Healthy communities live in healthy homes and neighbourhoods

1. Introduction

Housing and the neighbourhood environment affect people's health and wellbeing throughout their life and drive inequalities – they are wider determinants of health. Health reforms reflect that local government is best placed to influence these factors, alongside others, in partnership with clinical commissioning groups[1], service users and the public, and others such as the voluntary sector. The shift from 'top down' to 'bottom up' presents an opportunity for plans, policies and practice to connect locally, making the best use of resources to meet identified needs and priorities and to achieve improved outcomes.

Improving health and wellbeing is clearly a priority for the government, signified by the Comprehensive Spending Review (CSR) and health reforms. However, whilst housing is also important, CSR brought a considerable reduction in spending[2]. The government expects ambitions to be achieved through locally directed plans and policies and the use of existing assets and resources. This is a particular challenge given the economic climate. It will be difficult to meet housing needs and improve housing conditions, whilst welfare reform and changes to security of tenure present challenges about where people will be able to live in the future. There is a lot going on in the health sector at the moment, but local areas still need to consider and manage the impact of significant changes in housing policy and practice, and spending, on the future health and wellbeing of the population.

This note is intended to inform local discussion and debate and to support local government, health and wellbeing boards and housing providers in the West Midlands to identify how they can shape their housing and health policies, plans and practice together to improve outcomes. It provides:

- Suggestions for action at a local level, including the main issues for discussion and thoughts on how local areas might develop their longer term working relationships. It is hoped that emerging Health and Wellbeing Boards and local strategic housing partnerships will consider these together, as part of developing relationships and the new health and wellbeing strategy.

- A précis of the evidence that housing has an impact on health and wellbeing, based on earlier research for the region and updated with new evidence.

[1] Clinical commissioning groups replace GP consortia in current proposals for health reform, following the government's response to NHS Future Forum's report published in June 2011. Groups will involve a wider range of health professionals including doctors and nurses, social care professionals.

[2] The Department of Communities and Local Government saw spending reduced by 33%, with a 74% reduction in capital

- A summary of the proposals for reform in both the health and housing sectors, intended to bring practitioners up to speed, enabling local dialogue and action to begin now (speaking the same language will be important).

- More detailed appendices describing reforms in the housing and health sectors and the implications arising from these. Suggestions for stem primarily from this review.

The content will be of particular interest to those working in housing, planning, environmental health and social care in local government, elected members, housing service providers and public health practitioners. It will also be relevant to commissioners within the clinical commissioning groups eg, GPs, as they seek to understand how the housing sector works and what it can offer them in their role as commissioners and practitioners, and what they can offer in return.

This note builds on previous extensive research for the West Midlands, *Research to Identify the Contribution that can be made to Health Outcomes by Housing Policy*[i], undertaken on behalf of the former West Midlands Regional Housing Executive, working in partnership with Department of Health West Midlands and the former Regional Health Partnership in 2010. Recommendations remain broadly relevant to today's localism context.

This note also supplements and informs a programme of work in the West Midlands to support the transition to new health roles and responsibilities. Updated Health and Wellbeing briefings for local authorities which are developed from the former West Midlands Health and Wellbeing Strategy will be produced and provide the latest information on inter-relationships and suggested focus for Health and Wellbeing Boards, whilst training and events[ii] will be available across the West Midlands during 2011/12.

2. Suggestions for local action

The following recommendations are for Health and Wellbeing Boards, local strategic housing partnerships, local authority housing commissioners and elected members to consider.

2.1 Recommendations in relation to commissioning for improved health and housing outcomes

1. Explore where, within new local commissioning arrangements, the opportunities to integrate and align health and housing to achieve improve outcomes will be best explored

Reforms and spending decisions in both housing and health have the potential to impact on health and wellbeing. Given reduced capacity it makes sense to consider what the impact could be and to take action together to mitigate this.

Health reforms will result in significant changes to the local commissioning 'architecture' and present opportunities for a partnership approach. Housing involvement in the Health and Wellbeing Board would seem a sensible step in order to address these, to achieve improved outcomes and to enable accountability to the public.

2. **Consider how commissioning practices for health and housing can come together to make the best use of existing skills, expertise and knowledge to achieve shared outcomes.**

   Reforms require local authorities to provide strong leadership and to become more effective as commissioners. Unfortunately this area of work within authorities has seen reductions in capacity as authorities prioritise front-line activity. The capacity to commission in the health and social care sector is also changing as the commissioning architecture is reformed. There is an opportunity to consider whether experience and knowledge, skills and expertise in all sectors can be used more effectively.

3. **Develop the evidence base (the Joint Strategic Needs Assessment and housing market assessments) – to inform housing commissioning and joint commissioning between housing and health**

   A robust understanding of the local population's health and wellbeing is needed to achieve better health and wellbeing outcomes, reduce inequalities and to make the best use of resources. There will be a requirement for the JSNA to inform the new Health and Wellbeing Strategy and all local commissioning. As housing activity has a clear contribution to make, it makes sense for housing intelligence to link with health intelligence, including through housing market and needs assessments. Local Government Improvement and Development has recently published guidance and good practice on the JSNA, *a springboard to action*[iii]

4. **Consider the potential to share and target housing and health resources to achieve shared outcomes.**

   The health and housing sectors are both seeking to do 'better for less' – savings of £20bn are being sought in health through the Quality Innovation Prevention and Productivity programme, to reinvest elsewhere. The DCLG budget (the government department responsible for housing) has seen a 74% reduction in capital spending and a 33% reduction in revenue. Opportunities may exist for savings and efficiencies to be found from within the commissioning process and from service delivery.

