliminated, or at least offered some protections, if not prevented, once housing standards and supporting infrastructure had been improved. This included tackling infectious diseases, such as cholera and tuberculosis, as well as overcrowding and slum clearance.

The literature surrounding the relationship between housing and health is both well researched and accepted but categorically shows the complex relationship between the two often making it difficult to identify/determine which way round causes poor health and inequalities – does poor housing mean poor health or does having poor health offer the higher chances of living in poorer quality housing – which may also exacerbate poor health.

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.

Goldblatt also 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.

Whichever way round it is, it is the impacts on health from housing that 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.’

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.’

Housing 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 1800s, for example, with Friedrich Engels book ‘The Condition of the Working Class in England’ in 1844. He examined ‘mortality and municipal records to calculate the ratio of the living to the dead,’ concluding that the survival ratio was higher for those living in the ‘best houses in the best streets.’

Decent Homes

A Decent Home is described as:-

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41 Brought to Life, Exploring the History of Medicine, www.sciencemuseum.org.uk/broughttolife/people/edwinchadwick.aspx
43 The Black Report, Black, D, 1980
44 A Select Review of Literature on the Relationship between Housing and Health, Scottish Government Communities Analytical Paper, 2010
45 The Condition of the Working Class in England, Engels F, 1845
‘One that is wind and weather tight, warm and has modern facilities.’

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. Initiated in 1967 it 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 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.’

Further highlighted in this paper was 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.


Therefore, by creating decent homes and improved environments it would appear that health can be improved and as such, in 2004, the Government commenced 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.

This Government report continues to indicate that there are other links with poor housing to variations 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.

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46 Office of the Deputy Prime Minister, 2004
47 Housing and public health: a review of reviews of interventions for improving health’, an evidence briefing, NICE, 2005
48 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
50 A decent home: definition and guidance, Department for Communities and Local Government, 2004
Homelessness

Homeless is when ‘you don’t have a roof over your head.’ However, many people who are homeless are ‘hidden.’ Hidden because they aren’t sleeping on the streets at night but often ‘sofa surfing’ sleeping on friends’ sofas or spare room or in a squat. People can become homeless for a number of reasons such as home is unstable or there is severe overcrowding.

People may be entitled to help as a homeless person if they are:
- Temporarily staying with others or in shelter or hostel,
- Living in overcrowded conditions,
- At risk of violence or abuse,
- Living in poor conditions that affect health.

In relation to the PRS, unsecure tenancies can create a whole host of issues which can include becoming homeless. Losing a tenancy can be life changing and devastating.

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.\(^{56}\)

A research paper for the Chartered Institute of Environmental Health (CIEH), in 2006, stresses the complex interactions between housing conditions and mental ill health.\(^{57}\)

A research paper carried out in 2002 by the Chartered Institute of Environmental Health, 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.\(^{58}\)

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.’

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.’\(^{59}\)

For those who may lose a housing tenancy and have mental health issues the impacts can be severe. Potentially becoming homeless can lead to life on the streets and/or insecure accommodation which can exacerbate any conditions. It is also likely that they would have trouble accessing necessary services – although interestingly a briefing paper from Shelter notes that some people only accessed necessary services once they had lost a tenancy.\(^{60}\)

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.’\(^{61}\)

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.’\(^{62}\)

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\(^{56}\) Mental Well-being Impact Assessment (MWIA), National MWIA Collaborative (England), Cooke, A et al, 2011

\(^{57}\) Housing as a health determinant: is there consensus that public health partnership are a way forward?, Chartered Institute of Environmental Health, 2006

\(^{58}\) Poor Housing and Mental Health in the United Kingdom: Changing the Focus for Intervention, Chartered Institute of Environmental Health, 2002

\(^{59}\) Poor Housing and Mental Health in the United Kingdom: Changing the Focus for Intervention, Chartered Institute of Environmental Health, 2002

\(^{60}\) Good Practice: briefing, A long way from homes mental distress and long-term homelessness. Shelter

\(^{61}\) A Select Review of Literature on the Relationship between Housing and Health, Scottish Government Communities Analytical Paper, 2010

\(^{62}\) Poor Housing and Mental Health in the United Kingdom: Changing the Focus for Intervention, Chartered Institute of Environmental Health, 2002
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.

