Briefing

Health and Social Care Act: implications for housing associations

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Briefing - Health and Social Care Act: implications for housing associations

Briefing from the National Housing Federation on Health and Social Care Act

The Health and Social Care Act received royal assent at the end of March 2012. This briefing provides an introduction to Federation members on the key elements of the Act, highlighting opportunities to engage in the new structures and the key risks for successful implementation. It also summarises the Federation’s lobbying work on the Bill.

1.0 Executive summary

The scope and scale of the Health and Social Care Act led health think tank the King’s Fund to describe it as, ‘the biggest shake-up of the NHS since it was established’. This briefing summarises some of the main changes that will shape housing associations’ relationship with the NHS and local authorities’ health functions. This includes their importance as commissioners, providers of more integrated housing and health services and local partners and collaborators. This briefing covers:

- The opportunities for connecting housing with health
- Federation lobbying on the Bill
- The new organisations created by the Act. This includes, the NHS commissioning Board, Clinical Commissioning Groups, Monitor, Health and Wellbeing Boards, Public Health leadership and Health watch
- Highlight ways housing associations might approach the Any Qualified Provider system and the new outcomes frameworks for health and social care.
- How housing associations can work with local partners to get the most value out of local Joint Strategic Needs Assessments and Health and Wellbeing strategies.
- Next steps for the Federation’s work in this area

2.0 Introduction and context

The Health and Social Care Bill was originally introduced to Parliament in January 2011 and had a long and complicated legislative journey that included a legislative pause, 50 days of debate and approximately 2000 amendments.

The Government set out its direction for travel for reform of the NHS in the 2010 white paper Equity and excellence: liberating the NHS. The aim of the Act was to modernise the health service by cutting back on unnecessary administration in the system and giving responsibility for commissioning to clinicians, giving providers the freedom to innovate and improve services and supporting local authorities to take on new roles to improve public health. Appendix 1 provides the Department of Health’s diagram giving a simplified overview of the commissioning and provision arrangements in the new system.
Housing has a lot to offer to health and care. Safe, healthy homes underpin good health and wellbeing. The home is also an important delivery channel for services that enable vulnerable and older people to access or stay in contact with a variety of services they need to maximise independence. If the Act can achieve its ambitions, it should bring new opportunities for housing and health providers to deliver better outcomes through more integrated services. This Briefing sets out how the Act envisages the new system should function. In practice, the pace of change and appetite for integration with housing will vary across different areas and services. One of the challenges for our sector is making a constructive and practical offer to the right part of the health service in a way they can hear and act upon.

3.0 Health and Housing: the opportunities

There is an impressive and growing evidence base that shows housing related services can improve outcomes and reduce costs for the health services and other areas of public expenditure. Delivering services in the community, rather than in institutions also brings a sharper focus on social capital: helping people with health needs or long term conditions to build links with the community give and get support through informal social networks as well as specific services.

Housing is a ‘social determinant’ of health and has a major impact on community health and wellbeing. Social determinants of health are the key social factors that affect people’s health over their lifetime and can either increase or reduce health inequalities between different groups in society. In comparison to other important social determinants of health, investing in housing and related services are one of the few interventions shown in systematic reviews to narrow inequalities in health outcomes between social groups.¹

The QIPP framework (Quality, Innovation, Productivity and Prevention) is a major driver of reform within the NHS. The QIPP themes are a way of focusing commissioners and providers on ways of delivering savings, while sustaining or improving quality. There is an expectation that this will be achieved by focusing on outcomes, giving power to patients and devolving accountability to the frontline. The QIPP programme is expected to improve the quality of care the NHS delivers while making up to £20bn of efficiency savings by 2014/15. This scale of savings cannot be made by traditional efficiency savings alone. This will require the NHS to do things differently and transferring services that have traditionally only been available in primary care into the community.