5. **Identify how the housing contribution to health outcomes – and vice versa – can be scrutinised, and for organisations to be held to account for example through the local HealthWatch.**

   Reforms in the health and housing sector are intended to support increased accountability for outcomes and spending to the public. In health

and social care this will be enabled through the use of three outcomes frameworks, with commissioners sharing outcomes where a joint approach is needed. Proposals for accountability have been strengthened recently, following recommendations from the NHS Future Forum.

The housing sector does not have a single, national, outcomes framework, and activity can be fragmented in local areas. Local frameworks may exist, for example in relation to housing support services or homelessness, but it is unusual to find a comprehensive framework in place that will enable the public to scrutinise the overall approach to homes and housing services in an area.

6. **Explore the benefits of managing the housing and health provider market to best effect, particularly to enable good quality information and advice for all.**

   Health and housing reforms are intended to support the economy, to increase choice and control for local people. The market place is expected to change to enable this and it will be important that the new market is managed so that it offers a good quality service that will contribute to outcomes.

   The provision of information and advice is common to health and housing sectors and reforms expect this will develop to enable prevention and to support people to take responsibility for their own decisions. There is a risk of information overload and inconsistent information and advice if sectors don't work together.

   The use of behavioural insight and intelligence to inform a joint approach is recommended. This is already common to public health practice but less so in housing.

7. **Communicate the relationship between housing and health to the public, patients and other service users to inform decisions and to change behaviours.**

   Health reforms expect individuals to take greater responsibility for their own decisions, in return for information upon which they can make real choices. This information has to make it clear how housing circumstances can affect health and wellbeing, and to signpost people to the options they have to improve these.

   Better use should be made of information about what people need and want when they present to front-line services to inform local commissioning and, ultimately, to enable options for people to choose from.

2.2 Recommendations in relation to managing the impact of housing reforms on health and wellbeing

8. **Understand and plan for the impact of welfare reform proposals to mitigate potential impacts on health and wellbeing**

   Welfare reform is expected to have a significant impact on household income and, in turn, the ability of households to meet their own housing needs. It is possible that a number of low income and vulnerable households will have to relocate, or take decisions to reduce their other household expenditure. The impact on health inequalities and health and wellbeing should be considered locally.

9. **Consider and plan for the health implications arising from reform to the housing supply system.**

   Reforms to enable an increase in housing supply are the most developed. Proposals to change the planning system are intended to make development quicker, although not necessarily enabling local areas to ensure their aspirations are met. The way in which affordable housing is funded is also changing.

   New 'affordable rents' (these are up to 80% market rent, higher than social rent) for subsidised homes are intended to secure additional lending from the private sector. The model also requires a number of social rented homes to be converted to 'affordable rent' levels, and for organisations to draw on existing asset bases and reserves, and seek input from local authorities eg, land. This may mean that organisations will not have enough money to invest in other activities eg, those that are focussed on changing the lifestyles of their customers and communities.

   There is expected to be a greater use of the private rented sector to accommodate low income and vulnerable households eg, those who have been homeless.

10. **Given the known relationship between housing conditions and health, understand and plan for changes in funding for housing improvements.**

    Managing improvements in the quality of existing homes in the public and private sector should be considered in the context of reduced resources. It is clear there are already pressures eg, waiting lists for disabled facilities grants are rising.

    The use of existing assets is encouraged by the government and it is necessary to consider how people can be encouraged to meet their own housing needs using their own resources eg, homeowners who have equity in their property.

11. **Consider the potential impact on health and wellbeing of proposals to change security of tenure**

In addition to welfare reform, plans to charge affordable rents and a reduction in spending on housing generally, social housing reform will change security of tenure for new tenants and access to affordable and social rented accommodation. There will be no automatic right to a 'home for life' for new tenants. Strategic housing authorities will have a statutory duty to inform and direct these changes but Registered Providers (mainly housing associations) will have greater freedoms and flexibilities to determine the circumstances in which tenancies can be ended or renewed.

12. **Review the role of housing options and housing support services in achieving health and wellbeing outcomes as a matter of priority.**

The reduction in local government funding has impacted on spending on housing support (Supporting People) and homelessness services, despite hard evidence that these services contribute significant savings to health partners alongside positive outcomes for vulnerable people. The voluntary and community sector plays a considerable role in delivering support and homelessness services: reductions in spending will affect their contribution.

3. The impact of housing on health

This section provides an overview of the impact of housing on health and of the implications for intervention. Historically, the focus has been placed on the impact on physical health of poor quality housing but attention has continued to widen to include mental health and well being; the impact of the environment of the home and the vulnerability of such social groups as older people, the homeless, those with disabilities, BME communities and Gypsies and Travellers.

The quality of evidence of causation remains variable, and studies tend to focus on separate issues or a single health effect rather than assessing the 'cocktail effect' of combined housing risks, a cold and insecure house in a high crime area is likely to have multiple and cross-cutting health impacts.