**Housing, Health and the Built Environment**

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 became 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, 1946.63

Having and creating environments in which to live is essential and should enable communities to ‘inspire us and make us feel proud of our local areas.’64

A review of the evidence of the built environment and health was undertaken in 2012 for the Canadian Medical Association and examined the links between the social and built environment and health and well-being.

The review states that a ‘community that promotes good health is also likely to be one that promotes well-being and security,’ and is more likely to engage local citizens with empowerment for their areas.65

In this report the built environment refers to the way areas are ‘put together’ and the ‘make-up of surroundings,’ such as transport links and land use patterns and explores how the built

63 en.wikipedia.org/wiki/Garden_city_movement
64 Sustainable Development Commission www.sd-commission.org.uk
environment works with and interacts with other elements such as the social environment. The study states the inequality and distribution of ‘power, money and resources in society has direct impact on the green environment and ultimately on health.’

Evidence from the Strategic Review of Health Inequalities in England post 2010, explored the Built Environment and Health Inequalities. The Task Group who undertook this part of the review identified through the literature that there is a link between the built environment and inequalities in health and that there are certain ‘direct elements that have an impact on health outcomes,’ which include noise, space, housing, behaviour and mental health.

Climate change was also identified as having health impacts, which could vary between communities, with the more disadvantaged communities having ‘fewer resources and lower resistance.’

Other evidenced messages that have negative impacts and affect the most disadvantaged communities include:

- The conditions of neighbourhoods can lead to gaps between communities in both conditions and opportunities.
- Poor environmental conditions which can lead to lack of use, fear and possibly lead to social isolation.
- Those who come from ethnic minority groups are more likely to have poorer health and are often concentrated in poorer areas.
- Sustainable development is often considered of the bringing together of social, economic and environmental progress.

Empty Homes

It has been recognised that a significant number of people do not have access to decent housing, yet there appears to be an abundance of housing left empty. As of 2012, data published assessed that there were 710,000 empty houses in England, of which 259,000 were defined as long term empty (empty for longer than six months).

Summarised within the Chartered Institute of Environmental Health (CIEH) policy on empty homes a number of health impacts are likely if decent homes are not accessible. These can include lack of dignity, emotional and mental well-being.

Having empty homes within communities can also have significant impacts on neighbourhoods – loss of amenity, anti-social behaviour, pest infestations and the devaluing of property.

The importance of reducing the number of empty homes has resulted in an on-line toolkit to help all those in property to drive down these types of properties.

Public Health

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

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68 Empty homes. Chartered Institute of Environmental Health
69 Empty Homes, Parliamentary Briefings, W, Wilson, 2013
70 Empty homes. Chartered Institute of Environmental Health
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.

The Public Health movement was born with the introduction of the first Public Health Act in 1848 which saw support and a drive for urgent changes to population health, including infectious diseases, poor housing, poor sanitation and overcrowding.

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

*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 those with children, households where someone is disabled or who has a long-term illness.

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.

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.’ 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.

*Diagram 2 Fuel Poverty Diagram*

The potential or likely impacts on health from living in cold homes are widely acknowledged. The WHO recommends indoor temperatures – 21°C in living rooms and 18°C for bedrooms.

There is wide recognition that living in cold conditions can lead to poor health and a risk of poor health.

71 Sir Donald Acheson, 1988
72 Public Health and housing: we can get it right, Briefing Paper Two, Gill Leng Housing Solutions, Housing LIN, Leng, G, 2011
73 www.poverty.org.uk/80/index.shtml
74 The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
75 The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
76 Decent Homes Impact Study: The effects of Secure Warm Modern Homes in Nottingham, Jones, A, 2012
77 The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
78 The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team, 2011
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{79}

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{80}

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 therefore classed as winter deaths.

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.\textsuperscript{81}

\textit{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.’

