Strategic guidance for safeguarding and improving the health of communities affected by estate regeneration in Tower Hamlets
Written by Martin Birley (BirleyHIA), Andy Pennington and Hilary Dreaves (IMPACT, University of Liverpool)
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The members of the Steering Group were as follows.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex Thornton</td>
<td>Leaside Regeneration</td>
</tr>
<tr>
<td>Sarah Castro</td>
<td>Poplar HARCA</td>
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<td>Leaside Regeneration</td>
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<td>Tower Hamlets PCT</td>
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<td>Tower Hamlets Homes</td>
</tr>
<tr>
<td>Mick Lerpiniere</td>
<td>Tower Hamlets Homes</td>
</tr>
<tr>
<td>Ann Lucas</td>
<td>Tower Hamlets Homes</td>
</tr>
<tr>
<td>Joan Murphy</td>
<td>Poplar HARCA</td>
</tr>
<tr>
<td>Andrew Mahoney</td>
<td>Leopold Estate Board</td>
</tr>
</tbody>
</table>

### ii. Acknowledgements

The authors would like to acknowledge the assistance provided by the Steering Group members without whom this guide could not have been produced. Additional thanks to Bromley by Bow Centre who carried out a social survey of tenants’ health concerns and experiences.

### iii. Suggested attribution

1. Introduction

1.1 Aim of guide

The aim of this guide is to provide practical guidance for use at the strategic level for safeguarding and improving the health of stakeholders affected by regeneration and renewal of Estates within Tower Hamlets.

While this Guide was developed specifically for Tower Hamlets, it is expected that it will be of assistance to other boroughs in East London and further afield.

1.2 Objectives of guide

- To summarise information and knowledge about the impacts of housing interventions and regeneration on the health and well-being of tenants and other community stakeholders.
- To prioritise impacts on general and mental well-being, physical activity and diet.
- To include Estates in all redevelopment phases and new build.
- To make recommendations for safeguarding and improving health to inform the options for the future development of Estates in Tower Hamlets.

1.3 Audience

The audience for this Guide are the members of the regeneration professions (who need to know about health impacts), the members of the public health professions (who need to know about regeneration) and the communities who are affected by the regeneration process. The audiences include:

- Housing authorities
- Registered Social Landlords (RSL)
- Arms Length Management Organisations (ALMO)
- Social rented sector
- Policy/forward planners
- Private developers/landlords
- Public health units
- Communities.

In this guide, RSLs and ALMOs will be collectively referred to as the Social Landlords.

1.4 Values underlying this guide

The health of communities affected by regeneration is best protected and enhanced by engaging with them at all stages of the project in an open and transparent manner; by ensuring that development plans are sustainable; by reducing inequality; and by the ethical use of evidence.

1.5 Guide presentation

The guide is presented as a brief document. This is supported by detailed annexes that are in separate documents and stored online. The annexes include a health profile for Tower
Hamlets (Annex 3) and a literature review (Annex 4). The guide, summary guide and annexes will be archived in two websites [1, 2].

1.6 Scope of guide

For the purposes of this guide, regeneration is an activity undertaken by a Social Landlord that is responsible for a large number of homes and tenants as well as the surrounding public space. There will also be a small number of leaseholders who share the same Estate and they may have sublet their properties. The Social Landlord may also be responsible for a mixture of offices, retail outlets and local amenities. The regeneration may involve refurbishment of existing buildings, or clearance and new build.

The following components, amongst others, may be regenerated:

- Homes, communal spaces and the associated public realm.
- Offices, shops, food and drink outlets, community centres and services that are located on site.
- Green space, playgrounds, walkways, roadways, cycleways, bus stops, and car parking.

This guide focuses on the communities who live in and around an Estate that is being regenerated. Workforce issues and the movement of materials are managed by other external processes and are not included.

Regeneration takes place within a wider context and there are many cumulative impacts. There are social pressures such as the increasing shortage of homes and the continuing migration of people. There are environmental pressures such as climate change and fuel scarcity, with increased risks of flooding, extreme weather events and food scarcity. Estates must make provision for a changing energy regime in which fossil fuels have a diminishing role.

Health and wellbeing can be affected by all stages in the regeneration process. The impacts can be both positive and negative. For example, good design ensures that homes are safe and public realms are walkable. Demolition, construction and refurbishment can cause disruption and stress as well as exposure to hazardous materials. The operation of a regenerated Estate enables people to access the services that they need, to build community support networks, to feel safe and secure and to make healthy food choices.

Housing and neighbourhood improvement is a continual process of regeneration and renewal, as illustrated in Figure 1. Each stage of the process has impacts on health and wellbeing; there are also cumulative impacts. Examples of potential health outcomes are identified within Table 1 on page 9.
We hope that this guide will assist the user to avoid negative health impacts and to enhance positive health impacts of regeneration.

The pathways through which regeneration affects health are many and complex. Before describing them in any detail, a definition of health and its determinants is needed.

1.7 How do we define health and what are the determinants of health?

In this guide, health is defined as a state of complete physical, social, mental, and spiritual well-being and not just the absence of disease and infirmity [based on 4]. A wide range of factors can influence peoples’ health. These include genetic endowments, lifestyles, living conditions, social interactions, support networks, inequity and care giving institutions. These factors are referred to as the determinants of health. They are illustrated in the socio-environmental model of health shown in Figure 2 [based on 5, 6].
The consequence of many determinants acting together is a health outcome. Health outcomes include the presence or absence of mental illnesses, obesity and associated diseases, injuries and infections as well as deaths brought forward. Some of the health outcomes and determinants that may be influenced by the design of Estates are listed in Table 1 [based on 7].
### Table 1 Summary of health outcomes, determinants and associated considerations of Estate design

<table>
<thead>
<tr>
<th>Health outcomes</th>
<th>Some determinants</th>
<th>Some considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>Neighbourhood design, quality and maintenance</td>
<td>Access to open and green spaces including allotments</td>
</tr>
<tr>
<td></td>
<td>Housing design and density</td>
<td>Guidance is available on making higher density work</td>
</tr>
<tr>
<td></td>
<td>Housing quality</td>
<td>High standards, good maintenance and management</td>
</tr>
<tr>
<td></td>
<td>Fear of crime</td>
<td>Guidance available on designing safer places</td>
</tr>
<tr>
<td>Obesity and cardiovascular disease</td>
<td>Consequence of flooding</td>
<td>Designing for flood-resilience</td>
</tr>
<tr>
<td></td>
<td>Physical activity</td>
<td>Designing to encourage physical activity through access to open space and sports/leisure facilities</td>
</tr>
<tr>
<td></td>
<td>Access to good food retailers</td>
<td>Encourage healthy eating</td>
</tr>
<tr>
<td></td>
<td>Active living</td>
<td>Encourage active transport</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>Fine particulates and NOx</td>
<td>Reduce motor traffic, encourage active transport and “walkability” Measure and improve air quality</td>
</tr>
<tr>
<td></td>
<td>Indoor air quality</td>
<td>Limit exposure to indoor pollutants (e.g. from solvents, sealants and materials)</td>
</tr>
<tr>
<td>Excess winter and summer deaths</td>
<td>Heat islands Household thermal/energy efficiency</td>
<td>Insulation, ventilation, green spaces, orientation of new buildings, thermal mass, green roofs, shade</td>
</tr>
<tr>
<td></td>
<td>Winter cold</td>
<td>Insulation, heating, energy efficiency</td>
</tr>
<tr>
<td>Injuries</td>
<td>Motor traffic</td>
<td>Area-wide traffic calming, home zones, transport user hierarchy, provision for cycles</td>
</tr>
<tr>
<td></td>
<td>Trip &amp; fall hazards</td>
<td>Design of stairways</td>
</tr>
<tr>
<td>Violence</td>
<td></td>
<td>Community cohesion, security</td>
</tr>
</tbody>
</table>

Obesity and overweight, for example, has reached epidemic levels in the UK among both adults and children [8]. Part of the solution is weaving physical exercise into everyday life through urban/neighbourhood design and our means of transport. Respiratory disease rates, such as asthma in children, are also soaring and this is partly associated with car fumes and reliance on car use.