Housing should be an important part of reforming health and care services in ways that improve patient experience, outcomes and productivity. Broadly, the housing association offer includes,

- working with NHS Trusts to remodel service pathways to make greater use of supported housing and floating support, reducing the cost of expensive and unnecessary out-of-area placements and enabling quicker discharge
- delivering health services in the community, building on housing association's role as experienced neighbourhood manager and service provider able to reach vulnerable groups who may find it difficult to stay in regular or frequent contact with mainstream services
- Working with local authorities to integrate care or public health services with housing to make progress against community-wide outcomes.
- Making creative use of the NHS estate; using NHS land to deliver a mix of affordable, market, and specialist and supported housing projects to ensure NHS land delivers better health outcomes and a financial return.

Recent research and service pilots have highlighted a number of areas where housing-based interventions have been shown to be successful and are worthy of further exploration:

- improving quality, and extending life
- the use of telehealth and telecare to improve long term conditions
- bringing services closer to the customer, in their home and community
- supporting people with dementia, and their carers pre and post-diagnosis
- integrating services for people with multiple needs and or chaotic lifestyles whose needs are not met or resolved by traditional services.

The Federation has published a briefing with the NHS Confederation to highlight the practical links that can be made between Mental Health and Housing. In June 2012 we launched a set of case studies, On the Pulse, showing how housing can be used more effectively to improve health and care outcomes for older people, delivering the QIPP agenda.²

4.0 **Federation lobbying on the bill**

Over the course of the Bill the Federation worked with MPs, peers and partners in the sector to ensure key issues relating to housing and homelessness were debated. The Federation worked with St. Mungo’s and Homeless Link to put forward 9 amendments which were tabled and debated by MPs and peers. These probed two main issues:

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² *On the Pulse*: [www.housing.org.uk/publications/find_a_publication/care_and_support/on_the_pulse.aspx](http://www.housing.org.uk/publications/find_a_publication/care_and_support/on_the_pulse.aspx)
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- Integrating housing and homelessness into the new commissioning structures
- Testing the ability of commitments to reducing health inequalities to deliver for older and vulnerable people

Parliament debated Federation amendments alongside a number of proposals that aimed to integrate specific sectors with new local commissioning structures or the health and wellbeing board. The specific issue of housing representation on health and wellbeing was discussed. Care minister Paul Burstow MP in the Commons and Earl Howe in the Lords responded on this point. The Government acknowledged the importance of our arguments about genuine local integration, but emphasised the need to set minimum parameters to give local authorities flexibility and autonomy to meet local needs. We expect forthcoming guidance to endorse the inclusion of housing on health and wellbeing boards where there is a local will to do so. And as, the section on health and wellbeing boards acknowledge below, there are a number of opportunities to engage and integrate housing in local discussions, outside full membership of the Board.

In debate on other Federation-backed amendments received a number of useful clarifications and commitments, which will be useful for housing associations in developing their relationships with health and working with local authorities on service planning and commissioning arrangements. This learning has been included in the relevant sections below.

5.0 The NHS Commissioning Board

The NHS Commissioning Board is the new body that will take on the oversight of the NHS. Under the current system, many oversight and management functions are in the hands of the Minister of State and delegated to Primary Care Trusts (PCTs) and NHS trusts. The Health and Social Care Act gives specific responsibilities to the NHS Commissioning Board to:

- Set-up, co-ordinate and hold to account, Clinical Commissioning Groups
- Lead and deliver the NHS outcomes framework
- Ensure national consistency and quality in local services by promoting the NHS constitution and NICE quality standards.
- Promoting equality and diversity and the reduction of health inequalities.
- Be held to account to the Secretary of State for meeting its objectives
- Have full commissioning responsibilities for specialist and primary care services that will not be devolved to local CCGs, either because the services require a national network or where clinician-led commissioning would lead to a conflict of interest. This includes responsibilities for family and transplant services.

In practice, the Commissioning Board is likely to encourage providers and service user voices to push for health equalities locally via the health and wellbeing board. However, there are duties for the NHS Commissioning Board and local Clinical Commissioning Groups (CCGs) to promoting integration through commissioning where it will reduce inequality in outcomes.
The NHS Commissioning Board will be established as an independent body, at arm’s length to the Government by October 2012. The Board will take on its full range of responsibilities in the new landscape from April 2013. During the transition phase the majority of its work will be to work with local partners to establish and authorise CCGs.