\textsuperscript{79} Healthy lives, healthy people: our strategy for public health in England, Public Health White Paper, Department of Health, 2010
\textsuperscript{80} Fuel Poverty & Excess Winter Mortality, Fewtrell, L, EPSRC, 2012 \url{www.regionalvisions.ac.uk}
\textsuperscript{81} Fuel Poverty & Excess Winter Mortality, Fewtrell, L, EPSRC, 2012 \url{www.regionalvisions.ac.uk}
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.

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.\(^8^2\)

**Poverty**

Debate is occurring over defining poverty and deciding ‘how poor is too poor?’ and ‘what does a person need to participate in the society in which they live in the 21\(^{st}\) century.’\(^8^3\)

Poverty is a health inequality, driven by a number of socio-economic factors such as access and opportunity and stress and distress.

NHS Education for Scotland provides a wealth of information to provide an understanding about poverty. They report that access and opportunity are ‘linked to money and essentially purchase power.’ Having a low income can limit access to services, opportunities and housing as well as being able to access everyday needs such as food and fuel.

Opportunities can also be affected when on low incomes (whether benefits or income) and can lead to social isolation. This can happen when opportunities, participation and contribution cannot be engaged with and can affect individuals, families and communities.

Poverty can occur for a number of reasons and at times can be a combination of such reasons. These can include:-

- Having family to provide for,
- Unable to work due to incapacity,
- Being geographically isolated,
- A young person leaving the care system,
- Being a single parent,
- Living in sub-standard housing or experiencing homelessness and
- Lacking skills such as literacy and numeracy.\(^8^4\)

There is evidence that ‘adverse socio-economic circumstances have a cumulative effect throughout the life course.’

**Child Poverty**

The report ‘End Child Poverty’ reiterates that ‘poverty and social inequalities in childhood’

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\(^8^2\) Full house? How overcrowded housing affects families, Reynolds, L. (Shelter), 2005
\(^8^3\) england.shelter.org.uk/__data/assets/pdf_file/0003/39234/Crowded_House.pdf
\(^8^4\) www.poverty.ac.uk
   www.bridgingthegap.scot.nhs.uk
are likely to be significant and on-going from childhood into adult hood and be life-long.  

Poverty is seen as a determinant of health yet it remains a serious issue with figures suggesting that the numbers of children living in poverty are on the increase.

The key issues summarising the health impacts on children in poverty are shown below:
- Effects of poverty can be intergenerational,
- Poor infants are more likely to be born small and/or early,
- Death rates from injury or poisoning have fallen in all social groups except the poorest and these children are 13 times more likely to die from injury,
- The impacts on children’s lives of chronic illness, such as asthma, seems to be greater among poor children,
- Child abuse and neglect appear to be more common among poor families,
- Socially disadvantaged children are more likely to be exposed to high levels of cigarette smoke and consume more unhealthy foods and
- higher likelihood of heavier alcohol consumption and illegal drug use by adolescents in disadvantaged communities.

The new UK Child Poverty Strategy launched June 2014, highlighted the need to deal with the issue of poverty and that one of its commitments’ was to ‘tackle poverty at its source.’

**Welfare and Welfare Reforms**

Housing benefits are the Governments way of helping those in need of paying their rent. April 2013, saw major changes and reforms to the benefits system in particular what is referred to as the ‘Bedroom’ tax and Council tax.

The ‘Bedroom’ tax or under-occupancy rule is aimed at those who are deemed to have houses bigger than their requirements and thus have their benefits reduced. For those private renting, local Housing Allowance (the housing benefit for those in private rented accommodation) is available, however under the changes this could leave households with shortfalls in benefits especially as they are more likely to pay higher rents in the first instance.

Some of the impacts identified that could occur due to these changes in benefits include:
- Whether the benefit relates to households (housing benefits) or individuals (incapacity benefits),
- Ministerial view is that these changes to benefits will encourage people back into employment (although this makes an assumption that there will be the labour demand),
- The evidence suggests that Liverpool is the eighth hardest hit authority district mainly due to incapacity benefits as stated due its historical nature as an industrial city (pg14),
- The acknowledged correlation between those areas hit the hardest, and deprivation.