As we grow older, the neighbourhood becomes an increasingly important factor in the quality of everyday life. Opportunities for daily exercise and interaction with the community help to maintain physical and mental abilities [see also 9].

1.7.1 Inequity and inequality

Health inequalities exist within and across communities. People living in more affluent neighbourhoods consistently have better health, on average, than people living in poorer neighbourhoods. During 2010, a new strategy has been proposed for reducing these inequalities (The Marmot Review)[10]. A priority is to create and develop healthy and
sustainable places and communities. The physical and social characteristics of communities, and the degree to which they enable and promote healthy behaviours, all make a contribution to social inequalities in health.

Recommendations for reducing health inequalities include active travel, public transport, energy-efficient houses, availability of green space, leisure activities, healthy eating and reduced carbon-based pollution. The Marmot Review concludes that social inequalities in health, sustainable development and climate change must be tackled together; and that community capital must be improved across the social gradient. The report also recommends:

- Fully integrating the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- Supporting locally developed and evidence based community regeneration programmes that remove barriers to community participation and action, and reduce social isolation.

The Marmot Review [10] argues that the lived environment — urban settings, neighbourhoods, communities — can promote or inhibit access to goods and services, social cohesion, physical and psychological well being and the natural environment. Health related outcomes as diverse as obesity, depression and injury through violence or accident can all be linked to the way we live.

1.8 How does the physical environment affect health?

The physical environment includes both the built environment and the natural environment. The built environment includes housing, streets, local facilities and public spaces. It has both indoor and outdoor components. The natural environment includes local green spaces. Some of the relationships between the built environment and health are summarised in Figure 3 [11, 12]. There are both direct and indirect links between the physical environment and health and these are illustrated below.
1.9 How does housing affect health?

Housing is a particularly significant determinant of health. Some of the associations between housing and health are summarised in Table 2 and many more are discussed in Annex 4. Housing improvement can influence each of these factors.
Table 2 The associations between housing and health

<table>
<thead>
<tr>
<th>Key factors</th>
<th>Health effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indoor pollution (e.g. carbon monoxide, lead, asbestos, volatile organic compounds, radon)</td>
<td>Potentially severe impacts on physical health and associated mental and social health.</td>
</tr>
<tr>
<td>Lack of space/overcrowding</td>
<td>Overcrowding and living in high-rise flats is linked with physical and mental ill health.</td>
</tr>
<tr>
<td>Flat dwelling/high-rise dwelling</td>
<td>Linked to social isolation, crime, reduced privacy and opportunities for physical activity/play with impacts on social, physical and mental health.</td>
</tr>
<tr>
<td>Hygiene, sanitation and water supply</td>
<td>Linked to increased morbidity and mortality levels, e.g. from gastro-intestinal and diarrhoeal disease.</td>
</tr>
<tr>
<td>Excess heat, cold, damp and mould</td>
<td>Highest risks to health are from cold, damp and mouldy conditions, particularly for children’s health. Increased periods of excess cold linked to climate change may increase numbers of excess winter morbidity and mortality. Increased heat waves linked to climate change have already been linked to increases in morbidity and mortality.</td>
</tr>
<tr>
<td>Hazards in the home (e.g. trip, slip, fall, fire, burn, shock, gas, explosion, entrapment, structural collapse)</td>
<td>The presence of physical hazards in the home can greatly increase the likelihood of accidents with potentially severe, life threatening, consequences. Children and older people are particularly at risk from, e.g. trips, slips and falls.</td>
</tr>
<tr>
<td>Inadequate provision of amenities</td>
<td>Physical health impacts from links to hygiene and sanitation (covered elsewhere in this table). Potential impacts upon mental and social wellbeing.</td>
</tr>
<tr>
<td>Crime and safety/fear of crime</td>
<td>Crime has potentially severe negative impacts on the health and wellbeing of victims, perpetrators, friends and families. Fear of crime prevents people participating in the activities of everyday living with impacts on physical, mental and social health.</td>
</tr>
<tr>
<td>Provision of adaptations for elderly or disabled</td>
<td>Lack of appropriate and well maintained adaptations prevents people participating in the everyday activities of living with impacts on physical, mental and social health.</td>
</tr>
<tr>
<td>Cost/affordability of housing</td>
<td>High cost housing can restrict access to decent and appropriate homes, particularly in deprived communities. Increasing costs can take income away from essential household budgets (e.g. food and heating) and health promoting activities.</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Homelessness can greatly increase morbidity and mortality levels resulting from the potentially severe impacts on physical, mental and social health.</td>
</tr>
</tbody>
</table>

1.10 How does green space affect health?

There is good evidence on how the outdoor environment affects health and well-being [13]. Both physical and mental health is affected. Direct influences include access to natural spaces, reduction in air pollution, road traffic, noise, floods and climate change. Indirect
influences include accessibility, safety, mixed land-use, street design, encouragement for physical activity, social contact and natural spaces.

1.11 How does design affect health?

Urban design is concerned with the spaces and features that surround buildings and how buildings relate to one another. The needs of people are at the centre of all good urban design. The urban design of an Estate and the design of individual properties (architecture) influence many of the determinants of health. The Healthy Urban Development Unit (HUDU) provides extensive evidence and guidance [14]. The focus is on new development but equally applies to regeneration. The influences can be divided into two main categories: direct and indirect.

Table 3 Direct and indirect influences of urban design on health

<table>
<thead>
<tr>
<th>Direct Influences include</th>
<th>Indirect Influences include</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Housing</td>
<td>• Crime reduction and community safety</td>
</tr>
<tr>
<td>• Access to public services</td>
<td>• Access to healthy food</td>
</tr>
<tr>
<td>• Opportunities for physical activity</td>
<td>• Access to work</td>
</tr>
<tr>
<td>• Air-quality, noise and neighbourhood amenity</td>
<td>• Social cohesion and social capital</td>
</tr>
<tr>
<td>• Accessibility/inclusivity</td>
<td>• Resource minimisation</td>
</tr>
<tr>
<td>• Transport</td>
<td>• Climate change</td>
</tr>
</tbody>
</table>

(Based on HUDU [13])

HUDU provide a checklist for assessing planning applications [7]. A sample is reproduced in Table 4. Mile End Park in Tower Hamlets is regarded as an excellent example of how parks and leisure facilities can be designed so as to influence opportunities for physical activity [15].
Table 4 Sample of questions from the **HUDU checklist**