6.0 **Clinical Commissioning Groups (CCGs)**

Clinical Commissioning Groups (CCGs) are at the centre of the Government’s health reforms. When fully operational, CCGs will control approximately 80% of the NHS budget. The CCGs will give clinicians and other health professionals the lead on purchasing health services to meet the needs of their areas. A fundamental tenet of the Government’s health reforms is that PCTs have been too bureaucratic and too far removed from the services they commission and that putting the control of commissioning into clinicians hands will lead to more effective services being commissioned, greater accountability to patients, faster decision-making and more responsive services.

Over the coming year, emerging CCGs will go through an authorisation process to take on commissioning powers from Primary Care Trusts (PCTs). Once fully established, the status of CCGs will be similar to PCTs now. CCGs will only commission they will not be able to provide health services themselves. However, this is separate from work that individual GP practices that may do as members of the consortium grouping together to deliver services.

Clinical input to commissioning will also come through Clinical Senates. These groups will provide higher level clinical advice to CCGs and health and wellbeing boards. It is envisaged that the Senates will have a core steering group but with a much wider membership that extends beyond the NHS.

The focus and membership of CCGs will mean they have a strong focus on clinical services. However, there are important opportunities for the sector to press the groups to look more broadly at housing-based solutions. As part of their general duties set out in section 26 of the Health and Social Care Act. CCGs have a duty to promote integration to improve quality and reduce inequalities. This includes integrating both,

- health services with other health services, and;
- health services with health-related and social care services. For the purposes of the health and social care act community services like housing and housing-related support would be ‘health-related services’.
The Act sets out that CCGs can go beyond traditional clinical services to improve the health outcomes of people in their area and this could include devolving commissioning responsibilities to local authorities. CCGs approach to integration could include commissioning health-related services that deliver locally prioritised outcomes. CCGs could also comply with their duty of integration by choosing to commission services jointly with local authorities or outsourcing the commissioning of some services to local authorities or other public bodies with a clear expertise and experience in commissioning the outcomes they seek.

There may be opportunities for housing associations to explore through the transformation of Community services. Between 2009 and 2011, the Transformation of Community Services programme transferred £8.5bn worth of community based services from PCTs to community providers to ensure PCTs separated their commissioning and provider functions. Most of these contracts lasted for three years. Health market analysts have suggested that many of these services could be put out to tender in 2013/14. Previously, the NHS was the preferred provider for these services. However, the pressure for productivity savings and the changes created by the Health and Social Care Act could see the commissioning and purchasing process be used to identify more innovative routes for delivery.  

7.0 Monitor

Monitor is currently the regulator for Foundation trusts in England and has previously been the body that decides whether NHS Trusts should be granted the additional freedoms and independence that comes with Foundation Trust status. The Health and Social Care Act extends Monitor’s regulatory role across all health and care services in England. This puts more regulatory attention on economic regulation and oversight of the health and care market than previous regulation in health and care.

Monitor will regulate to deliver,

- Fair competition to deliver more choice and control to patients.
- Licensing the ‘Any Qualified Provider’ system. This will include NHS and voluntary organisations and commercial companies to provide NHS services. We explain the AQP system in more detail below.
- Regulate prices for NHS services through the NHS Tariff
- The financial mechanisms to ensure continued access to NHS services.

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3 Health Service Journal, 30 November 2011, ‘Private sector could take £2bn slice of community services’
The NHS tariff sets out how providers of NHS services are paid for the patients they treat. The Act gives Monitor the responsibility for developing this, probably from the 2014/15 tariff. Assurances were given that as Monitor and the National Commissioning board develop this, it will need to consider among other factors the impact of variations in the range of services provided by different providers and the differing needs of the patients treated.

Monitor’s role was the subject of a lot of debate during the legislative process, because of concerns over the risk of more aggressive commercial competition within the health market. As a result of amendments to the Bill, Monitor’s duties now cover stimulating integration of services and build in patient voice through its regulation. Clause 97 of the Act establishes Monitor with the powers to set and enforce licence conditions to enable integration and cooperation between providers where this would improve quality, efficiency or reduce inequalities.