The potential to intervene is dependent on the quality of local evidence of the incidence of unhealthy housing conditions, of vulnerable groups and of the overlap between the two - effective interventions requires sound evidence. The starting point in identifying these two critical requirements is the relevant Joint Strategic Needs Assessment (JSNA) and Housing Market Assessment (HMA) but it is likely that neighbourhood and consumer specific data will be required.

3.1 Context

Three contextual issues are relevant to understanding the impact of housing on health:

- The greater health consequences for vulnerable groups need to be taken into account for all impacts: including for children, those with disabilities, BME communities, gypsies and travellers and the homeless.

- Trends in the older population: including the very large increase in the older population and involving tensions between the effects of improvements in life expectancy and 'healthy life expectancy'.

- Economic change and reductions in public spending: where growing dependence on low incomes, inadequate housing supply and associated problems of affordability are likely to increase associated health impacts.

3.2 Approach

With these considerations in mind, this overview has been constructed around two broad themes:

- The impact of the home on physical and mental health.

- The impact of the wider home environment on physical and mental health.

The impact of the home on physical and mental health

Four key impacts are:

- Unhealthy housing: especially non-Decent pre-1919 housing and exacerbated by fuel poverty, the impact of poor housing conditions on physical health is widely accepted, especially cold and damp, but also extending to poor air quality and inadequate noise, space and light. The causal relationship between cold housing and ill-health is one of the most strongly established with cardio-vascular and respiratory conditions resulting in 'excess winter deaths' among older people.

- Unsafe housing: accidents are major causes of injury and death in the home, especially to children and young people, but the incidence also increases with age.

- Unsuitable housing: especially associated with those with a disability or limited mobility, with families living in overcrowded conditions and with older people living in under-occupied and difficult to manage housing.

- Insecure housing: among a wide range of groups from the homeless to gypsies and travellers who are unable to access suitable housing, who fear or experience the loss of their home, or who are insecure in their own home due to domestic abuse, all of which can result in anxiety, a sense of hopelessness and depression.

Potential interventions associated with each impact are:

- Unhealthy housing: the Housing Health and Safety Rating System (HHSR) provide the basis for identifying potential risks, especially from Category 1 Hazards. The ability to prioritise is essential, requiring the most vulnerable housing areas and properties to be identified, and the health needs of their occupants to be assessed. Improvements to insulation and heating systems are basic requirements but the lack of effective equity release schemes is an obstacle to intervention.

- Unsafe housing: community-based initiatives providing free smoke alarms combined with safety checks may reduce fire-related injuries. Home safety promotion visits combined with health education and media campaigns identifying hazards can be effective in encouraging parents and older people to make their homes safer.

- Unsuitable housing: the provision of adaptations, as simple as grab rails, can reduce the risk of falls; initiatives to reduce under-occupation in social housing have the corollary of improving the supply of family housing and reducing overcrowding.

- Insecure housing: the fundamental issue is one of housing supply and cost, especially for vulnerable groups and families in high demand, high value areas. There are no easy answers to this dilemma but interventions can range from developing housing options and advice services to working with private landlords to improve the supply of more affordable homes.

The residential environment: impact on physical and mental health

This is a complex area involving consideration of:

1. The direct health effects of the quality of the residential environment, such as the incidence and fear of crime and anti-social behaviour, traffic, noise and air pollution.

2. The indirect health effects of the quality of the residential environment, such as access to services and facilities, including health provision, the appearance of the area and general satisfaction with living there. This is an area of specific relevance to gypsies and travellers.

The implications for intervention require consideration of improvements to existing areas and/or ‘designing in health’ through spatial and physical planning combining:

- Improvements in home and neighbourhood security and design: this can have a major impact on the incidence and fear of crime and reduce anxiety and stress.

- Improvements to neighbourhood safety: including traffic calming, speed restrictions, cycle routes and developing Home Zones reducing the incidence of traffic-related accidents.

- Improvements in accessibility: changes to promote healthier lifestyles including creating 'walkable' neighbourhoods and designing in such green infrastructure as open and play spaces, community gardens and allotments. Physical activity reduces the risk of heart disease and has a positive impact on mental health and well being and reducing obesity.

In summary, the greatest health impact is likely to be achieved when the following conditions are targeted:

- Cold and damp housing

- Overcrowded and under-occupied housing

- The incidence of accidents in the home

- Poor security and high crime, and

- Inadequate public and open space.

4. An introduction to the government's reforms in housing, health and social care

Proposed reforms for health, social care and housing share some common ground. In summary the proposed reforms are:

- Intended to support the government's localism[iv], Big Society[v] and personalisation agendas i.e., individuals and communities should be supported to become confident and capable of getting involved in shaping (and possibly delivering) services in their local area, of taking informed decisions about their own lives, and be able to hold other decision makers to account.

- Emphasising the need to identify and address discrimination and inequalities within local strategic planning and commissioning, as required by the Equality Act 2010[vi]

- Expected to contribute towards a sustainable and resilient economy, one that is 'rebalanced' across regions, public and private sectors. The public sector will not be 'default' service provider in the future.

- Planned to encourage a population-wide, preventative, approach (also referred to as a universal approach), whilst enabling inequalities and

disadvantage to be tackled[3] (the government's focus on 'early years' and child poverty is an example of consideration to both prevention and intervention).

- Reflective of the government's ultimate priority – to reduce the deficit in a 'fair and responsible way'.