<table>
<thead>
<tr>
<th>Housing</th>
<th>Does the proposal contain homes that have a high code for sustainable homes rating? Are all homes wheelchair accessible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to public services</td>
<td>Have public service needs, location and accessibility been considered? Has assessment of health care demand been estimated? Have Primary Care Trust requirements being assessed?</td>
</tr>
<tr>
<td>Opportunities for physical activity</td>
<td>Does the proposal prioritise and encourage walking? Does the proposal prioritise and encourage cycling?</td>
</tr>
<tr>
<td>Air-quality, noise and neighbourhood amenity</td>
<td>Does the proposal minimise construction impacts? Does the proposal minimise air pollution?</td>
</tr>
<tr>
<td>Accessibility and transport</td>
<td>Does the proposal facilitate streetscape accessibility, legibility and permeability? Is the proposal including buildings accessible for people with mobility problems or disability impairment?</td>
</tr>
<tr>
<td>Crime reduction and community safety</td>
<td>Has the proposal designed out crime? Does the proposal incorporate effective security and street surveillance?</td>
</tr>
<tr>
<td>Access to healthy food</td>
<td>Does the proposal facilitate local access to healthy food supply? Does the proposal avoid food being monopolised locally by a single provider?</td>
</tr>
<tr>
<td>Access to work</td>
<td>Does the proposal provide access to employment and training opportunities? Does the proposal provide diversity in jobs for local residents?</td>
</tr>
<tr>
<td>Social cohesion and social capital</td>
<td>Does the proposal contribute towards opportunities for social interaction? Has the proposal address local inequalities?</td>
</tr>
<tr>
<td>Resource minimisation</td>
<td>Does the proposal make best use of existing land? Does the proposal encourage recycling?</td>
</tr>
<tr>
<td>Climate change</td>
<td>Does the proposal incorporate renewable energy? Does the proposal provide a sustainable approach to transport?</td>
</tr>
</tbody>
</table>

HUDU also supply a planning tool (**HUDU Model**) for assessing the additional health care facilities required by new communities. This could potentially be used as a basis for calculating charges for the new **Community Infrastructure Levy** or **Section 106 agreements**.

Extensive guidance is also available from the **Commission for Architecture and the Built Environment** (CABE) [9]. CABE is the Government’s advisor on architectural and urban design. They describe how good design makes healthy places in both healthcare facilities and neighbourhoods. CABE review much of the evidence and provide links to toolkits and relevant organisations. Their advice is aimed at architects, community groups, councillors, developers, green space managers, landscape architects, planners/urban designers, public sector clients (including local authorities, publicly funded agencies, healthcare trusts), students and teachers. They emphasise the importance of compact mixed-use development, sustainable transport, inclusive access, re-use of brownfield sites and the potential benefits of green spaces.

The **Royal Town Planning Institute** (RTPI) has issued guidance on the links between spatial planning and health [16]. Among many issues, their guidance discusses active transport, lifetime homes and co-location of services.
A health checklist has been developed for local authorities which provides a series of questions to ask when reviewing a planning proposal [17]. The checklist has 34 questions in 7 major categories:

- Governance
- Social and cultural
- Environment
- Housing
- Transport
- Economy
- Services.

Typical questions from the checklist are illustrated in Table 5.

### Table 5 Example questions from the checklist

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are large developments planned as balanced communities with a range of housing types and tenures?</td>
<td>Developments should not have the effect of segregating areas or excluding certain groups.</td>
</tr>
<tr>
<td>Are well-designed places available where people and voluntary groups can gather and use, for example shared places of worship, community centres, sports facilities, community spaces?</td>
<td>Is there community involvement in the design and management of such places?</td>
</tr>
<tr>
<td>Are developments designed to minimise opportunities for crime, and maximise opportunities for community control and defence of the local area?</td>
<td>Is community involvement an integral part of this approach?</td>
</tr>
</tbody>
</table>

This checklist has been developed into a set of healthy design principles. For each question, these include reference to the appropriate planning policy guidance and the relevant stage in the planning process [18]. A typical healthy design principle is illustrated in Table 6.

### Table 6 Example healthy design principle

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-category</th>
<th>Relevance</th>
<th>Healthy design principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Public involvement</td>
<td>A high level of public engagement is associated with improved population health status and reduced demand for health care resources</td>
<td>Ensure plans are developed with the active involvement of all those likely to be affected</td>
</tr>
<tr>
<td>Policy guidance</td>
<td></td>
<td>Planning Policy Statement : Delivering sustainable development (PPS1) [19]</td>
<td></td>
</tr>
<tr>
<td>justification</td>
<td></td>
<td>At outline planning stage</td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td></td>
<td>Statement of Community Involvement</td>
<td></td>
</tr>
</tbody>
</table>

### 1.12 How does housing improvement and new build affect health?

Impacts occur during four main phases: before, during, early post-works and late post-works. Positive and negative health impacts occur at each stage. The impacts can affect physical, social and mental health.

#### 1.12.1 Before the works

Before the works refers to the period when occupants are informed that refurbishment is planned for their block or neighbourhood. It is a time of expectation, waiting and worry.
During this phase, the resident is living in a poor physical environment that may be cold, damp and unsafe. This may be accentuated by worklessness and anxieties such as poverty and fear of crime. The resident may be disabled and awaiting housing adaptation. This is a time of anticipation and delay. The resident may be offered choices about the design of fixtures and fittings and be consulted about other potential home improvements.

Whole house and high-rise refurbishments typically involve the relocation of existing residents during the period of improvements (decanting). Relocation can either be temporary, while homes are refurbished, or permanent. Relocation may be voluntary or compulsory. Residents are moved to unfamiliar locations with unfamiliar neighbours and this can be a time of anxiety, uncertainty and fear. Compulsory relocation has potentially greater negative health impacts.

1.12.2 During the works

During the works refers to the construction phase, when occupants have work taking place in or around their home. It is a time of confusion, disruption, and inconvenience.

During this phase, the resident is exposed to environmental hazards including dust, noise, solvents and disruption to everyday life. The resident may be offered temporary respite accommodation. The Considerate Constructors schemes should ensure high standards of safety so that children and vulnerable adults do not enter building sites and that the workforce treats the residents with care [20].

1.12.3 Early post-works

Early post-works refers to the time when new or newly refurbished homes are first occupied. It is a time for experimenting with new facilities and enjoying the novelty.

During this phase, the resident first experiences the improved home environment and there may be an associated sense of improved well-being and euphoria. If the works themselves have had a major disruptive effect, then the stress may continue into this phase. There may be raised exposure to indoor air pollutants. Faults and snags may await correction.

1.12.4 Late post-works

Late post works refers to the long-term impacts of intervention. During this phase, feelings of improved well-being and euphoria may have diminished, as improvements have become part of everyday life. The novelty wears off. If well maintained, the determinants of some chronic medical conditions have been permanently improved and the home environment is safer and warmer. The physical and social environment outside the home and the social situation of the resident may remain just as before. Rises in rent and energy costs may have eroded any potential financial benefits.

Table 7 summarise some of the positive and negative health impacts of refurbishment during the three main phases.
Table 7 Summary of positive and negative impacts of refurbishment

<table>
<thead>
<tr>
<th>Physical well-being</th>
<th>Impact</th>
<th>Before</th>
<th>During</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Chronic medical conditions deteriorating</td>
<td>Pollution, injury, safety</td>
<td>Pollution, snagging</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>Prioritizing needs of vulnerable people</td>
<td>Considerate construction</td>
<td>Diet, physical activity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental well-being</th>
<th>Impact</th>
<th>Before</th>
<th>During</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Uncertainty, expectations, fear of crime</td>
<td>Confusion, disturbance, frustration, annoyance</td>
<td>Elation, disappointment</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>Hope</td>
<td>Considerate construction</td>
<td>Esteem</td>
<td></td>
</tr>
</tbody>
</table>

2. Policy context for considering health during estate regeneration

Estate regeneration takes place within a wide policy context. This will always include health, housing and planning policy, but should also appropriately consider policies concerning the main determinants of health, such as economic, education, transport, green space, building design and so on at local, regional, national and international levels. For example, Decent Homes and Affordable Warmth policies are likely to improve health and wellbeing in the short to medium term, but these policies do not wholly consider the future impacts of the energy crisis and climate change. The cost of central heating may become too expensive for tenants in the longer term, although still within the time span of a regeneration programme. As another example, the land may be owned by a social landlord, but the tarmac on the road surface and the street furniture are within the domain of the local authority. This can create practical challenges for estate infrastructure planning and maintenance if there is a lack of local policy coherence between the RSL and local authority.