Monitor has a duty to notify commissioners if it believes delivery of critical health services are at risk because of how services are configured in their area. The National Commissioning Board and CCGs have to have regard to this notification. These powers give Monitor the mandate for broader oversight of health provision when regulating. This means Monitor, should, in principle, look broadly at the level type and quality of local provision when regulating, not just the remit of the individual trust or provider it is focusing on.

8.0 Any Qualified Provider

The broad commissioning model of ‘Any Qualified Provider’ (AQP) is currently used in elective care. The Health and Social Care Act will extend this to a wide range of community services. In principle, this approach will open up opportunities from the NHS, independent and new social enterprise providers to deliver health services. As long as an organisation meets quality and price standards then they can be part of the NHS marketplace. The National Commissioning Board and Monitor have the responsibility to ensure competition is focused on quality and choice for patients, rather than price.

It is envisaged that AQP will give more patients the right to choose a service and a place that is most appropriate to their needs and will make it easier for providers to develop and offer new services. AQP will require national accreditation and local registration with CCGs. The latter will not be a binding regulation but is necessary to ensure providers are involved in local service planning and care pathways. National accreditation as an AQP is likely to involve:

- Registration with CQC and Monitor
- Agreement with national or local tariff of payment
- Zero-hours based contracts
- Evidence of a track-record of delivery / evidence of outcomes
- Agreement to standard contract terms and any locally specified quality requirements
Commitment to managing any conflicts of interest and promoting right to choose to patients

The expansion of AQP could bring opportunities for housing associations to position themselves as qualified providers for whole pathways as well as specific services where housing-related health or support services have shown to improve outcomes. However, AQP status will also place demands on organisational systems and may require some changes and investment in infrastructure to meet the demands of Monitor to maintain Qualified Provider status. This could include conforming to the highest standards of data confidentiality, for instance, or addressing clinical governance.

There are also more system-wide risks. AQP could fragment care pathways and make true integration harder if CCGs take a narrow approach to competition between providers. The Department of Health has emphasised that there is a range of options for CCGs to decide what the most appropriate way of delivering choice in different services and areas to reassure providers and commissioners that this does not force services down the route of competition on cost. The range of approaches could include, AQP, competitive tendering or using commissioning process to ensure an NHS provider will provide or make available through other providers the sufficient choice and range of options for patients.

9.0 Outcome frameworks for the NHS, social care and public health

In order for the value of housing to health to be recognised by health commissioners, the sector will need to communicate the difference our services make through the outcomes set out in the frameworks for the NHS, Social Care and Public Health.

Each of these frameworks has indicators organised under four or five domains. A small number of ‘impact indicators’ are common across all three frameworks. There will be central provision of reporting of indicators via the NHS Information Centre for Health and Social Care. The National Institute for Health and Clinical Excellence (NICE) are also developing Quality Standards across health and social care outcomes.

This new outcomes approach could be highly important for providers of health services. It forms the accountability framework for the results the NHS delivers. The NHS outcomes framework sets out the areas that Government will use to track the performance of the commissioning Board, and that the NHS will use to identify ways of improving services.
The outcomes frameworks are central to the Government’s approach to devolve the control of the health service to patients, clinicians and health professionals. The Social Care framework emphasises that the outcomes approach is not about focusing resources on hitting narrow targets: ‘There will be no national performance management, no targets or league tables’. Rather, it is about giving control over services to patients and professionals and ensuring a clear accountability for the results they deliver. If this approach achieves its aims there should be more freedom for commissioners to develop services that deliver key outcomes for patients and less of a focus on output targets through traditional models of delivery.