The summary of reforms for each sector, presented in the next sections, reflect that health reform is more substantial and more developed than for housing. The health section focuses primarily on changes to the commissioning architecture; the housing section considers proposals and their potential impact on local areas, health and wellbeing in more detail. This highlights that even though the health sector is undergoing huge transformation, unless local authorities and their partners want to take a backward step in health outcomes, there are some serious and urgent conversations to be had locally about the impact of housing reform on health and wellbeing. Focussing on the challenges identified here should enable local areas to shape relationships, partnerships and commissioning arrangements based on a real understanding of the issues and how these can be addressed by working together. Form will follow function.

[3] Action should also address inequalities related to the protected characteristics within the Equality Act 2010

5. What the housing sector needs to know about the health sector

5.1 Ambitions for health

The government's ambitions are to reduce health inequalities and improve health outcomes, improving the "health of the poorest, fastest", and enabling people to have greater independence, choice and control throughout their lives.

These ambitions are not fundamentally different to the previous government's ambitions, but how they will be achieved is. Significant reform is proposed, and underway, in health and social care, with a completion date of April 2013. The housing sector needs to understand what will be different so it can support and engage with health, and begin to shape and manage the housing offer to improved health outcomes.

There are four main publications that describe health and social care ambitions and reform (*Healthy Lives, Healthy People, Equity and Excellence: Liberating the NHS*[vii]*, Vision for Adult Social Care: Capable Communities and Active Citizens*[viii], and *the Health and Social Care Bill*[ix]*).* Together these make it clear that the government expects approaches to health and wellbeing to be evidenced, and that individuals are expected to take greater personal responsibility for the choices they make about health (this is discussed further in Appendix One). Following the government's recent 'listening exercise' a number of changes have been made to proposals for reform, based on recommendations from the NHS Future Forum[x].

Healthy Lives, Healthy People will be of particular interest to the housing sector. Public health responsibility will return to local government, providing an opportunity for local areas to address determinants of health such as housing. The public health approach will focus on five stages in life, from starting well (focussing on pregnant women, infants and parenting) to ageing well (focussing on the ageing population, particularly mental and physical wellbeing) – this framework will be useful when identifying appropriate housing solutions to support improved health outcomes.

The government has also made more specific statements on health and wellbeing relating to:

- Outcomes for people with mental health problems (*No health without mental health*[xi]*):* the government wants to see mental and physical health treated equally and local authorities in their public health role will have responsibility for public mental health

- Child poverty: a new strategy aims to end child poverty by 2020, tackling the family and home environment, housing and health, amongst other things, to improve life chances (*A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives*[xii]*)*

- Supporting people to recover from drug and alcohol misuse (*The Drug Strategy 2010* [xiii]

- Ending violence against women and girls (*Call to End Violence Against Women and Girls Action Plan*[xiv])

- Special educational needs and disability (*Support and aspiration: A new approach to special educational needs and disability*[xv])

- The health of offenders, and particularly those with mental health problems, *(Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders*[xvi])

- A policy statement on Early Years (0 – 5 year olds) will be published later in the year, setting out the vision for reform. The Department for Education and Department of Health are working together to develop this.

Although this note does not go into the detail of these more specific statements, focussing instead on overall plans for reform, local areas will need to consider what housing and health will need to contribute to ambitions in each, and how integrated plans, policies and practice can enable this.

A more detailed review of how the ambitions for health are to be achieved is provided at Appendix One focusing on:

- *The commissioning architecture*: this is changing significantly and the housing sector should understand who the new partners are. Individuals will also become commissioners as there are plans to increase the use of personalised budgets/direct payments.

- *The evidence base for commissioning*: the duty to pay attention to the Joint Strategic Needs Assessment in local commissioning is being strengthened to inform all local plans. This should include local housing commissioning.

- *Making best use of resources*: despite a real term increase in health spending, significant savings are to be found and redistributed. Working with the housing sector might offer opportunities to achieve these for both sectors

- *Accountability*: the intention is for individuals and communities to be able to hold the new commissioning architecture to account in terms of outcomes and quality. The contribution housing makes to health and how this is held to account will need to be explored.

- *The market place and economy:* the government expects efficiencies and greater choice to be enabled by a more diverse provider market. The public sector will not be the default provider. Commissioners in health and

housing will want to explore how they can manage the market place so that quality is not affected and that outcomes are still achieved

- *Personal responsibility, choice and control:* the government expects individuals to take greater responsibility for the choices they make, based on information and advice. The proposed approach is being informed by behavioural insight and intelligence.

6. What the health and social care sector needs to know about the housing sector

6.1 Ambitions for housing

The government aims to 'meet peoples housing aspirations' (the previous government referred to 'housing needs') which, in more detail, means that 'up to' 150,000 new affordable homes should be built by 2015 (bringing empty homes back into use is expected to contribute to this), there will be continuous improvements in energy efficiency in new homes, there will be increased mobility amongst social housing tenants and fairness in the use of social housing (a reduction in homelessness and over-crowding is expected as part of this).

Ambitions and reforms are primarily described in *DCLG's business plan 2011-2015*[xvii], in *Local Decisions: A fairer future for social housing*[xviii], the *Localism Bill*[xix] and the *Energy Bill*[xx].