Careful consideration should be given to understanding the background context of policy, particularly at a local level. There is evidence that RSLs in particular, are much more likely to be familiar with national policy (and associated regulatory frameworks) than the local agenda beyond housing and planning policy [3]. For example, alcohol policy is a matter of crime and disorder, not health. There is emerging evidence that the associated legislative agenda is becoming a rather less effective tool with regard to antisocial behaviour and community nuisance as the societal pattern of purchase, access and consumption of alcohol changes. There is also evidence that strengthening local links between RSLs and local NHS service provision could result in signposting and referral of hard to reach population subgroups to support services. For example, where smoking is over represented within an estate community, contributing greatly to individual health improvement, population health improvement and reduction of health inequalities [3]. This is a potentially important role for RSLs, since a more reciprocal relationship could better inform RSLs about health needs of their population and planned regeneration would be less likely to either maintain the status quo or inadvertently adversely impact upon health inequalities.

There has been a plethora of advice, good practice guides, guidance, case studies, discussion for a and more from the centre, with core policy increasingly hard to single out, particularly in unfamiliar policy areas.
The central policy context is currently changing as a result of the global financial crisis, the UK recession and the recent change in Government. Many policies are frozen in anticipation of a comprehensive spending review and substantial reductions in spending.

At the time of writing and in anticipation of the publication of the forthcoming Public Health White Paper, there is an opportunity for the users of this guide to capitalise on yet to be determined policy developments. This may include localisation, local democratisation in health and a forthcoming general power of competence for health and wellbeing boards, should they be established as part of the new Public Health Service.

2.1 Decent Homes Standard and the Housing Health and Safety Rating System (HHSRS)

The HHSRS is a risk based evaluation tool to help local authorities identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings. It was introduced under the Housing Act 2004 and came into effect on 6 April 2006 [21]. It applies to residential properties in England and affects all owners and landlords, including social landlords [22]. The assessment method focuses on the hazards that are most likely to be present in housing. Tackling these hazards will make more homes healthier and safer to live in [23]. See Annex 4 for more details.

A Decent Home is ‘one which is wind and weather tight, warm and has modern facilities’ [24]. Homes that meet this standard are likely to enhance health. To set a national target a common definition of decent is needed so all social landlords can work towards the same goal. A decent home meets the following four criteria:

- The current statutory minimum standard for housing.
- A reasonable state of repair.
- Reasonably modern facilities and services.
- Reasonable degree of thermal comfort.

A home lacking two or less of the above is still classed as decent. Consequently, it is not necessary to modernise kitchens and bathrooms if a home passes the remaining criteria [25]. The Government set the target ‘To have all social rented homes meeting the Standard by 2010’ [24]. The Decent Home Standard incorporates the Housing Health and Safety Rating System (HHSRS) as a hazard assessment tool.

Properties are assessed for the likelihood of harm arising from a hazard, and the degree of harm that may occur. The HHSRS assesses 29 categories of housing hazard in four groups: Physiological, Psychological, Infection and Accidents (see Table 8). The assessment shows the presence of any serious (category 1) hazards and other less serious (category 2) hazards. If a local authority discovers serious category 1 hazards in a home, it has a duty to take the most appropriate action [23].

The assessment is designed to be a trigger for action and owners/landlords are required, as a legal minimum, to remove category 1 hazards. Councils also have discretionary powers in relation to category 2 hazards.
Table 8 Potential housing hazards according to HHSRS

<table>
<thead>
<tr>
<th>Accidents</th>
<th>Physiological</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Falls associated with baths etc</td>
<td>• Damp and mould growth etc</td>
</tr>
<tr>
<td>• Falling on level surfaces</td>
<td>• Excessive cold</td>
</tr>
<tr>
<td>• Falling on stairs etc</td>
<td>• Excessive heat</td>
</tr>
<tr>
<td>• Falling between levels</td>
<td>• Asbestos etc</td>
</tr>
<tr>
<td>• Electrical hazards</td>
<td>• Biocides</td>
</tr>
<tr>
<td>• Fire</td>
<td>• CO and fuel combustion productions</td>
</tr>
<tr>
<td>• Flames, hot surfaces etc</td>
<td>• Lead</td>
</tr>
<tr>
<td>• Collision and entrapment</td>
<td>• Radiation</td>
</tr>
<tr>
<td>• Explosions</td>
<td>• Uncombusted fuel gas</td>
</tr>
<tr>
<td>• Position and operability of amenities</td>
<td>• Volatile organic compounds</td>
</tr>
<tr>
<td>• Structural collapse and falling element</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infection</th>
<th>Psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Domestic hygiene, pests and refuse</td>
<td>• Crowding and Space</td>
</tr>
<tr>
<td>• Food safety</td>
<td>• Entry by intruders</td>
</tr>
<tr>
<td>• Personal hygiene, sanitation and</td>
<td>• Lighting</td>
</tr>
<tr>
<td>• Drainage</td>
<td>• Noise</td>
</tr>
<tr>
<td>• Water supply</td>
<td></td>
</tr>
</tbody>
</table>

Implementation/enforcement of the HHSRS has been criticised [26]. Current implementation is limited to the immediate, most severe, life threatening hazards required by the Housing Act.
3. Community health profiles

The existing state of health of most communities in England has been mapped. This information enables detailed comparisons to be made, at borough level, of a range of health indicators. Public health departments use this data to identify health needs and priorities. Housing providers can use profiling to inform their understanding of local needs and tenant vulnerabilities. An example of a detailed health profile for Tower Hamlets (who commissioned this guide) is provided in Annex 3 and a summary is included below.

3.1 Summary community health profile for Tower Hamlets

The community health profile is organised using the five layers of influence in Figure 2.

3.1.1 Demography

Tower Hamlets has one of the youngest populations of all London boroughs with a high birth rate and around 60% of deliveries to Bangladeshi mothers. On the other hand, teenage pregnancy rates are lower than the London average [27].

There is a high proportion of BME groups. Some 49% of the population is non-white compared to 29% in London and 9% nationally. The main BME groups are Bangladeshi (33%), Black (6%) and Chinese (3%) [27].

3.1.2 Lifestyle

Tower Hamlets has amongst the highest prevalence of risk factors for cancer, cardiovascular disease and respiratory disease in London. It is estimated that three out of ten adults smoke, seven out of ten eat less than five fruit and vegetables a day and a lower proportion participate in sport or recreational activity. Although alcohol consumption rates are lower overall, indicators of alcohol-related harm are above average for London suggesting high rates of consumption in some segments of the population [27]. Levels of childhood obesity are amongst the highest in London. Some 13% of children in reception and 26% of children in year 6 are obese, compared with London averages of 11% and 21% respectively [28].

Levels of participation in sport and active recreation in Tower Hamlets are amongst the lowest in London (17% compared with a London average of 21%) [28].

3.1.3 Social and community networks

The percentage of people who believe people from different backgrounds get on well together in their local area in Tower Hamlets was the second lowest in London Local Strategic Partnership areas (LSPs). The percentage of people who feel that they belong to their neighbourhood was lowest in Tower Hamlets (43%) compared to the 32 LSPs in London. However, Tower Hamlets has the highest percentage of civic participation in the local area compared to London (24% compared to an average of 17%). Participation in regular volunteering was similar to the London average [28].
About 36% believe they can influence decisions in their local area compared to London and this is similar to the London average and substantially higher than the average for South East as a whole (28%) [28].