The domains of the NHS outcomes framework can be linked to housing interventions, for instance:

- **Preventing premature death** – housing interventions can delay, reduce or avoid the need for more intensive interventions.
- **Improving quality of life for people with long term conditions** – preventing acute admissions through avoiding crises, accidents, providing help.
- **Helping recovery from ill health or injury** – for housing associations, this could include preventing or reducing readmission for people with chronic conditions, recovering from an injury, trauma or stroke.
- **Ensuring that people have a positive experience of care**
- **Treating and caring for people in a safe environment; and protecting them from avoidable harm**

The housing contribution to public health indicators is identified in the public health section below.

While there are no specific housing indicators, across the domains there are a range of indicators associated with housing, including:

- Under 75 mortality rate from respiratory disease
- Enhancing quality of life for people with mental illness
- Helping older people to recover independence after illness or injury

### 10.0 Health and Wellbeing Boards

The Health and Social Care Act establishes health and wellbeing boards to provide local oversight over commissioning of services. Health and wellbeing boards should bring together the main interests and services in the local area that affect health and wellbeing. They will provide a forum and space to bring a co-ordinated approach to healthcare and health improvement. The aspiration of the Act is for boards to drive quicker and clearer integration of services by bringing together heads of service areas in the local authority that have an interest in improving health outcomes and reducing health inequalities. Boards should maximise the impact of local investment in health by delivering a co-ordinated approach to health improvement across the NHS, social care and public health.
As with any newly established forum there is a risk that some Health and wellbeing boards become places where discussion happens but no clear priorities are set. To make the most of the opportunities these boards bring, it can be helpful to focus on the specific roles and duties Health and Wellbeing boards have in the Health and Social Care Act.

- The health and wellbeing board will lead a Joint Strategic Needs Assessment for their area. Legally, there is a joint duty on the local authority and the CCG to produce the needs assessment. And the Act specifies that this legal duty has to be discharged by the health and wellbeing board. The needs assessment will be the basis of the co-ordinated health and wellbeing strategy.
- Boards have an important role in scrutinising the plans, intentions and activities of Clinical Commissioning Groups. They have the ability to challenge Clinical Commissioning Groups on their priorities and plans if the local board believe they are not consistent with local needs or in line with other strategies. This includes the ability to refer a plan to the National Commissioning Board.
- CCGs have a duty to involve all relevant health and wellbeing boards in preparing or revising its commissioning plans. The CCG must include the final opinion of the health and wellbeing board in their commissioning plan.
- There is a requirement for health and wellbeing boards to encourage integrated working between commissioners of health and social care services. In particular they must provide advice assistance or other support as they think appropriate for the purpose of encouraging the making of arrangements under section 75 of the NHS Act 2006 in connection with the provision of health and social care services. These arrangements include the pooling of funds, leads commissioning and integrated provision. The NHS Confederation has published a useful briefing for Boards on making the best use of shared resources.
- Health and wellbeing boards are able to expand into new roles and take on additional responsibilities. The Act allows local authorities to delegate functions to the health and wellbeing board. The draft guidance on JSNAs and local health strategies suggests this could services relating to the determinants of health that are in the local authority’s functions, like housing and children’s’ services.

Formally, health and wellbeing boards will be committees of local authorities, but membership can be expanded across health, care and health-related services. The Act specifies a minimum membership for Boards of:

- A local councillor
- A representative of the local Healthwatch (see section on healthwatch below)
- A representative from the clinical commissioning group
- The director for adult social services
- The director for children’s’ services
- The director for Public Health
The Act is clear that this membership is the minimum required. Health and wellbeing boards are free to extend membership to include additional service area expertise, perspectives and representatives. Over and above the minimum membership criteria, the boards have a duty to take into account the needs of all local people. The Department of Health’s draft guidance for health and wellbeing boards highlight housing as an example of an important social determinant of health that local boards may want to expand their membership to. We believe ensuring a voice and role for housing through the Board is an important way of ensuring the boards and transform local services. However, there are other opportunities to contribute to local priority setting and service design.