Identifying the potential health impacts of these welfare changes is challenging, due to the

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85 Health Consequences of Poverty for Children, Spencer, N, (undated)
86 Health Consequences of Poverty for Children, Spencer, N, (undated)
88 Housing benefit changes and welfare reform, Shelter www.england.shelter.org.uk
89 Hitting the Poorest Places Hardest, The local and regional impact of welfare reform, Beatty, C and Fothergill, S, Centre for Regional Economic and Social Research, Sheffield Hallam University, 2013
fairly recent implementation. However, there are a number of perceived impacts on certain vulnerable groups. This is supported in a research report ‘Social Policy in a Cold Climate’ which states ‘…..at this time of profound and complex change, a sustained and systematic programme of research is required both to document and analyse of these combined changes…….’

These include (or could include):
- Those who are disabled, potential reduced benefits especially given that there is evidence to suggest that ‘life costs more if you are disabled and therefore are likely to get into debt,’
- Uncertainty of these benefits can bring on feelings of anxiousness and stress,
- Concerns for people with mental health problems and those with learning disabilities and that any welfare system should empower them with their lives.

**Housing Tenure**

As already noted in the introduction, there are two main forms of housing tenure:
- Home ownership – which includes those homes mortgaged or owned outright and
- Rented – which includes both social rented housing and private rented housing.

The evidence is strongly suggesting that there are likely to be serious health consequences in relation to type of housing tenures.

Housing tenure can be defined as:-

‘legal status under which people have the right to occupy their accommodation.’

Reported in the Black Report, 1988, that ‘People who live in houses which they own have lower rates of mortality than those who rent their homes from private landlords, who in turn have lower rates than those who are tenants of local authorities.’

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. 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 mortgage payments, this could lead to an increase in insecurity and poorer mental health.

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90 Social Policy in a Cold Climate, a research programme on recession, spending changes, policy reform and distribution in the UK, 2007-2014, London School of Economics and Political Science,
91 Carers UK www.carersuk.org
92 Welfare Reforms and Mental Health, Royal College of Psychiatrists www.rcpsych.ac.uk
93 Housing Tenure, Shelter, 2009
94 as cited in the Leeds Landlord Accreditation Scheme Health Impact Assessment, Swift, J.D and Dolman, M. 2007
95 Housing standards: a glossary of housing and health, Howden-Chapman, P, J Epidemiol Community Health, 2004;(58:162-168)
96 Explanations for health inequalities between owners and social renters [presented paper].
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{97}

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{98}

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{99} 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{100}

**Private Rented Sector**

For the purposes of this report only the Privates Rented Sector will be explored.

The PRS has over recent years seen a decline but has recently this decline is seeing a reverse and is now seen as pivotal to supporting the housing crisis the UK is experiencing. This revitalisation of the sector also experiences a lack of professionalism and poor standards of management.\textsuperscript{101} The 2004, Housing Act has driven a much more rigorous regulation of the PRS.

**Box 2 Summary of the Private Rented Sector**

- 1910 9 out of 10 houses were rented from private landlords.
- 1992 saw a drop with less than 1 in 10 houses being rented in the private sector.
- This has seen a growth to 11% of households (equal to 2.33 dwellings).
- Supply of private rented is dominated by small-scale and part-time landlords.
- It is estimated that there are 700,000 private landlords in England, with an average of between two and four properties. Although it is estimated that 33% only own one property.
- Private renting is predominately the tenure of the young, of which two-thirds are economically active – similar data to owner-occupier but double those in social rented accommodation.
- **Note** this report presents data that 21% of ethnic groups live in this tenure type – but

\textsuperscript{97} [www.bma.org.uk/images/Housinghealth_tcm41-146809.pdf](http://www.bma.org.uk/images/Housinghealth_tcm41-146809.pdf)
\textsuperscript{98} A Select Review of Literature on the Relationship between Housing and Health, Scottish Government Communities Analytical Paper, 2010
\textsuperscript{99} A Select Review of Literature on the Relationship between Housing and Health, Scottish Government Communities Analytical Paper, 2010
\textsuperscript{100} A Select Review of Literature on the Relationship between Housing and Health, Scottish Government Communities Analytical Paper, 2010
\textsuperscript{101} The Future of the private rented sector, Bill, P, Hackett, P, and Glossop, C, The Smith-Institute, 2008
note the report is dated 2008, although no indication that this is still not an accurate picture of likely populations.