3.1.4 Living and working conditions

Tower Hamlets has the second highest number of non-decent council homes in London (58% in 2008/09). This compares to an average of 31% in London and 18% in the South East of England [28]. Economic activity rates are low compared to other areas. Rates are particularly low for women, non-whites and disabled people. The employment rate is lower at all working ages, but particularly in the younger and older working age groups [29].

Tower Hamlets has the third highest level of multiple deprivation in the country and this is a major factor in explaining inequalities in health between Tower Hamlets and [28].

3.1.5 Health status and morbidity

Levels of limiting long-term illness are high in Tower Hamlets (20%) compared to London (15%) and the South East (15%) [27].

Of the people in Tower Hamlets, it is estimated that:
- Over 14% have high blood pressure.
- Over 5% have diabetes.
- Nearly 5% have with asthma.
- Over 4% have chronic obstructive pulmonary disease (COPD).
- Nearly 4% have chronic kidney disease.
- 3% have coronary heart disease (CHD).
- 2% have a long-term neurological disease (excluding epilepsy).
- A substantial number of people are living with at least two significant conditions [27].

The prevalence of limiting long-term illnesses is likely to be higher amongst the tenants of social housing than in other groups [30, 31] (see section 3.3).

There are potentially substantial variations in the prevalence of certain chronic health conditions by ethnicity. Tower Hamlets has a higher prevalence of diabetes than elsewhere and this is associated with a higher prevalence in South Asians [27].

Nationally mental illness accounts for over 30% of all illness and disability. It is estimated that around 9,000 (4%) Tower Hamlets residents have a level of depression that would benefit from mental health services, 1,500 (0.7%) have dementia and 1,200 (0.5%) have schizophrenia; this is around three times the national average [27].

3.1.6 Life expectancy

In 2005, life expectancy in Tower Hamlets was 75.2 in males and 80.2 in females. This was 2.1 years shorter in males and 1.3 years shorter in females compared to England and ranked Tower Hamlets in the bottom 20% of all local authority areas [27].
3.1.7 Key health characteristics

Some of the key health characteristics of Tower Hamlets are summarised in Table 9 and compared to England as a whole. Other health concerns include excess winter deaths and poor eating habits. Some of these health characteristics are affected by regeneration programmes.

Table 9 Summary health characteristics for Tower Hamlets compared to England as a whole

<table>
<thead>
<tr>
<th>Negative aspects</th>
<th>Positive aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Life expectancy is lower</td>
<td>• Rates of smoking during pregnancy are lower</td>
</tr>
<tr>
<td>• Drug misuse, violent crime and tuberculosis rates are higher</td>
<td>• Adult obesity rates are lower</td>
</tr>
<tr>
<td>• There are some very deprived areas</td>
<td>• Breast feeding initiation is higher</td>
</tr>
<tr>
<td>• There are higher early death rates from cancer, heart disease, and stroke</td>
<td>• There is less binge drinking among adults</td>
</tr>
<tr>
<td>• Death rates from smoking are higher</td>
<td></td>
</tr>
<tr>
<td>• Child poverty and obesity rates are high</td>
<td></td>
</tr>
<tr>
<td>• Prevalence of diabetes is high</td>
<td></td>
</tr>
<tr>
<td>• A relatively high proportion of over-65s are “not in good health”</td>
<td></td>
</tr>
</tbody>
</table>

3.1 Sources of health information

Building a health profile for a community from available data is by no means straightforward. For example, the area for which the data has been collected may have different boundaries to the area of the regeneration programme and information may be stored in a variety of different locations. Standard data sources, at the time of writing, include the following.

- Tower Hamlets public health reports (www.towerhamlets.nhs.uk).

3.2 Using Geographical Information Systems to illustrate health inequalities by location

Significant variations in health exist within Tower Hamlets and across London. These are referred to as health inequalities. Routinely collected deprivation data can be used as a proxy measure to illustrate the spatial distribution of health inequalities. Figure 4 uses Indices of Multiple Deprivation (IMD) data to provide an example [32]. The figure shows the IMD 2007 rankings for the Lower Layer Super Output Area (SOA) for Tower Hamlets. Lower Layer SOAs are areas smaller than wards and contain a minimum of 1,000 people and 400 households with a mean population of 1,500 people. LSOA rankings are between 1 (most deprived) and 32482 (least deprived). The figure illustrates the spatial variations in deprivation in Tower Hamlets.
The LAPs shown in Figure 4 are Local Area Partnerships. Some Tower Hamlets data is aggregated at LAP level.

### 3.3 Households with vulnerable members

Households with vulnerable members will require special care during regeneration programmes. Vulnerable members of society include, but are not limited to, those identified by equality legislation (race, ethnicity, gender, age, religious beliefs, disability and sexual orientation).

Vulnerable household members may include:
- Frail elderly
- Persons with a physical impairment or disability
- Persons with a learning difficulty or disability
- Persons with mental health problems
- Persons with drug or alcohol dependencies
- Persons with sensory impairment
- Families with young children.

Vulnerable residents have a wide range of needs. About 42% of social renting households in England contain a member with a serious medical condition or disability [30]. In London about 25% of social renting households have at least one occupant with special physical or mental needs (not including medical conditions) [31]. About 10% of these have more than one occupant with special needs. The special needs can be divided into two main
categories: about 75% are physical and 25% mental. The rate is about twice that in other forms of tenure and it is increasing. The rates on specific Estates are likely to be higher, but detailed data are not available.

Social Landlord need to know the identity of each household with a vulnerable occupant and sufficient information to inform their management of them. For example, someone with mental disability may require extra assistance with planning, decanting and rehousing.

### 3.4 Social landlords information systems

Social Landlords cannot safeguard the health of their tenants if they cannot identify them. While they know much about the properties that they manage, Social Landlords frequently know less about their tenants than they assume. National data, London-wide data, the health profiles for Tower Hamlets and local surveys on the estates suggest that more than 20% of households may have at least one member who is especially vulnerable. The information system of a social landlord may only be able to identify half this number. See annexes 2 and 3 for details.

Special vulnerability may arise in a number of different ways including physical disability, sensory impairment, learning disability, mental health and language. For example, our survey elicited responses such as:

- Husband had diabetes and 3 heart attacks. Wife had diabetes, a heart attack and a stroke.
- Wife had arthritis and high blood pressure. Husband had mental health problem and was diabetic.
- Husband had gout, walking problems, prostate cancer and diabetes, and had a carer who helped wash and dress him in the morning.
- Husband and wife had diabetes and 17 year old son had Downs syndrome.

Social Landlords maintain information systems that enable them to identify the properties that they manage and the principal tenant. In order to identify vulnerable tenants, these information systems should interface with health and social service teams and the contractors responsible for refurbishment work. There is often a multiplicity of different information systems and they are not always integrated or maintained. Often, responsibility for identifying vulnerable tenants lies with the contractors contact team who may not have the relevant training, skills or tools.

#### 3.4.1 Challenges to obtaining information

Good management of a regeneration programme depends on good access to relevant information; this access should not be assumed. It depends on "buy-in" by key stakeholders. These stakeholders may be within the Social Landlords organisation or in support organisations, such as a Primary Care Trust and its successor. Individuals within different units of these organisations are asked to supply information. The requests will interrupt their primary responsibilities, causing extra work and delays. Repeated requests for the same information may be required. This, too, may produce no response unless there is active support from senior management. These barriers and associated delays need to be acknowledged in project planning/management.
4. Engaging with communities

Community engagement is the process of involving people in decisions that affect them [33]. It allows people to identify existing local level health issues and the potential impacts of interventions such as home improvements. Engagement can also provide people with an opportunity to identify recommendations to reduce negative and promote positive impacts, and prioritise interventions or mitigation measures.