A review of how the ambitions for housing are to be achieved is provided at Appendix Two focusing on:

- *Joint and local commissioning:* in the absence of 'top down targets' for housing supply (these were provided by regional agencies that have been abolished) local government is expected to understand the issues and direct activity to address these. Strong local leadership and direction will be needed, informed by robust intelligence. Working with health colleagues could enable this more effectively

- *Welfare reform:* many households will find they have a lower income, requiring choices to be made about their housing circumstances. These choices may affect their health and wellbeing eg, if they have to move home, or if they choose to pay a higher rent but spend less money on food or heating

- *Housing supply:* there is much less public subsidy available for affordable homes so the model of new supply relies on charging higher rents and lending from the private sector. This will reduce the overall supply of social rents for people. It is unlikely there will be new supported housing developments in this model. Greater reliance on the private sector is expected. There are health implications from these changes

- *Housing conditions:* investment in decent homes in the council-owned housing sector has reduced, and the remaining funding has been backloaded to 20104/15. There is no government funding specifically for improvements in the private sector but local authorities can choose to invest if they have resources. This is impacting already on the waiting lists for disabled facilities grants.

- *Security of tenure and rent levels:* The government wants to see a fairer use of social and affordable housing, by enabling housing providers to use fixed term (flexible and non-secure) tenancies where appropriate locally. Insecurity is known to affect health and wellbeing

- *Housing support and homelessness services – prevention:* In response to overall reductions in local authority grant, authorities have taken decisions to reduce spending in these areas, particularly for households for whom local authorities have no statutory duty towards. This is despite significant evidence of savings to other partners eg, health.

APPENDIX ONE: How the ambitions for health will be achieved

Reforms are intended to change how services will be commissioned and delivered; local areas should consider how the housing sector can be integrated at both levels. This supports a recommendation from the Marmot review: planning, transport, housing, environmental and health systems should be fully integrated to address the social determinants of health in each locality.

Commissioning architecture

The Cabinet Office describes commissioning as 'the cycle of assessing the needs of people in an area, designing and then achieving appropriate outcomes'. Reforms are intended to ensure that the NHS, Public Health England and local authorities tackle health inequalities as a priority through commissioning.

Primary Care Trusts and Strategic Health Authorities are being abolished, with responsibilities for primary care and public health already being moved to other organisations. Existing health improvement and protection bodies such as the National Treatment Agency for Substance Misuse will become part of Public Health England.

Commissioning for primary care is proposed to be undertaken by clinical commissioning groups, working in partnership with the local authority and engaging patients and the public in the commissioning process. The government has recently strengthened the role of the local Health and Wellbeing Board's role in the clinical commissioning group; the Board should be involved throughout the process as clinical commissioning groups develop their commissioning plan. An independent NHS Commissioning Board will lead on health outcomes, allocate and account for NHS resources, lead on quality improvement and promote patient involvement and choice. The Commissioning Board will also have to take health and wellbeing boards' views into account in their annual assessment of commissioning groups.

Commissioning for public health will be undertaken by three organisations who will form an integrated national public health service; upper tier and unitary local authorities through Health and Wellbeing Boards (from April 2013 there will be a new public health duty requiring local authorities to take steps to improve the health of their population); Public Health England; the NHS Commissioning Board[1].

- Public Health England will combine experts from public health bodies such as the Health Protection Agency and the National Treatment Agency as part of the Department of Health, and will integrate leading expertise, advice and influence into one organisation. It will be accountable to the Secretary of State for Health, with a mission to achieve measurable improvements in public health outcomes, provide effective protection from public health threats and to 'inspire, challenge and commission' partners from all sectors

- Reform sees the return of public health responsibilities to local authorities, bringing with them a new imperative to put health at the heart of public services. Upper tier and unitary local authorities will employ a Director for Public Health (DPH). The DPH will play an integral role in promoting joint working, and advocating for the public's health, and will provide an annual report on the health of the local population.

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

Commissioning for adults and children's social care will remain the responsibility of the upper tier local authority. There is however a commitment from this sector to increase the use of personal budgets[1].

More individuals and communities are also expected to become commissioners, identifying services that best meet their needs and paying for these through personalised budgets/direct payments (social care), and person-centred planning (health. Personal budgets are also being piloted).

Strategic commissioning for the local area will be undertaken by a statutory Health and Wellbeing Board (in each upper tier local authority area). The Board will have a duty to promote integrated working between health and social care commissioners, as well as promoting joint working with commissioners of services that impact on wider health determinants (for example, housing or education). The Board will also have a duty to involve the public and users, particularly in developing the joint Health and Wellbeing Strategy which will be developed by each Board.

The evidence base for commissioning

All local commissioning, including clinical commissioning, is expected to be based on a robust evidence base. Using a shared evidence base should provide a good footing for the main commissioners to work together – including housing commissioners. The Joint Strategic Needs Assessment (JSNA), a statutory requirement since April 2008, is expected to have the main role in informing local commissioning; the health and wellbeing board will be responsible for leading enhanced JSNAs (guidance has recently been updated by Local Government Improvement and Development[1]).

National intelligence will be available, provided by, for example, Public Health England which it is expected will incorporate the functions undertaken by the Public Health Observatories. An information strategy is expected to elaborate on how information will be shared between the various agencies that patients and other users come into contact with eg, social care.

The evidence base is expected to provide the basis for dialogue with, and accountability to, citizens and communities. The JSNA process should enable people to express their views about the issues and what should be done to address these. Boards and commissioners will need to engage the public, through such forums as the local HealthWatch and with involvement from the voluntary and community sector who are likely to represent a wider range of needs.