- The social rented sector are more likely to have high concentrations of the poorest families, whilst the PRS has a similar proportion of the poorest, it is not nearly as concentrated and also accommodates some of its wealthiest.\textsuperscript{102}

Over the past 30 years there have been substantial changes in policy that has affected and had an impact on housing tenure and seen an increased move to owner occupier with a corresponding drop in social rental. These include, Right to Buy (where tenants had the opportunity to purchase their council-owned property at a discounted price), stock transfers (a big move since 1988 where local authorities transferred their housing stock and the management of this – more than 970,000 council homes have been transferred since 1988/89 in England) and Mortgage Tax Relief (this enabled borrowers to get tax relief on mortgage interest for the first £30,000 but was abolished in 2000. This was one of the prevailing factors that saw a decrease in the private rented sector as it became a major driver for home-ownership).\textsuperscript{103} Other programmes have been promoted to enable access to home-ownership in particular Buy-to Let mortgages (1993) which has enabled smaller private landlords to access funds which has been the increase in this private rented sector.

A report by the All Party Urban Development Group, 2007, explored the ‘what needs to be done to deliver an improved and enhanced urban housing offer,’\textsuperscript{104} especially given the need to provide two million homes by 2016 and three million by 2020 as stated in the Housing Green Paper in 2007.

A review by the National Housing and Planning Advice Unit (NHPAU) (2007) indicates that more mixed communities, better quality and environmentally friendly housing with improved infrastructure delivery is required to support the determined housing growth.\textsuperscript{105}

It is acknowledged that the PRS ‘encourages that sector to flourish and play a full role in meeting housing need in urban and rural areas through the provision of good quality accommodation for private rent.’\textsuperscript{106}

The ‘Rugg Review’ was undertaken on the PRS. This report states the main emphasis has been on the ‘capacity of the sector’ but also presents a number of challenges which would support ‘property quality, management standards and security of tenancy,’ whilst recognising the PRS is a complex area of housing.\textsuperscript{107}

The central focus of the Rugg Review was to set about driving change so that the PRS isn’t perceived as the ‘third’ option and advises a set of recommendations that ‘maximises the full potential of the PRS as a flexible, well-functioning element of England’s Housing market.’

The review breaks down the varying groups that are likely to use the PRS – these include:-

| Young professionals – presenting a complex mix of choice and constraint. | Students – often being ‘over-ridden’ by larger and branded landlords. |

\textsuperscript{102} The Future of the private rented sector, Bill, P, Hackett, P, and Glossop, C, The Smith-Institute, 2008
\textsuperscript{103} Housing Tenure, Shelter, 2009
\textsuperscript{104} Delivering urban homes, The role of the public and private sector, All Party Urban Development Group, Betts, C et al, 2007
\textsuperscript{105} Delivering urban homes, The role of the public and private sector, All Party Urban Development Group, Betts, C et al, 2007
\textsuperscript{106} Firm Foundations: The Future of Housing In Scotland, A Discussion Document, 2007
\textsuperscript{107} The Private Rented Sector: its contribution and potential, Rugg, J, Rhodes, D. Centre for Housing Policy, University of York, 2008
Those on housing benefit.  
Immigrants – most immediate option is private renting. 
Temporary accommodation – financed through specific subsidies. 

Slum rentals – at the very bottom of the PRS, often where vulnerable households are housed in the poorest quality. 
Asylum seekers – housed through contractual agreements. 
High income renters – often corporate lettings. 

The make-up of areas is likely to differ from area to area and even differ between neighbourhoods.  

Whilst it is recognised that the PRS can play a more positive role within the housing market it is also understood and acknowledged that there are concerns and issues that have the potential to impact on the health and well-being of tenants (in particular), landlords and the wider communities. 

Health impacts and issues identified through a variety of different reports and stakeholder engagement are summarised in the table below. 