There are a number of challenges to conducting community engagement in the social housing context (our experience in Tower Hamlets and elsewhere [3, 34]. These include the following.

- Practical participation difficulties for certain groups, for example, people with young children, physical disabilities and people working shifts.
- Literacy problems.
- Problems resulting from over-surveying of certain groups/localities.
- Bad past experiences with engagement.
- Language and cultural issues.
- Gaining access to “hard to reach” groups.
- Availability of trained staff to conduct engagement (experienced workshop and focus group facilitators and interviewers).
- Resource issues relating to the costs of holding workshops, conducting interviews and analysing results.
- Community distrust of how landlords will use their responses.

These issues need to be identified, acknowledged and overcome for successful, representative community engagement to occur. Remaining issues need to be explicitly identified within the analysis and reporting of engagement findings.

4.1 Survey

During the preparation of this guide we engaged with the community by undertaking a brief survey on three estates to establish the opinions and experience of residents about health and regeneration. The details are included in an annex 1. Approximately 100 respondents were interviewed from each of three estates. Care was taken to obtain as representative a demographic sample as possible and to use interviewers who were part of the community. The interviewers noted that respondents were concerned that their answers would affect their relationship with their landlords. This reflects experience elsewhere [3] and suggests that the nature of the tenant/landlord relationship may not be entirely balanced.

Respondents also described a wide range of chronic medical conditions that managers should take into consideration when identifying vulnerable tenants.

Respondents experience of their estates included concerns about gangs, litter, housing conditions, drugs and noise. However, there were many positive responses as well. Many respondents had a good experience of refurbishment. Relatively few found it stressful, disturbing, dusty, noisy or messy. Respondents thought that refurbishment would have positive impacts on health and well-being though some were concerned about relocation, disruption and upheaval and the effect of construction works. Some respondents thought that the period prior to work commencing would be a time of increased stress and that
there was a need for more information and communication. During the refurbishment period the most common responses referred to pollution, disruption and upheaval. However, many residents felt that there would be no effect. After completion of the refurbishment, many respondents felt there would be reduced stress and improved well-being. The need for continual maintenance was mentioned.

Respondents were asked whether they had any suggestions would help to prevent negative or promote positive health impacts of refurbishment and regeneration. The most common suggestions included better communication, additional security measures and avoiding delays. Other responses included providing temporary relocation or respite, avoiding sleep disturbance and more choice and consultation.

4.2 Methods

A range of methods can be used to engage with communities [33]. These include:
- Workshops and focus groups
- Engagement with existing groups
- Telephone surveys
- Door to door surveys
- Online questionnaires

In the Tower Hamlets context the involvement of trained members of the community was essential for engaging with local people and hard to reach groups. Advice on engagement should be sought from community engagement, and equality and diversity officers employed by Local Authorities, Public Health Services and RSLs.

5. Recommendations

Safeguarding and enhancing the health of communities during the Estate regeneration process clearly requires a number of specific actions by Social Landlords and their contractors at each stage of the process. See Table 10.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design and planning</td>
<td>Discussions with community</td>
</tr>
<tr>
<td>Before work commences</td>
<td>Identify vulnerable people in collaboration with contractors.</td>
</tr>
<tr>
<td>During the works</td>
<td>Considerate contractor schemes. Management of interactions between migrant workforces and local community. Assisting vulnerable people.</td>
</tr>
<tr>
<td>After the works</td>
<td>Checking for snags</td>
</tr>
</tbody>
</table>
5.1 General recommendations

The refurbishment and rebuild processes offer a number of opportunities for health improvement, as well as a number of occasions when unintended health impacts can occur. The following general list of recommendations is based on our experience of housing and neighbourhood improvement interventions [3, 34].

5.2 Interventions to reduce home hazards and improve provision of amenities

- Rectify HHSRS class 1 and 2 hazards and consider rectifying class 3 and 4. Examples include removal of trip hazards for vulnerable groups.

5.3 Amenities

- Amenities should be designed to take account of the current and future needs of vulnerable tenants.

5.4 Affordable warmth interventions

- Consider prioritising the implementation of affordable warmth interventions to vulnerable groups such as the elderly.
- Take into consideration the vulnerabilities of tenants when planning the timing of implementation (e.g. don’t leave elderly people without heating during cold periods and avoid working in homes with students during revision/exam periods).
- Ensure consistent use of high quality insulation and other materials based on the best available evidence.
- Consider providing additional air vents in the homes of smokers.
- Consider noise issues relating to external vents.
- Ensure high standards of maintenance of the improvements.

5.5 Security improvement interventions

- Work with partners to ensure appropriate levels of street lighting in all areas, particularly those near local facilities, to reduce fear and incidence of crime/anti-social behaviour.
- Improve CCTV coverage of properties, and other high-risk areas, such as parking areas and local facilities.
- Work with partners to ensure maintenance of the local environment and provide tenants and other users with information and mechanisms to report problems such as graffiti, vandalism and litter.

5.6 Improvements to general physical environment

- Develop and implement a coherent plan to improve and maintain the general physical environment in conjunction with partners (public, private and voluntary).
- Implement improvements to the general physical environment as early as possible and alongside home improvements.
- Consider the CABE and HUDU best practice examples of environmental improvements and apply to all housing and neighbourhood improvement areas.
• Work with partners to ensure maintenance of the local environment and provide tenants and other users with information and mechanisms to report problems such as graffiti, vandalism and litter.
• Conduct a greenspace typology study, or retrieve results from any conducted by Council’s greenspace planners, to identify the availability, accessibility and suitability of local greenspaces by type (e.g. informal sports, formal sports, walking/dog walking, local nature).
• Promote/provide access to a range of greenspace typologies through improved quality and range/type of greenspaces.
• Provide information and support to tenants to promote ‘growing things’ at home and in local greenspaces/allotments.
• Safeguard greenspaces and allotments during land use developments.
• Work with partners to provide more “user friendly” environments in order to prevent injuries, for example separate pathways and crossings for cyclists, safe surfaces in play areas, reduced-height monkey bars, play areas that are close to homes and are overlooked, reduced speed restrictions (20mph) on all residential streets and traffic calming measures.
• Try to provide inclusive access to open and green spaces though good design and location of spaces.
• Try to provide a park or small supervised (overlooked) play area within walking distance of every home.
• Encourage active travel by providing secure cycle storage and good quality bus stops.

5.7 Aids and adaptations for the disabled
• Continue to provide high quality aids and adaptations at the earliest possible point in time.
• Ensure aids and adaptations are maintained to a high standard.
• Regularly review the aids and adaptation needs of disabled people.
• Publicise this service so that all groups are aware of it.
• Ensure staff and tenants are aware of other sources of support such as Job Centre Plus Access to Work grants [35]. This scheme can help with the costs of equipment and related training for a wide range of disabilities including people with learning difficulties (e.g. dyslexics).

5.8 Whole house and high-rise refurbishments – the residential relocation process
• Develop a clear, coherent residential relocation strategy for whole house and high-rise refurbishments and new build.
• Define open, transparent and equitable housing relocation systems and processes.
• Make the strategy publicly accessible through a Website.
• Involve tenants in the development of the strategy.
• Offer support to tenants who are to be relocated as early on in the process as possible.
• Support all tenants who are to be relocated through needs planning that identifies health and other forms of support - before, during and after relocation.
• Tailor support to the needs of individuals, with particular attention to the needs of vulnerable tenants.
• Prepare document templates with notification of address changes for GPs, social services, schools etc.
• Re-locate tenants within, or as close as possible to, existing communities.
• Where possible give tenants choices as to where they relocate.
• Inform staff and partners of relocation developments and support for residents.