While involvement of housing on boards is important for genuine integration and transformation to take place, full membership of the board is just one route to getting the voice of housing recognised. A local board with a wide and diverse membership will not automatically be more effective at joining-up services and driving better commissioning and outcomes than a board with a tighter or closed membership that brings in specific contributions from housing on themes, services or pathways. As structures and ways of working are emerging now, it is too early to identify the most effective ways of running boards as these. The Federation will seek to share promising practice with its members as this develops. At this stage we can identify a variety of different approaches being taken. This includes,

- Narrow and focused boards: led by local authorities, with a core group of key commissioners from the local authority to work with CCGs and agree major priorities to drive commissioning strategies of different services
- Wider membership convened along the lines of previous Local Strategic Partnership working, with voices from local authority and wider independent sector.
- A core-and-periphery approach: with a closed core membership that acts as an decision-making group, supported by a broader panel or sounding board of local expertise from across different service areas

In April 2012, the King’s Fund published the results of a survey 50 English health and wellbeing board areas to track early progress and highlight the issues that had been encountered. This research highlighted that,
- To make the most of their role, Boards need to be clear about what they want to achieve. The King’s Fund research found potential tensions between the function of overseeing commissioning and encouraging integration across health and health-related commissioning
- Local authorities who use the opportunity to take new and more creative approaches to working with local partners will have more success than areas that re-brand or re-purpose existing partnership arrangements
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- It is a big challenge for local areas to provide the kind of leadership required to integrate across all the areas that impact on health and care outcomes.⁴

11.0 Effective Joint Strategic Needs assessments and local health and wellbeing strategies

Joint health and wellbeing strategies will set out how partners will work together to deliver the agreed priorities of the health and wellbeing board. These strategies need to be based on a clear picture of current and future health and care needs of the area. JSNAs should not limit themselves to the main areas of health or care provision; they should consider all the current and future needs that are capable of being met. The Health and Social Care Act puts a duty on the local authority and the CCG to develop a Health and Wellbeing Strategy for meeting the identified needs.

At the time of writing we are waiting for consultation on the statutory guidance for developing JSNAs and health and wellbeing strategies. The initial draft guidance, published in early 2012, sends some clear messages about what effective JSNAs will do and how they should be linked in to health commissioning. CCGs, the NHS Commissioning Board and local authorities are must have regard to the relevant JSNA and strategy as they exercise their functions. JSNAs and strategies do not have to be re-worked annually, but they do need to inform each annual commissioning plan by the CCG. And those plans need to be in place before the start of each financial year. It will be down to health and wellbeing boards to agree how to update them each year. This could be an opportunity to tie-in health commissioning to local authority commissioning cycles and also to take a thematic approach to focus on the particular health and care issues or service area or geographic community.

The aspiration of the Act is for the JSNA and local health strategy to reach beyond the limits of the health service to be tools to bring a health and wellbeing element to wider functions and commissioning so all relevant local services help improve health and care outcomes. This could include the CCG’s work to reduce health inequalities through improving access to clinical services, but also through delivering non-health duties like housing and planning, reduction of crime and anti-social behaviour.

The draft guidance emphasises the need to involve groups and local people in the preparation of the JSNA and strategy, including wider engagement with voluntary and community sector and providers who have a role in both providing evidence and delivering services that will meet identified local need.

As with the involvement of housing through local boards, different JSNAs will capture housing and housing-related services different ways. A variety of approaches could be effective, but housing associations should make the case to local boards for housing to be addressed in a way that recognises its full contribution to local services and outcomes.

In some JSNAs housing might be most effectively addressed as a determinant of health: a contextual and causative issue rather than a strand of health provision or need. In other areas it is treated as a cross-cutting theme for a variety of specific services to address or for it to emerge as a theme and need in a number of different patient pathways. In addition to these approaches, housing could be approached as an important topic, service and need in its own right. The availability of good quality housing stock and a range of options for housing and support could be included as an important asset.

Housing associations have a variety of data and intelligence that will enhance local needs assessments and make them more meaningful and focused. Social housing providers collect a wide range of information about their tenants, service users and their families that could help deepen the local intelligence on health needs. It can be helpful to consider the different elements of provision to map this, including, data on lettings property condition and customer insights.