<table>
<thead>
<tr>
<th>Impact</th>
<th>Associated Health Impact</th>
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<tbody>
<tr>
<td>73% of Local Authorities said there was high demand for private rented accommodation with 60% stating there was an issue with supply and 50% raising concerns over the affordability of this type of accommodation and 31% raising concern over the condition of this sector along with problems of poor management and tenant behaviour.</td>
<td>Possible homelessness.</td>
</tr>
<tr>
<td>Insecure tenancies</td>
<td>Functions can range from maintaining the physical environment, quality of stock to dealing with anti-social behaviour.</td>
</tr>
<tr>
<td>No standard model for housing management.</td>
<td>Impact on community spirit and reduced social cohesion.</td>
</tr>
<tr>
<td>Good management is required especially in mixed communities.</td>
<td>Dissatisfaction, drive more mobile households out of the area.</td>
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<tr>
<td>Case studies indicated that in smaller areas where there is an increasing number of private rented houses the areas saw a more transient population. Poor standards of housing can compound many of the other problems.</td>
<td></td>
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<tr>
<td>There was disappointment from local authorities, residents and tenants that the licencing was restricted to HMOs. Selective licensing was seen as one part to improve neighbourhood areas and to support housing strategies</td>
<td>Other aspects included 'wider regeneration, community capacity building, landlord support and close partnership working particularly with police and neighbourhood wardens.'</td>
</tr>
</tbody>
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Some negative impacts included concerns about local authorities being able to ‘track down and enforce bad landlords’ and over regulation. Differing ways that complaints about landlords are dealt and is felt there is a need for a change and learning within local authorities.

<table>
<thead>
<tr>
<th>Children and poor quality housing.</th>
<th>Mental health problems such as anxiety, depression and respiratory problems.</th>
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</thead>
<tbody>
<tr>
<td>Make-up of the populations particularly in social housing due to density, however, would this be an issue for mixed tenure communities?</td>
<td>Generally associated with having higher rates of unemployment and ill health.</td>
</tr>
<tr>
<td>Investment is required in both the new and existing housing markets.</td>
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<tr>
<td>Over 500,000 people living in overcrowded conditions.</td>
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<tr>
<td>Fuel poverty. See fuel poverty section.</td>
<td></td>
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<tr>
<td>Tenant awareness Landlords in scheme and rights.</td>
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</tbody>
</table>

Tenants’ rights and awareness of these rights is of concern. A report by Citizens Advise Bureau, June 2007, ‘A Tenants’ Dilemma’ highlighted the issue surrounding tenants and their rights within the PRS. Currently landlords can use a Section 21 of the 1988 Housing Act to evict tenants when they ‘exercise their rights’ to complain or request safety action for their rented property, and is often used as a ‘retaliation tactic.’ This appears to have two major concerns. Firstly, the use of this tactic could deter people from taking action and thus having a knock-on effect to government targets to increase the number of decent homes and secondly the potential impact on homelessness, for example, 2006 saw 10,470 households accepted as homeless following eviction from assured short-hold tenancies.

Eviction from assured short-hold tenancy agreements is one of the most common reasons for households becoming statutorily homeless. In order to support these tenancy agreements that legislative changes needed to occur and the tenants required more security when challenging their rights to live in decent accommodation.\(^{112}\)

Concern is growing with the possibility of increased rent to tenants if pressure is put on landlords to improve and make decent their rental properties. Rents generally in the PRS tend to be higher than in social rented accommodation and are often dependent on the type of tenancy.\(^{113}\)

**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.’\(^{114}\)

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,

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112 The tenant's dilemma, Warning: your home could be at risk if you dare complain, Crew, D, Citizens Advice Bureau, 2007
113 Shelter, Rent Increases when renting privately
114 Oxford English Dictionary
• degraded neighbourhoods and environments and
• the complex interactions of these factors over the life course.\textsuperscript{115}

As the evidence strongly suggests there is a correlation between poor housing and deprivation and more often than not the most vulnerable people in society live in the poorest communities and poorest quality of housing. This can bring about a number of health impacts including social isolation.