Making best use of resources

Although there will be a small real-term spending increase in the health sector, there is still an expectation that considerable efficiencies will be found through reform and reorganisation (NHS management costs, for example, are expected to reduce by 45% over four years). These efficiencies are required to reinvest in other parts of the sector. The Quality Innovation Productivity and Prevention (QIPP) programme is seeking to achieve these.

Local authorities will have a ring fenced public health budget, currently estimated to be around £4bn. This is subject to further analysis of current spend on prevention activities, but a shadow budget is expected in 2012/13 based on relative population health need and weighted for inequalities. There are expected to be some conditions as to how this is used. In addition to a baseline allocation, authorities will also receive an incentive payment, or 'health premium', that will depend on the progress made in improving the health of the local population and reducing health inequalities, based on elements of the Public Health Outcomes Framework[1] (see later bullet point).

As part of local government, there are also some difficult decisions to be made about spending in social care, with some local areas increasing the Fair Access to Care Services eligibility criteria. More people will be expected to make a contribution towards, or pay for, their care.

Accountability

Three outcomes frameworks are proposed (NHS, public health and adult social care) to enable organisations to be held to account nationally and locally. These include a number of the same or complementary indicators where joint or integrated services are required. There are a number of housing specific or related indicators e.g., the public health framework proposes to measure fuel poverty, statutory homelessness and over-crowding. Involvement of children's services on the local health and wellbeing board reflects that the Every Child Matters outcomes framework must also be linked.

Quality standards will be developed by the National Institute for Health and Clinical Excellence (NICE)[1] which will set out the evidence-based characteristics of a high quality service for a particular clinical pathway or condition.

Initial proposals for accountability in public health have been consulted on and there are likely to be changes. Proposals consulted on included a role for Public Health England to publish national performance data against public health outcomes (these were also subject to consultation), for local authorities to be accountable to Public Health England. Local accountability arrangements for public health, and for the role of the Health and Wellbeing Board, are still emerging. Proposals for accountability in primary and social care suggest that:

- The role of the Care Quality Commission as an effective quality inspectorate across both health and social care will be strengthened

- HealthWatch England will be an independent consumer champion within the Care Quality Commission (CQC), supported by local HealthWatch[1] which will represent the views of patients, carers and the public to commissioners, provide local intelligence and help people get information about the choices they have

- An economic regulator, Monitor, will promote effective and efficient providers of health and care, competition, regulate prices and safeguard the continuity of services.

The market place and economy

The imminent *Open Public Services White Paper* (expected July 2011) is expected to provide clarity on reforms for health, social care and other public sector service areas. A number of consultations (referred to next) are expected to inform this.

Services are expected to offer more consumer choice, quality improvements and value for money as a result of increased competition, innovation and efficiency. Providers should have more freedom to deliver the services that communities and individuals need; the government has consulted on whether proportions of specific services should be delivered by non-state providers including voluntary groups.

There is an expectation that mutuals, co-operatives, charities and social enterprises (civil society organisations) will be created and expanded[1] to deliver services. Guidance for healthcare and social care staff on taking up the 'right to provide' services, for example, has been published[1], whilst the Localism Bill introduced the 'right to challenge' for community and voluntary sector organisations where they believe they could run services differently or better.

Attracting external investment and expertise into the public sector to deliver better and more efficient services will be important: innovative equity investment opportunities are to be proposed for some areas of public service.

Commissioners should consider the full social, environmental and economic value of services in their contracting i.e., it should be outcomes focussed.

Payment-by-results, personal and community budgets are expected to be used more widely to devolve purchasing decisions to the appropriate level, to integrate funding, and to enable outcomes-based accountability. The government is considering issues of demand and supply, the need to maintain continuity of service and manage risks, associated with these and other reforms.

Personal responsibility, choice and control

Information and advice provided at the right time, in the right place and in the right way, is the backbone of prevention. Plans for the provision feature in both the NHS and Public Health white papers:

- Public Health England will focus on national resilience against things like flu pandemics and other health threats, as well as being a 'knowledge bank' for the best and most up to date evidence on behaviour change techniques and monitoring data. Public health responsibility will be driven forward by the Secretary of State, working with industry, charities, and leading experts from the field. The intended outcome is to make it easier for people to make healthy choices. For example, through better food labelling, more information about alcohol harms, and much bigger contributions from industry around campaigns like Change4Life.

- NHS reforms aim to "give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health". An information strategy is expected in autumn 2011 but it's likely this will include more use of information on-line, alongside support from NHS Choices (a range of third parties) for people who do not access on-line health advice, or who would particularly benefit from more intensive support.

- The government is keen to apply behavioural insight to addressing health inequalities (also referred to as 'nudge theory'), drawing on insights from behavioural science and behavioural economics. It plans to take a less intrusive approach, staying out of people's everyday lives wherever possible. This follows a model called the Nuffield Council of Bioethics Ladder of Interventions, which means that instead of reaching for choice-limiting regulations at every opportunity, the government aims to employ a range of evidence based approaches to improve health.

  The ladder increases in intrusiveness as follows:

- **Do nothing** or simply monitor the situation. Some behaviour trends are minor and fizzle out, so intervention isn't needed.
- **Provide information**. Giving people the information and education to make a choice for themselves based on evidence.