In addition to this, housing associations providing care and support can add significant information on groups likely to be experiencing poor health outcomes or severe health inequalities. This should be drawn on to inform accurate priority setting and targeting interventions at the local level. This might mean, for instance using housing associations' information on people with multiple needs. Or it could involve giving existing data important contextualisation for health. Housing benefit data may be a useful trigger for looking more deeply at specific needs e.g. families who are out of work for long periods and have contact with children services.

Because of the potential broad scope of the JSNA, local authorities and housing and support providers could benefit from taking a gradualist and practical approach that might deepen over several years.

The aim of the joint health and wellbeing strategy is to jointly agree what the greatest issues are for the local community based on evidence in JSNAs, what can be done to address them; and what outcomes are intended to be achieved. To be effective, strategies need to select clear priorities for the area, rather than try and address every possible health need.

Strategies could consider how commissioning can link in with the functions of the health service and local authority commissioning. This might include making specific commissioning arrangements to ensure services will improve health outcomes. The Act gives local authorities and clinical commissioning groups a duty to consider how the use of existing flexibilities under section 75 of the NHS Act 2006, such as pooled budgets and lead commissioning, as a route to meeting the needs identified in the JSNA.
12.0 Public Health – a new focus on health improvement

Through responsibilities set out in the Health and Social Care Act, there will be a new emphasis and drive to improve public health and wellbeing. This will be lead by local authorities, through a Director of Public Health. It will be supported by a new national agency, Public Health England and the national Public Health outcomes framework.

The Act gives local government a new duty to improve the health of the population. This involves, duties to

- Commission services from providers to improve population-wide health and reduce health inequalities.
- Work with CCGs to integrate care pathways to improve access to services
- The local authority will provide some mandatory public health advice to CCGs
- Giving advice to the NHS on the health needs of local communities
- Integrating commissioning through the health and wellbeing boards
- Ensuring effective plans are in place to protect health.

To deliver their duty to improve health, local authorities will appoint a Director of Public Health. These posts will be the lead officer for health improvement within the local authority and will champion health improvement across the local authority’s area of operation. The Director of Public Health is expected to sit independently within the local authority but have direct access to elected members and direct accountability to the local authority chief executive to help the director deliver their function.

As well as bringing a focus on health inequalities across the local authority’s functions the Director of Public Health is required to work strategically and corporately to drive reductions in health inequalities. This means working closely with the NHS and other partners to take health improvement approach to issues such as crime reduction, violence prevention and reducing reoffending, which will also reduce health inequalities. They can do this through links to existing partnership working and through new relationships, for example with incoming Police and Crime Commissioners. The Department of Health’s own briefing states that, to do this successfully will require a willingness to use all the tools at local authorities’ disposal in a new way and not just rely on commissioning traditional services. The Director of Public Health should,

- Ensure health is included in all policy areas to maximise the health benefit of a range of different services
- Invest in high quality public health services from a ring-fenced public health budget
- Promoting accessible local environments that will improve health, including access to green spaces and transport
- Supporting local communities to develop their own social networks and activities that help citizens to engage with their community and develop links and connections between different groups and communities of interest
The Federation believes these public health functions and the nature of the Director of Public Health role means there is a clear need and potential in connecting public health with housing and housing-based interventions for older and vulnerable people. This might include, for instance, targeting interventions in particular geographic areas and maximising the impact of interventions by partnering with social landlords. It could also cover concentrating some public health work on particularly severe inequalities to complex needs, or expanding an ‘every contact counts’ approach to extend the reach of public health interventions to communities who need it most who won’t otherwise connect with traditional health services or community projects.

The intention of the Act is to give local authorities a clear lead to deliver their own public health priorities and services. There are a small number of mandatory services that local authorities have to commission. These include sexual health services, NHS health checks and the National Child Measurement Programme. A ring-fenced public health grant will support local authorities in carrying out their new public health functions. The Department of Health has made shadow allocations to local authorities for 2012/13 to help them prepare for taking on formal responsibility in 2013/14.

The new national agency, Public Health England, will,

- Deliver some services required at national level: health protection, public health information
- Provide a national lead for public health by building relationships and the evidence base and supporting the development of the public health workforce.