5.9 Climate change (excess summer heat/heat waves)
• Develop an explicit, multifaceted approach to managing excess summer heat including improvements to ventilation, green spaces and deciduous tree planting, orientation of any new buildings, green roofs and shade.
• Consider fitting windows that can be opened wide while remaining secure to allow better cooling.

5.10 Energy scarcity
• Ensure improvements are energy efficient and adaptable to a lower energy regime. For example, make provision for the location of electric car charging points.

5.11 Identification of vulnerable tenants, information management and customer support
• Enhance the information management system and data/information collection techniques (see section 3.4) to enable the systematic identification of all vulnerable groups including those with learning, organisational and mental health issues alongside the information that is currently collected about physical health issues/vulnerabilities.
• Ensure all frontline staff (including RSL and contractor contact staff) have access to, and training in, the use of handheld flagging systems that can be used when identifying vulnerable tenants, and potentially dangerous tenants. Ensure consistent approaches within and across organisations.
• Integrate the findings of customer surveys that identify vulnerable tenants. Expand the list of questions in surveys to identify further vulnerable groups/individuals.
• Ensure that the system is accessible to all relevant staff, appropriate agencies and actors.
• Obtain advice on the support needs of vulnerable tenants from health and social services.

5.12 Tenant participation and involvement in decision making
• Continue and expand the involvement of tenants in decision making. Explore opportunities and techniques for involving a wider range of tenants; for example, address the practical and financial issues associated with tenants attending events such as those relating to access and childcare. Consider new and innovative techniques for customer participation, for example, using disposable cameras or voice recorders (for children or people with literacy difficulties) to capture local issues.
5.13 Construction safety
• Extend safety awareness programmes to the general neighbourhood. As children are one of the main concerns, conduct awareness raising campaigns in local schools. Deliver leaflets on safety to houses in the general area of the interventions.

5.14 Complaints and the Considerate Contractors Scheme (CCS)
• Some tenants may feel uncomfortable complaining about contractor work practices to site managers or directly to the CCS complaints team. Ensure that tenants have additional information about making complaints directly to their RSL/housing provider. Ensure that complaints are then relayed to site managers and the CCS complaints team and provide evidence of improvement.
• Provide information to neighbours on how they can complain if they are affected by poor work practices.

5.15 Phasing of works
• Ensure that the phasing of works is designed to reduce the frequency and severity of disturbance for tenants.
• Ensure the timing of interventions (e.g. fitting double glazing/doors) is sensitive to the vulnerability of tenants.

5.16 Partnerships
• Strengthen links to other local agencies including Local Authority (LA) and health department community engagement officers, and the LA’s regeneration team.

5.17 Policy
• To assist in demonstrating LA contribution towards implementation of the recommendations of the Marmot Review, consider appropriate utilisation of some of the framework of indicators provided in Annex 2 [10].
• Consider strengthening the links between RSL policy and local and regional policies.
• With the exception of commercially sensitive policies, make all RSL policies publicly accessible.

5.18 Health impact assessment
• Consider adopting HIA procedures for specific projects as described in section 6.

5.19 The process of implementation/construction and communication with tenants
• Provide a minimum of 2 and preferably 4 weeks notice before work commences and provide detailed information on the nature and phasing of work to tenants.
• Provide tenants with regular updates and early prior notice of any delays/cancellations.
• Address language issues and also consider the use of alternative forms of communication, for example, videos and audio CDs.
• Consider increasing the frequency of newsletters during the design, construction and early post works stages and the possibility of collaborative newsletters with other partners.
Include answers to Frequently Asked Questions (FAQs) in a regular feature about the improvements in newsletters; repeat on Websites. FAQs should be identified by customer support and helpdesk officers and/or tenants through a small representative survey of what tenants want to know.

5.20 Planning for climate change and fuel scarcity

All projects that are designed today will have to operate during the next 40 years, under very different conditions to those at the time of design. As a consequence of climate change [36] and increasing energy scarcity [37], fossil fuel will be in very limited supply and greenhouse gas emissions will be some 80% lower. The effects of climate change will become more apparent — with increased summer temperatures and more extreme weather events. These changes are expected to amplify existing health risks and inequalities. Elderly people are most vulnerable to temperature extremes [38].

The reduced availability and high cost of fossil fuels is likely to affect private car transport. Small electric vehicles are likely to be more common, especially for the elderly and disabled, or those who cannot use public transport. Public charging points and bays will be needed on Estates to cater for this. Cycles may continue to grow in popularity and secure cycle storage will be needed, together with dedicated cycleways. The health co-benefits of changes in diet and transport in response to climate change are substantial [39].

Many local authorities are developing special plans to cope with heat waves and Social Landlords should be aware of them. For example, passive design features can improve solar gain to heat buildings in winter and windows that open wide but remain secure can provide summer cooling.

6. Assessing the health impact of specific projects

This Guide highlights some of the general health considerations associated with housing regeneration. More specific tools may be required for particular projects. One such tool is Health Impact Assessment (HIA). HIAs identify health issues for specific projects and strategies and result in evidenced based recommendations designed to promote positive impacts and reduce negative impacts. HIAs include community engagement which can promote wellbeing and may help to reduce opposition to development.

Using HIA, from a strategic perspective, requires screening, procurement and a steering group. Screening simply means deciding which of all the regeneration projects should be assessed. Table 11 is an example. Procurement means deciding who is competent to undertake the HIA, what resources are needed, what the scope should be and how the Terms of Reference should be written. Services can be procured from an existing member of staff, someone with expertise from local health services or the local authority, or an external consultant. HIAs should be open, transparent and community led processes. The steering group should have representation from all the main stakeholders, including local public health officers and tenant associations.
Example of screening criteria for the HIA of a regeneration project

- The size of the Estate/intervention; very large Estate regeneration projects should require an HIA.
- Whether the Estate has particularly difficult to manage features.
- The vulnerability of local populations.
- The cumulative impacts of local developments over time.
- The extent of local opposition.
- The scale of relocation and compulsory purchase.

A HIA can be iterative: first a rapid piece of deskwork requiring a staff-week; later, if justified, a more comprehensive piece of work with more community engagement. The objectives of the HIA are to hear and respond to all the health concerns expressed by stakeholders and to provide justifiable and practical recommendations for safeguarding and enhancing health.

The process of HIA helps to create a dialogue between planners, social landlords, the public health community and the resident community. A consensus may grow from this dialogue about the priority concerns, the affected community groups and the action required.

There are many detailed guides for carrying out an HIA and new ones continue to appear as experience grows. They are usually stored on the HIA Gateway [2], maintained by the Association of Public Health Observatories.

6.1 Changes in the NHS

At the time of writing, NHS service provision is currently commissioned by a Primary Care Trust (PCT). The public health function is lead by a Director of Public Health (DPH), a joint post with the local authority. The DPH produces an independent annual public health report which lists priorities and targets for the health of the local population. The government has announced plans to return the public health function to the local authority. A Public Health Service is being created. The local authority will lead the joint strategic needs assessment process upon which commissioning of NHS services will be based. GP consortia (accountable to the local authority) will be responsible for commissioning health and wellbeing services. PCTs will be disestablished.

6.2 Outline implementation plan

Recommendations that are accepted should be incorporated in a specific management or implementation plan. An example of an outline plan is shown in Error! Reference source not found. The plan should be based on a detailed understanding of the resources that are available for implementation. Stakeholders should be given opportunities to contribute to the detailed development and delivery of the plan.