- **Enable choice**. Give people a ‘nudge’ in the right direction so they can change their behaviour. For example, through access to public exercise facilities, cycle paths, or safe playgrounds.
- **Change the default** to help guide choice. Using positive ‘social norms’ is a way of encouraging this.
- **Guide choice through incentives**. A ‘points mean prizes’ approach, for example the more a child walks to school, they earn points for healthy prizes like an activity day.
- **Disincentives**, such as taxation or other price related action, to discourage people from smoking or drinking.
- **Restrict choice**, probably through regulation, such as raising the legal age for smoking or banning trans fats.
- **Eliminate choice altogether**. Rarely used, but most common examples include making seatbelts compulsory and making dangerous drugs illegal.

APPENDIX TWO: How the ambitions for housing will be achieved

Local and joint commissioning

Reforms to the housing sector are more piecemeal than for health; joining-up at a national level is less evident. The government expects local areas to manage the impact of change, but it's not yet clear what the impact will be.

In terms of the commissioning architecture, the biggest change in the housing sector has been the abolition of regional agencies. The Regional Assembly previously provided housing supply targets and plans that directed capital investment to new and existing homes. Local authorities, with their communities and partners, are now expected to establish local housing targets that reflect priorities and direct investment. This presents many challenges to local strategic planning as identified by the Commons Select Committee[xxi].

Unitary, metropolitan borough and district local authorities are already commissioners for housing activity[4]. In future it's clear that authorities will need to provide strong leadership and direction, and bring local partners together to achieve outcomes from housing activity. In some cases, for example in planning for new development, this will require considerable work with the local community to gain support to achieve outcomes. Capacity and capability to provide this role has been affected by reductions in local government spending.

Welfare reform

Welfare reform requires the housing sector to change how it plans for and accommodates households on a low income. People are likely to need to move home, but the sector cannot predict what action people will take, for example they may choose to pay for their home and struggle to afford other essentials. Reform proposals include reduced housing benefit for households who are under-occupying their home, for households between the age of 25 and 35 (they will need to share their accommodation) and for lone parents.

A proposal to pay housing benefit (which will be part of the proposed universal credit) direct to tenants (direct payment) is also threatening the security of rental income for housing providers. Housing providers will need to review their business plans and their approach to managing risk. Housing providers contribute far more to local areas than just housing management services, for example supporting community projects which reduce isolation, encourage participation and contribute to mental health and wellbeing. These 'non-core' services are at risk (see also housing supply later).

Housing supply

[4] With the exception of housing support – in two tier areas this is the County Council's commissioning responsibility.

On the basis that housing supply has a role in meeting people's needs and aspirations and in the wider economy, the government's expectations in this area are the furthest developed.

The existing planning framework is being overhauled, with new planning objectives expected by the end of 2011. The proposed National Planning Framework is intended to support economic development, as outlined clearly in the recent budget[xxii]. By consolidating existing policy, circulars and guidance the intention is to make the system much simpler, removing bureaucracy for those who want to develop (new sustainable development principles will be the test for permissions where a local plan is not in place), and enabling local communities to get involved in decisions about where homes are built. There will also be a new Duty to Cooperate on councils to work together to address planning issues that impact beyond local boundaries such as transport, housing or infrastructure. However, proposals for neighbourhood plans (a new tier of local planning) will present a challenge to authorities seeking to take an overall strategic view; community groups will be able to draw up proposals for a neighbourhood plan.

There will be incentives for communities and individuals to support new development, or even build homes, for example councils that approve developments are eligible for payments equal to the council tax revenue generated from the homes for six years after they are completed (for affordable units there is an additional payment of £350 a year) (the New Homes Bonus[xxiii]), whilst the Community Infrastructure Levy is proposed to enable community amenities.

In addition to changes in planning, revisions will be made to existing design standards and building regulations to make it easier for homes to be developed. A recent change is that developers are no longer required to build homes to meet the Sustainable Code for Homes to level 6 – level 3 is the minimum.

Public subsidy for affordable homes has been much reduced to £4.5bn for the period 2011 - 2015, of which £2.3bn has already been committed. What remains is being used in a different way:

- Developers, including registered providers (mainly housing associations) were asked to submit proposals to enter into a 4 year framework agreement by 3 May 2011[xxiv].

- Proposals were expected to identify how other resources can be used to fund new homes, with public subsidy very much the last resort. Other resources are expected to include an organisation's reserves, assets (and those provided by other partners e.g., the local authority), the New Homes Bonus, planning contributions (also referred to as Section 106 monies) and the Community Infrastructure Levy. Housing providers may have to choose between new development and the provision of other, non-core, services (referred to earlier)

- Significantly, proposals are also expected to include funding generated from increasing the rent of new homes, and a proportion of existing homes, to a new affordable rent level - up to 80% of market rent. In some areas this is much higher than current social housing rent

- There is an element of 'payment-by-results': grant will be payable on completion of the scheme

Developers are being provided with opportunities to 'build now, pay later'[xxv]: a scheme in Telford is one of six nationwide where the developer will build and then pay for the land. This is intended to kick-start the construction industry. This is alongside a budget announcement for 'First Buy'[xxvi], a scheme to enable first time buyers to purchase new-build homes.