**Anti-Social Behaviour**

Definition of anti-social behaviour:

‘Acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household.’\textsuperscript{116}

However anti-social behaviour (ASB) can come in a number of guises and can include graffiti, fly-tipping and noise to serious organised crime, violent crime (including domestic violence and sexual crimes) to gun crime and drug related offences\textsuperscript{117} and therefore make it very broad and difficult to produce a single definition that captures all aspects of ASB. This is due to the nature and varying factors of ASB which include context, location, community tolerance and quality of life expectations.\textsuperscript{118} Although this broad approach does ‘give the widest powers to those taking legal action and increase the discretion of the judicial decision makers.’\textsuperscript{119} This can be seen in the Housing Act, where legal powers allow the eviction of tenants that create behaviours that ‘cause or is likely to cause nuisance and annoyance.’\textsuperscript{120}

A briefing by the Chartered Institute of Environmental Health (CIEH) reports how anti-social behaviour has become high profile and that is can have significant impacts on people and communities.\textsuperscript{121} Due to the varying nature of ASB much of it falls into the remit of Environmental Health within Local Authorities, whilst seen as the lower end of ASB, (graffiti, fly-tipping, noise for example) it can have huge impacts on communities if left unchecked.

A toolkit was developed for Environmental Health Officers in 2005 with a focus on the law relating to ASB but within the toolkit was placed significant importance is the consideration of environmental crime.

\textsuperscript{115} Vulnerable People, Groups, And Populations: Societal View, Mechanic D, Tanner J, 2007
\textsuperscript{116} www.yale.edu/bioethics/contribute_documents/Resource-VulnerablePops.pdf
\textsuperscript{117} Crime and Disorder Act, 1998
\textsuperscript{118} Liverpool Citysafe’s Annual Plan, 2013-2014
\textsuperscript{119} The Norris Green Trailblazer Health Impact Assessment, Haigh, F, Scott- Samuel, A, IMPACT, 2006
\textsuperscript{120} The Norris Green Trailblazer Health Impact Assessment, Haigh, F, Scott- Samuel, A, IMPACT, 2006
\textsuperscript{121} Housing Act 2004, Legislation.gov.uk
\textsuperscript{121} Tackling Anti-Social Behaviour, Chartered Institute of Environmental Health
\textsuperscript{121} www.cieh.org/policy/anti-social Behaviour
## 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>Anti-social Behaviour Act</td>
<td>2003</td>
<td>Government Legislation</td>
<td>Housing, landlord policies, injunctions, security of tenure, truancy, groups, the environment (noise, graffiti, etc).</td>
</tr>
<tr>
<td>The Children Act</td>
<td>2004</td>
<td>HM Government</td>
<td>Partnership working, physical, mental and emotional well-being, education training and recreation, contribution to society.</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>Youth Matters Green Paper</td>
<td>2005</td>
<td>DfES</td>
<td>Engagement with young people living in deprived areas in the most challenging circumstances, contribute to improving their health, stay safe, enjoy sport, make personal achievements, contribute to their local community, and prepare them for the job market. Anti-social behaviour, social and community cohesion, community engagement, improved quality of life.</td>
</tr>
<tr>
<td>New Horizons: a shared visions for Mental Health</td>
<td>2009</td>
<td>HM Government</td>
<td>Safeguarding good mental health, stigma, prejudice, partnership working, decent homes, exclusion, individuals and communities.</td>
</tr>
<tr>
<td>Title</td>
<td>Year</td>
<td>Author</td>
<td>Key Points</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Liverpool 2024 A Thriving International City – Sustainable Community Strategy</td>
<td>2009</td>
<td>Liverpool City Council</td>
<td>Competitiveness, connectivity, Distinct sense of place, thriving neighbourhoods, health &amp; well-being.</td>
</tr>
<tr>
<td>Liverpool Sustainable Community ‘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>A National Framework for Youth Action and Engagement</td>
<td>2010</td>
<td>The Russell Commission</td>
<td>The Report details the Commission’s recommendations for delivering a step change in youth volunteering in the UK – a step change in diversity, quality and quantity. Looks at gaps in provision for sport and how it deters young people from volunteering, decreasing their ways of contributing positively to their community. Anti-social behaviour, social and community cohesion, community engagement, improved quality of life.</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>Lifetime Homes, Lifetime Neighbourhoods, A National Strategy for Housing in an Aging Society</td>
<td>2011</td>
<td>Department of Health</td>
<td>Access to information, control, choice.</td>
</tr>
<tr>
<td>Liverpool City Centre Strategic Investment Framework.</td>
<td>2012</td>
<td>Liverpool Vision</td>
<td>Carbon emissions, partnership, quality of life, neighbourhood improvement, sustainable transport.</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>
Quality of life, choices, climate change and energy, address environmental inequalities.
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 Liverpool City Council.