Table 12 Example of outline management/implementation plan

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Accept/Reject</th>
<th>Champion</th>
<th>Budget</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Remove/repair trip and fall hazards in the homes of older people. Prioritise people with a history of falling and men aged 75 years and over.</td>
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<tr>
<td>2.</td>
<td>Identify vulnerable tenants in a systematic manner</td>
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</tr>
<tr>
<td>3.</td>
<td>Ensure public space is improved at the same time as homes</td>
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<td></td>
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</tbody>
</table>
7. Glossary and Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALMO</td>
<td>Arm’s-Length Management Organisation</td>
</tr>
<tr>
<td>CABE</td>
<td>Commission for Architecture and the Built Environment</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic Group(s)</td>
</tr>
<tr>
<td>HIA</td>
<td>Health Impact Assessment</td>
</tr>
<tr>
<td>HUDU</td>
<td>Healthy Urban Development Unit</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>RSL</td>
<td>Registered Social Landlord</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>

The following information was taken from the World Health Organization Glossary of Terms and adapted for use in this Guide [40, 41].

**Best available evidence**

Conclusive evidence of the links between, for example, socio-environmental factors and health or the effectiveness of interventions is not always available. In such cases, the best available evidence (that which is judged to be the most reliable and compelling) can be used, but with caution.

**Community engagement/participation**

Involving the community in an activity such as the planning of projects or carrying out a HIA. There are a number of models of community participation, some of which are outlined in the Gothenburg consensus paper on HIA (WHO, 1999).

**Determinants of health**

Determinants of health are factors which influence health status and determine health differentials/variations or health inequalities. They are many and varied and include, for example, natural biological factors, such as age, gender and ethnicity; behaviour and lifestyles, such as smoking, alcohol consumption, diet and physical exercise; the physical and social environment, including housing quality, the workplace and the wider urban and rural environment; and access to health care [42, 43]. All of these are closely interlinked and differentials in their distribution lead to health inequalities.

**Evidence base**

The evidence base refers to a body of information, drawn from routine statistical analyses, published studies and “grey” literature, which tells us something about what is already known about factors affecting health. For example, in the field of housing and health there are a number of studies which demonstrate the links between damp and cold housing, respiratory disease and quality of life (Thomson et al., 2001).

**Health gain**

Improvement in health status.

**Health impact**

A health impact can be positive or negative. A positive health impact is an effect which contributes to good or improving health. A negative health impact has the opposite effect, causing or contributing to ill health.
Health Impact Assessment
A combination of procedures, methods, and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. HIA identifies appropriate actions to manage those effects.

Health inequality and inequity
Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary/avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health.

Healthy public policy
Healthy public policy is a key component of the Ottawa Charter for Health Promotion (WHO, 1986). The concept includes policies designed specifically to promote health (for example banning cigarette advertising) and policies not dealing directly with health but acknowledged to have a health impact (for example, transport, education, economics) (Lock, 2000).

Impact assessment
Impact assessment is about judging the effect that a policy or activity will have on people or places. It has been defined as the “prediction or estimation of the consequences of a current or proposed action” (Vanclay and Bronstein, 1995).

Monitoring and evaluation
Monitoring is the process of keeping track of events. For example, the monitoring of a project may involve counting the number of people coming into contact with it over a period of time or recording the way in which the project is administered and developed. Evaluation involves making a judgement as to how successful (or otherwise) a project has been, with success commonly being measured as the extent to which the project has met its original objectives.

Multidisciplinary approach
Using the experience and expertise of a wide range of “stakeholders”. These may include professionals with knowledge relevant to the issues being addressed, key decision makers, relevant voluntary organisations and – perhaps most importantly – representatives of the communities whose lives will be affected by the policy (Barnes and Scott-Samuel, 1999).

Neighbourhood
The term neighbourhood usually refers to a local area which is defined in some way physically (for example, an estate or an area bounded by major roads) or by people’s perceptions of what constitutes their local area. Neighbourhoods are usually fairly small.
Health indicator
A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).

Health outcome
A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status. Examples of health outcomes include levels of obesity, heart disease, depression and mortality, and levels of mortality and life expectancy.

Multiple deprivation
Multiple deprivation is several forms of deprivation acting together, for example, unemployment, poor housing and low income.

Partnership
A group of people or organisations brought together with a common purpose such as developing a regeneration programme or undertaking. In the context of this guide partners may include, amongst others, Tower Hamlets Homes, Tower Hamlets Council and PCT.

Policy
A policy can be defined as an agreement or consensus on a range of issues, goals and objectives which need to be addressed (Ritsatakis et al., 2000).

Process
A course of action or series of (related) activities.

Programme
The term programme usually refers to a group of activities which are designed to be implemented in order to reach policy objectives (Ritsatakis et al., 2000). For example, the housing improvement programme has a range of themes. Themes often include health, community safety, employment and housing. Within these themes are a number of specific projects which, together, make up the overall programme.

Project
A project is usually a discrete piece of work addressing a single population group or health determinant, usually with a pre-set time limit.

Proportionate universalism
‘To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and an intensity that is proportionate to the level of disadvantage. We call this proportionate universalism’ (Marmot et al, 2010).

Qualitative and quantitative
Generally speaking, quantitative evidence is based on what can be counted or measured objectively whilst qualitative evidence cannot be measured in the usual ways and may more subjective, for example, encompassing people’s perceptions, opinions and views. Both forms of evidence are valued and used in HIA.
**Regeneration**
Regeneration is a broad concept used to describe a wide variety of measures that are designed to revive disadvantaged (mainly urban) areas. This might include modifying the physical environment, altering lifestyles, improving leisure opportunities and enhancing the training and employment prospects of local residents. Regeneration can be a continual/cyclical process.

**Resource allocation**
The process of deciding what is needed to carry out an activity and providing for those needs. This can include making provision for financial resources (money), capital resources (such as buildings and computer hardware) and staff resources (including the number of staff needed and the skill mix required).

**Scoping**
Scoping involves defining what will be assessed by the HIA and the boundaries of the assessment. HIA tends to set boundaries relating to the affected population groups (e.g. tenants, local residents, local workers and tourists) and boundaries relating to the availability of data/evidence (e.g. data aggregated to LA), rather than just using (potentially over simplistic) geographic boundaries.

**Screening**
Screening usually refers to an initial step being taken in order to determine whether a policy, programme or project should be subject to a HIA. Screening can be used to determine priorities (i.e. which intervention is most in need of a HIA) when resources are limited.

**Social gradient**
The social gradient is the gradient in the social and economic circumstances of individual members of a population. It is correlated with average health status.

**Steering group**
A group of people brought together to oversee a piece of work such as a HIA. Typically, a steering group might be made up of representatives of relevant professional groups, key statutory agencies and the local community (Barnes, 2000). The steering groups Terms of Reference (ToR) is an agreed set of guidelines, for example, including frequency of meetings and roles and responsibilities of the steering group.

**Strategy**
A series of broad lines of action intended to achieve a set of goals and targets set out within a policy or programme (Ritsatakis et al., 2000).

**Sustainability and sustainable development**
‘Development which meets the needs of present generation without compromising the ability of future generations to meet their own needs’ (United Nations, 1987). Health equity is a prerequisite of sustainable development.
Vulnerable people/groups

Vulnerable people/groups are those who are more susceptible to the (positive and negative) health impacts of a policy or intervention. They vary according to the nature of the policy/intervention but are likely to include:

- Elderly people
- Disabled people
- Children
- People with chronic health conditions
- Families with young children
- Certain ethnic groups
- People on fixed or low incomes
- The unemployed
- People with mental health problems
- People with learning or organisational difficulties.

Workshops

Workshops involve bringing together a group of people for a specific purpose. In HIA this might involve, for example, identifying key stakeholders’ health concerns in relation to the policy, programme or project being addressed. Workshops are usually structured in some way with a mixture of presentations and “hands on” participative work.
8. References and further reading