The private rented sector is expected to play a much greater role in meeting people's needs and aspirations. The sector has grown considerably as first time homebuyers are unable to access mortgage finance. As new supply and access to affordable accommodation is not expected to grow to meet demand, this growth is expected to continue. There is a danger (see next paragraph) that this sector will not offer good quality homes.

Housing conditions

Investment in decent homes in the social rented sector has reduced, with available funding back-loaded towards 2015[xxvii]. In the West Midlands five local authorities with council owned homes bid for funding – only two were successful. There is a funding gap to improve housing conditions.

Local authorities with housing stock will, from 2012, be 'self-financing' i.e., they will be able to use rental income to improve their housing stock. This is different to the current subsidy system; the change means that local authorities with housing stock will take on a new and very considerable debt. Rental income has to pay for this as a priority, followed by improvements in stock to maintain rental income. A debt 'cap' will limit the capacity of the local authority to invest significantly in improvements or new supply.

Funding to improve and replace poor quality homes in the private sector has ceased, impacting on large scale market renewal and smaller interventions provided by local authorities:

- This is significant for the areas previously covered by the two housing market renewal pathfinders in the West Midlands: Urban Living covering Birmingham and Sandwell, and RENEW North Staffordshire covering Stoke, East Newcastle-under-Lyme and East Biddulph.

- Many local authorities 'topped up' government funding for adaptations; their capacity to do this has been significantly reduced. The disabled facilities grant payable to local authorities is also not ring-fenced. Waiting lists are already reported to be rising.

Local authorities are expected to improve the quality of homes in the private sector using existing regulatory powers, although some of these have been changed, for example the Empty Dwelling Management Order can be used now only for homes empty for more than two years that are a blight on the neighbourhood. Local authorities are expected to encourage landlords to join voluntary accreditation schemes.

Achieving carbon reduction targets and improving energy efficiency is one route through which improvements are expected to be made to existing homes. The Energy Bill proposes a Green Deal, where improvements will be made 'upfront' by energy suppliers and paid for through bills. Energy companies will be obliged to target vulnerable households and 'hard to treat' homes, whilst private landlords are expected to allow improvements. The current 'Warm Front'[xxviii] grant will cease to exist from 2012/13 (it is currently closed to new applicants as demand outstripped funding).

Finally, there is an expectation that citizens and customers of housing management services will play a greater role in holding organisations to account for the quality of their homes and housing services. In the social (and affordable rent) sector, tenants are expected to provide a scrutiny role. External regulation by the Tenant Services Authority[5] has been reduced to focus on economic viability. This suggests that local government will want to take a greater interest, with tenants, in the performance of housing providers in their local area.

Security of tenure

The government wants to see a fairer use of social and affordable housing, by enabling housing providers to use fixed term (flexible and non-secure) tenancies where appropriate locally. The term for the tenancy has to be a minimum of two years but providers can use their discretion above this. The sector is generally supportive of a five-year tenancy, in recognition of the role that affordable housing plays in the lives of vulnerable and low income households who need security in order to get their lives on track.

At the end of the tenancy providers are expected to provide information and advice to tenants to enable them to move from these tenancies if they are deemed no longer to be in need of the home e.g., if their household income has increased. Local authorities are expected to develop a tenancy strategy (a statutory requirement, to be legislated for through the Localism Bill, for publication in 2012/13), whilst providers should develop a tenancy policy that makes it clear when and why certain tenancies will be granted and ended.

Local authorities will be able to discharge their statutory homelessness duty by accommodating a household in this sector (tenancies will be for 12 months instead of the typical 6 month assured short-hold tenancy). However, there is

[5] The regulatory role is moving to a committee within the Homes and Communities Agency and the Tenant Services Authority will seek to exist.

increased competition for this sector (see earlier section on supply and quality of homes).

Mobility amongst existing social tenants is expected to increase by removing perceived barriers such as competition with households in priority housing need (existing tenants are currently allocated homes under a local allocations policy which applies to all households in need). Housing providers should also enable mobility by signing up to a relevant scheme.

Housing support and homelessness services - prevention

Housing support (Supporting People), homelessness funding and disabled facilities grants are now payable to local authorities as part of the formula grant. They were previously ring-fenced and named budgets. Despite the government indicating that the level of grant for these activities had reduced slightly (approximately 11% reduction for Supporting People) or not at all (homelessness funding), the housing sector considers that the reality is very different. Supporting People reductions in some areas are much greater than 11% (up to 50%). Local authorities have, in attempt to balance books, taken decisions to reduce spending in these areas, particularly for households for whom local authorities have no statutory duty towards. Services are expected to reduce for the most vulnerable with increased homelessness and reduced tenancy sustainability predicted. Households who are likely to have additional health needs that impact on their housing needs and aspirations will be affected including older people, people with physical, sensory and learning disabilities, people with mental health problems, young people and families at risk of homelessness, Gypsies and Travellers will be amongst those who will be affected.

The main aim of the Supporting People programme was to help end social exclusion by preventing crisis and more costly service intervention and enabling vulnerable people to live independently both in their own home and within their community through the provision of vital housing-related support services. The biggest single source of Government revenue funding for the voluntary and community sector (last year estimated to be over £1 billion per year), there is evidence of the financial benefits of the programme[xxix]. A 2009 Select Committee Inquiry [xxx]also recommended that local areas should retain a joint commissioning approach (the programme was commissioned by health, social care, Probation and housing commissioners), amongst other things.

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