Services will also be co-ordinated and tracked through the Public Health Outcomes Framework. This sets out indicators of public health from the wider determinants of health through to effectiveness in reducing premature mortality. The over-arching aims of the new public health function to increase healthy life expectancy and reduce health inequalities. The public health outcomes framework focuses on four domains:

- reducing numbers of people living with preventable ill health and people dying prematurely
- protecting the population’s health from major threats
- improving health through supporting healthier lifestyles and choices
- improving the wider determinants of health and wellbeing.
The social determinants of health include housing as well as education and employment. There are a number of indicators in the public health outcomes framework that directly link to housing. Under the theme of the social determinants of health, there are indicators on both statutory homelessness and the number of people with mental illness and or disability in settled accommodation.

Public Health England will support the NHS Commissioning Board’s decision-making and prioritisation. It will assist directors of public health and their teams in advising CCGs as required in the commissioning and delivery of services.

Successfully meeting public health outcomes will require local authorities to identify and target vulnerable population groups and developing clear commissioning priorities to meet these needs. The public health advice to NHS commissioners includes identifying vulnerable populations, marginalised groups and local health inequalities. It also includes advice on commissioning to meet these health needs, and using profiling information to look at connections between needs, available services and outcomes for different equality groups.

13.0 Healthwatch

In the new system voices of patients and service users will be heard, channelled and brought to bear through National and local Healthwatch. Local Healthwatch organisations will gather and represent views on the NHS, public health services and social care at the local level and bring these together at health and wellbeing boards. National Healthwatch will act as a champion for collective patient and public voice on health and care with the explicit role to influence the national decision-makers on health and care like the NHS Commissioning Board, Monitor and the CQC. National Healthwatch will be located within the CQC.

Local authorities are already working with LINks and other community organisations to shape the development of local Healthwatch in their area. While Department of Health is supporting this development through an implementation plan, their approach is focused on using local organisations and networks who are already expert in supporting community voice and advocacy in health and social care.

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   www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

6 Department of Health, Healthy lives, healthy people: Improving outcomes and supporting transparency(2012),
A number of housing associations who provide care and support and help give voice to vulnerable groups have been involved in LINks to date. Local Healthwatch is being developed from LINKs, using their local experience. However, Healthwatch more formal than LINks and established as corporate bodies with specific statutory functions. There has been some debate over the ability for Healthwatch to speak independently because they will be funded by and thus accountable to local authorities and their partnership structures for their statutory duties.

The key functions of Local Healthwatch are to:

- ensure views and experiences from people who use health and social care services and other members of the public are an integral part of local commissioning across health and social care.
- provide a source of on the ground experiences for people to Healthwatch England, including reporting concerns about the quality of care by service-providers; and
- if commissioned by the local authority, provide NHS complaints advocacy.

14.0 Next Steps

As this briefing outlines, there are a variety of routes in the new health system for housing associations focusing more on health outcomes. Many of our members are already engaging with parts of the existing and new health landscape. Clearly, careful planning and prioritisation of particular offers to different parts of the NHS and local authorities will help organisation maximise their impact. However, because of the scale of the change and the massive pressure of productivity savings the final shape of the NHS and public health functions of the new system is still unclear. To help members manage this uncertainty and find the most effective route for their organisation, the Federation is taking forward several elements of work. These are,

- Partnership work with the NHS Confederation to better connect housing associations and NHS trusts
- Planned work with Department of Health on sector-specific guidance on the housing contribution to the Joint Strategic Needs assessment
- Regionally, our care and support forums are mapping and tracking member engagement with Health and Wellbeing Boards and CCGs
- Discussions with individual Directors of Public Health on how best to harness the potential of housing in improving physical environments, people’s lifestyles in a way that reducing health inequalities.
- Working through the Dementia and Housing Working Group, set up by the Federation with DCLG, to highlight positive practice and to position housing as key to improving the lives of people with dementia.
Appendix 1: Department of Health diagrams of regulation in the reformed NHS

Source: Department of Health (2012), *Protecting and Promoting Patients' Interests: the role of Sector Regulation*, p2,