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).\(^{122}\)

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.\(^{123}\)

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 79.2

\(^{122}\) Annual Report of the Joint Director of Public Health, Liverpool Primary Care Trust, NHS, 2011-2012

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{124}

\textsuperscript{124} Annual Report of the Joint Director of Public Health, Liverpool Primary Care Trust, NHS, 2011-2012
General Liverpool Population\(^{125}\)

- 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%.

Liverpool Housing Data

- Liverpool contains 214,757 dwellings.
- 77.9% of the dwellings are houses, 19.9% flats/maisonettes and 2.4% bungalows.
- Percentage of decent housing in the PRS increased from 58% (2006) to 70% (2010).
- The average energy efficiency rating in the private sector has increased from 56 to 61.
- Private rented housing is significantly older than in the owner occupied sector.\(^{126}\)
- 23.4% of the population of Liverpool rent their properties from private landlords.
- 42.8% fail to comply with the Government’s decent homes standard.
- Environmental health has responded to 6,224 complaints relating to housing conditions within the PRS, in the last three years.
- Through the landlords accredited scheme only 2,000 landlords are registered.
- In 2012, Liverpool City Council Cabinet approved a number of initiatives to bring empty homes back into use.
- 5.4% of total housing stock is vacant as compared to 3% nationally.

Crime and Anti-social Behaviour Data\(^{127}\)

- 1,000 high risk cases of domestic violence were dealt with.
- 359 hate crime referrals, with 29 victims of hate crime having their homes made secure.
- Youth offending has increased but marginally by less than 1%.
- 829 ‘troubled families’ have been identified and supported through the Supporting Families Team.
- 764 Anti-social behaviour cases dealt with.
- 1,000 individuals have been treated for alcohol misuse.
- 4,777 individuals have been treated for drug misuse.
- Several community engagement events have been undertaken, working closely with Neighbourhood staff, community and resident groups.
- Problem Profiles are being conducted to inform partnership activities in vulnerable locations.

\(^{125}\) Liverpool Joint Strategic Needs Assessment (JSNA), Liverpool City Council & Liverpool Primary Care Trust, 2012

\(^{126}\) Liverpool Housing Strategy, Liverpool City Council, 2014

\(^{127}\) City Safe Annual Plan, Liverpool City Council 2013 - 2014
Other socio-economic related Liverpool Data

- Liverpool fails to meet EU legal air quality standards.
- **Worklessness** – Liverpool’s unemployment rate is two thirds higher than the England rate.
- **Unemployment rate** – 6.7% as at September 2011 as compared to 3.8% for Great Britain and 5.6% rate for Core Cities average.\(^{129}\)
- **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, 13\(^{th}\) 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 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.
  - 301 were attributable to lung cancers,
  - 9% were colorectal cancers and
  - 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** –
  - Breast – 2010/11 – 69% of eligible women had screening.
  - Cervical – 2010/11 – 73% of eligible women were screened.
- **Alcohol** –
  - Binge drinking – it is estimated that 22.6% of adults in Liverpool binge

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\(^{128}\) Liverpool Joint Strategic Needs Assessment (JSNA), Liverpool City Council & Liverpool Primary Care Trust, 2012

\(^{129}\) City Safe Annual Plan, Liverpool City Council 2013 - 2014
drink, compared to the national average of 20.1%.

- 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.
- 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.
- 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).
- 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.
  - 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.
  - 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:-
  - Residents will have to pay towards Council Tax,
  - Housing Benefit (Bedroom Tax) – likely to affect 11,600 Liverpool residents,
  - Housing Allowance – likely to affect 65,000 residents in Liverpool.130
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